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## Federal Findings and Questioned Costs

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**2015-003    The Department of Social and Health Services improperly charged \$5.6 million to multiple federal grants.**

<b>Federal Awarding Agencies:</b>	U.S. Department of Agriculture U.S. Department of Health and Human Services U.S. Social Security Administration (SSA)
<b>Pass-Through Entity:</b>	None
<b>CFDA Numbers and Titles:</b>	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 93.566    Refugee and Entrant Assistance – State-Administered Programs 96.001    Social Security - Disability Insurance (DI) 96.006    Supplemental Security Income (SSI)
<b>Federal Award Numbers:</b>	15147WAWA4Q2519, 15147WAWA4Q2520, 15157WAWA4Q7503,1502WATANF, 1501WARCMA, 1501WARSOC, 15-0404WADI00, 15147WAWA4Q2514,
<b>Applicable Compliance Component:</b>	Period of Availability
<b>Questioned Cost Amount:</b>	\$5,610,700

### Background

The Department of Social and Health Services administers multiple federal grant programs and spent approximately \$4.8 billion in federal grant funds during fiscal year 2015. 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 period during which program costs may be obligated. Payments for costs obligated prior to the beginning date of a grant are not allowed without prior approval by the grantor.

In our fiscal year 2014 audit we reported a finding that the Department improperly charged \$54,377 to the Refugee and Entrant Assistance program prior to the start of the grant. This was reported as finding number 2014-022.

### Description of Condition

Most of the Department's federal grant awards have a fiscal year 2015 grant period that began on October 1, 2014. We found four programs obligated expenditures in September 2014, but the costs were charged to the fiscal year 2015 grants. The grant programs and amounts improperly charged were:

- Temporary Assistance for Needy Families, \$2,833,046
- Supplemental Nutrition Assistance Program Cluster, \$2,688,151
- Disability Insurance/SSI Cluster, \$58,628
- Refugee and Entrant Assistance, \$30,875

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

### **Cause of Condition**

In prior years the Department's understanding was an obligation was not incurred until payment for service is made. The Department believed it was allowable to charge these costs to the new grants, even though they occurred prior to the grant start date. While the Department was made aware of this issue during the prior audit, the costs had already been charged for the current audit period.

### **Effect of Condition**

We are questioning improperly charged grant expenditures of \$5,610,700 made prior to the start of the four grant's periods of availability.

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

### **Recommendation**

We recommend the Department only charge expenditures to federal grants if they are obligated during the period of availability. The Department should consult with the grantors to determine what, if any, of the questioned costs should be repaid.

### **Agency's Response**

*The Department concurs with this finding.*

*The Department's Economic Services Administration, Division of Finance and Financial Recovery will establish, sponsor and lead a cross-agency committee comprised of ESA, Financial Services Administration, Health Care Authority, Office of Financial Management and Washington Technology Solutions staff. This committee will review the processes involved and recommend implementation of changes to the existing Cost Allocation System (CAS) methodology. These changes will ensure that federal grant-related accruals are accounted for in the appropriate period of performance (grant year).*

*As an immediate fix to rectify the existing issue (including questioned costs), ESA will utilize a manual process (journal vouchers) to ensure full compliance until the revised CAS methodology is implemented.*

*The committee will also work with the appropriate Federal agencies to discuss changing and/or updating the compliance supplement to better align with the State's business practices for cash draws and reporting of the federal grants. We will continue discussions with our Federal partners*

*regarding what, if any, of the questioned costs should be repaid and acceptance of our prospective corrections.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2015, Part 3 – Compliance Requirements, states in part:

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

#### **Compliance Requirements**

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

**2015-004 The Office of Superintendent of Public Instruction did not have adequate internal controls over and did not comply with federal reporting requirements for the Child and Adult Care Food Program.**

**Federal Awarding Agency:** U.S. Department of Agriculture  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 10.558 Child and Adult Care Food Program  
**Federal Award Number:** 14137WAWA4N1050, 14147WAWA4N1050, 15147WAWA4N1050, 15157WAWA4N1050, 14137WAWA3N1099, 14137WAWA3N2020, 14147WAWA3N1099, 14147WAWA3N2020, 15147WAWA3N1099, 15147WAWA3N2020, 15157WAWA3N1099, 15157WAWA3N2020  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

## **Background**

The Office of Superintendent of Public Instruction administers the Child and Adult Care Food Program (CACFP). This program provides aid to child and adult care institutions and day care homes for the provision of nutritious foods that contribute to the wellness, healthy growth, and development of young children, and the health and wellness of older adults and chronically impaired disabled persons. The child and adult care institutions and day care homes are considered subrecipients of the Office.

The program is required to submit the Report of the Child and Adult Care Food Program (FNS-44) monthly to the federal grantor. These reports present data on the claims for reimbursements from the Office's subrecipients detailing the number of meals served during the report month.

The program also submits the Financial Status Report (FNS-777) quarterly, which captures the state agency's spending levels of Federal funds for the CACFP. The federal grantor uses the data captured by this report to monitor state agencies' program costs and cash draws.

In fiscal year 2015, the Office spent approximately \$48 million in federal funds on the program.

## **Description of Condition**

The Office did not have adequate internal controls to ensure the FNS-44 reports were submitted with correct data. We found for 16 of 24 required reports there was no supporting documentation to support the number of homes and number of meals that were reported. Additionally, previous year's data was used in some instances to populate some of the reports.

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

## **Cause of Condition**

The Office implemented a new online claim system for program application, claims and reporting in October 2014. The new system could not create supporting documents to substantiate critical line items on the FNS-44 reports and also generated incorrect numbers on the reports. Management was

aware the system was generating incorrect numbers and submitted the reports using data from the previous year.

### **Effect of Condition**

We could not verify the accuracy and completeness of the data submitted on 16 of the FNS-44 reports due to lack of supporting documentation. Also, six of eight FNS-777 reports were also affected by the condition as one of the inputs used to calculate a line item on the FNS-777 report is obtained from the FNS-44 report.

By submitting the required reports with data that was known to be incorrect, the Office was not in compliance with grant requirements. Grant conditions allow the grantor to penalize the Office for noncompliance, suspending or terminating the award and withholding future awards.

### **Recommendation**

We recommend the Office revise its procedures to ensure reports are completed accurately and supported by adequate documentation.

### **Agency's Response**

*During the implementation of the new application and claiming system, Washington Integrated Nutrition System (WINS), there were issues with the system data query developed for the FNS-44 reports. OSPI has worked closely with the WINS contracted developer to ensure the system data queries are now complete and accurate.*

*OSPI will print and maintain all WINS generated FNS-44 reports as well as the detailed backup documentation.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement 2015*, Part 4 – Compliance Requirement states in part:

L. Reporting

3. Special Reporting

a. *State Agency Special Reporting*

FNS-44, *Report of the Child and Adult Care Food Program (OMB No. 0584-0594)* – To receive CACFP funds, a State agency administering the program compiles the data gathered on its subrecipients' claims for reimbursement into monthly reports to its FNS regional office. Such reports present the number of meals served, by category and type, in institutions under the State agency's oversight during the report month.

An initial monthly report, which may contain estimated participation figures, is due 30 days after the close of the report month. A final report containing only actual participation data is due 90 days after the close of the report month. A final closeout report is also required, in accordance with the FNS closeout schedule. Revisions to the data presented in a 90-day report must be submitted by the last day of the quarter in which they are identified. However, the State agency must immediately submit an amended report if, at any time following the submission of the 90 day report, identified changes to the data cause the State agency's level of funding to change by more than (plus or minus) 0.5 percent.

*Key Line Items* – The following line items contain critical information:

(1) *Part A – No. Homes*

- (a) Line 6 – *No. of sponsoring organizations of day care homes administering between (ranges for numbers of homes given in columns)*
- (b) Line 7 – *No. of homes for which sponsors are eligible to receive reimbursement based on rate for (ranges for numbers of homes given in columns)*

(2) *Part E*

- (a) Lines 22 through 30 – *Breakfasts*
- (b) Lines 31 through 39 – *Lunches*
- (c) Lines 40 through 48 – *Suppers*
- (d) Lines 49 through 57 – *Snacks*
- (e) Lines 58 through 60 – *Total Free, Reduced Price, and Paid Meals Served (Respectively)*

**2015-005    The Department of Commerce did not have adequate internal controls to ensure HOME Investment Partnerships Program income was used before requesting federal cash draws.**

**Federal Awarding Agency:** U.S. Department of Housing and Urban Development  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 14.239 HOME Investment Partnerships Program  
**Federal Award Number:** M12-SG53-0100, M13-SG53-0100, M14-SG-53-0100  
**Applicable Compliance Component:** Program Income and Cash Management  
**Questioned Cost Amount:** None

**Background**

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

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

In fiscal year 2015, the Department requested approximately \$5 million of HOME funds. The program generated approximately \$928,438 in program income.

During our fiscal year 2012, 2013 and 2014 audits we determined the Department’s HOME program did not have adequate internal controls to ensure that program income was used prior to drawing federal funds. This was reported as finding numbers 12-08, 2013-004 and 2014-005.

As part of our fiscal year 2015 audit, we reviewed the Department’s finding and corrective action plan to determine the status of the prior audit finding. The Department established new procedures that require the Accounting Office to identify the balance in the HOME program income account at least twice a month prior to drawing federal funds and maintain a register showing the deposits made to the HOME program income account. Additionally, approval is required for the federal draw, program income payment, and program income account bank reconciliation. The desk manual for HOME program income and federal draws was updated to reflect the new procedures. The completion date of the corrective action was listed as June 2015.

**Description of Condition**

We found the Department’s internal controls were still not adequate to ensure all HOME program income was used before requesting additional federal HOME funds. We commend the Department



for taking steps to reduce the program income account balance. However, it did not fully implement its corrective action plan during fiscal year 2015.

Specifically, we found program income was not drawn prior to requesting federal funds. In order to determine the effectiveness of the steps the Department took we examined the months of April, May and June 2015. Federal draws made during the months tested totaled \$1,227,561. While the Department did use some of their program income, drawing approximately \$119,061 during the months tested, it did not draw program income to zero at any time prior to drawing additional federal funds.

Additionally, the program income account balance was \$18,100 in early April, but had risen to \$292,232 by the end of the audit period. The average program income account balance at the time of making a federal draw during these three months was approximately \$85,000.

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

### **Cause of Condition**

The program income account is reconciled monthly by fiscal staff and reports are forwarded to program staff. Program staff update the records and determine whether to use program income or federal funds for payments that need to be issued. The process is not effective to ensure records are updated timely so program income funds are drawn when required. Additionally, management did not establish sufficient oversight to ensure compliance with federal requirements.

### **Effect of Condition**

The Department received excess federal funds of approximately \$216,000 during the months we examined. Without an adequate process to ensure that all available program income receipts are drawn prior to drawing federal funds, the Department is not in compliance with federal requirements.

The Department could be required to submit interest earned on this money to the federal government, if the interest earnings exceeded \$100.

### **Recommendation**

We recommend the Department:

- Draw all available program income receipts prior to drawing federal funds.
- Follow policies and procedures necessary to disburse HOME program income before requesting additional federal cash draws.
- Consult with its grantor and the state Office of Financial Management to determine if any interest earnings are owed to the federal government.

### **Agency's Response**

*The Department concurs with the finding. The Department is currently conducting a Lean process improvement event documenting the current process, including functions in both the accounting and program areas. The process improvement team is identifying and documenting barriers, and proposing a new process to eliminate those inefficiencies. The new process will include a number of improvements designed to increase efficiency and internal controls.*

*The Department will continue to:*

- *Maintain a “check” register showing the deposits made to the HOME Program Income account.*
- *Identify the balance in the HOME Program Income account at a minimum of twice a month.*
- *Require the approval of the Federal Draw and the HOME Program Income payment be completed by the supervisor that oversees banking authorizations.*
- *Require the approval of the HOME Program Income account bank reconciliation to be conducted by the Accounting Manager*

*The Department will:*

- *Implement additional process improvements as identified by the process improvement team.*
- *Update the desk manual for HOME program income and federal draws to include the process identified above.*
- *Identify, document, and communicate roles and responsibilities.*
- *Update policies and procedures and ensure it is communicated to all necessary staff.*
- *Provide training on the updated policies and procedures to all necessary staff both initially and ongoing.*

*In addition, the Department will consult with the federal grantor to determine if any interest earning are owed to the federal government and respond accordingly.*

### **Auditor’s Concluding Remarks**

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

### **Applicable Laws and Regulations**

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

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

(c) Disbursement of HOME funds.

- (1) After complete project set-up information is entered into the disbursement and information system, HOME funds for the project may be drawn down from the United States Treasury account by the participating jurisdiction by electronic funds transfer. The funds will be deposited in the local account of the HOME Investment Trust Fund of the participating jurisdiction within 48 to 72 hours of the disbursement request. Any drawdown of HOME funds from the United States Treasury account is conditioned upon the provision of satisfactory information by the participating jurisdiction about the project or tenant-based rental assistance and compliance with other procedures, as specified by HUD.
- (2) HOME funds drawn from the United States Treasury account must be expended for eligible costs within 15 days. Any interest earned within the 15 day period may be retained by the participating jurisdiction as HOME funds. Any funds that are drawn down and not expended for eligible costs within 15 days of the disbursement must be returned to HUD for deposit in the participating jurisdiction's United States Treasury account of the HOME Investment Trust Fund. Interest earned after 15 days belongs to the United States and must be remitted promptly, but at least quarterly, to HUD, except that a local participating jurisdiction may retain interest amounts up to \$100 per year for administrative expenses and States are subject to the Intergovernmental Cooperation Act (31 U.S.C. 6501 et seq.).
- (3) HOME funds in the local account of the HOME Investment Trust Fund must be disbursed before requests are made for HOME funds in the United States Treasury account.

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

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

**2015-006 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 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-25237-14-55-A-53  
UI-26568-15-55-A-53  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** None

## **Background**

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

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

- Have worked enough 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 amount of job searches each week.

Claimants are required to keep a weekly job search log that documents what jobs they applied for 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. When Department staff determine logs do not comply with state and federal requirements, it requires the claimant to come in for an in-person meeting. When logs are found to be incomplete, unallowable or are not submitted, a second unit, which has the authority to require the claimant to repay benefits, will review the claimant's logs.

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 activities. Department staff perform this verification by contacting employers listed on the job search log to verify the claimant did in fact apply with their company.

In fiscal year 2015, the Department paid approximately \$1.1 billion in grant funds, 92 percent of which was paid for benefits to workers.

## **Description of Condition**

The Department did not have adequate internal controls in place to ensure the weekly job search review process was followed, adequate documentation was retained and the minimum number of work search verifications were performed.

In fiscal year 2015 approximately 20,000 job search log requests were sent to claimants. The Department was unable to support how reviews and work search verifications were monitored to ensure they met state and federal requirements.

We randomly selected and examined 45 job search log reviews and found:

- Three were missing job search logs.
- Adequate attempts to contact one claimant to receive their logs were not made.

We randomly selected and examined 22 work search verifications and found:

- Nine did not have adequate documentation to determine if the reviewer made a proper assessment.
- Three of the nine verifications should have been forwarded for further review because the employer stated the claimant did not contact them.

We also found the Department only completed 462 of the 2,078 work search verifications required by its own policy.

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

## **Cause of Condition**

Department staff did not follow policies and procedures to ensure the correct number of work search verifications were being reviewed. The Department lacked adequate written policies and procedures to ensure weekly in-person reviews and work search verifications were being completed. Management did not sufficiently monitor or review the work of Department staff to verify state and federal requirements were met.

## **Effect of Condition**

By not monitoring the weekly in-person reviews and work searches, the Department failed to:

- Review the required 10 percent of work search verifications.
- Identify claimants that were potentially overpaid.

The Department is at a higher risk of providing benefits to ineligible claimants. The federal grantor could take action that would have an adverse effect to the state.

## **Recommendation**

We recommend the Department revise its written policies and procedures to ensure in-person reviews and work search verifications are being performed, completed and properly documented.

We also recommend management monitor the job search review process to ensure accuracy and completeness.

### **Agency's Response**

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

- *Develop new policies and procedures to improve Work Search Verification and Job Search Review processes.*
- *Create new internal control procedures that will be reviewed and monitored by management on an ongoing basis.*
- *Initiate separation of duties and increased managerial oversight to ensure program compliance.*
- *Develop new procedures to meet the program documentation retention requirements.*
- *Develop new policies and procedures to ensure the minimum number of verifications are completed by the Department.*
- *Implement a new monitoring process to ensure the Work Search Verifications and Job Search Reviews are performed timely, accurately and properly.*

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

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

### **Applicable Laws and Regulations**

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

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

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

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

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

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

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

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



RCW 50.20.240 Job search monitoring, states in part:

- (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.

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

**Policy**

Job Search Review – Ten percent of the claimants selected for the JSR interview are also selected for verification of their job search activities.

**2015-007 The Employment Security Department paid Trade Readjustment Allowance program benefits to participants who were not eligible to receive them.**

**Federal Awarding Agency:** U.S. Department of Labor  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 17.225 Unemployment Insurance  
**Federal Award Number:** UI-25237-14-55-A-53  
UI-26568-15-55-A-53  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** \$5,530  
**Likely Questioned Cost Amount:** \$60,830

### **Background**

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

The Unemployment Insurance program may provide additional benefits under several other programs including Trade Readjustment Allowance (TRA). TRA provides additional weeks of unemployment benefits so eligible participants can train for careers in high-demand fields. Eligibility requirements for TRA include being enrolled in training prior to a specific deadline, or receiving a waiver exempting a participant from this requirement.

In fiscal year 2015, the Department spent approximately \$1.1 billion in program funds, 92 percent of which was paid for benefits to workers. Approximately \$11 million were TRA program funds.

### **Description of Condition**

We examined \$219,748 in payments to 22 TRA participants who received their first payment during fiscal year 2015. We reviewed each payment to determine whether:

- Participants signed up for an approved training program or received a training waiver on or before their training deadline.
- When a participant did not sign up for training before the deadline, or their training plan was revoked, benefit payments were stopped.

We found one participant was paid \$660 after the training deadline had passed and no waiver had been approved. We also found two participants were paid \$4,870 after a training waiver had been revoked.

### **Cause of Condition**

The Department did not have written policies and procedures in place to ensure only eligible participants receive benefits. Additionally, management did not sufficiently monitor or review the work of Department staff to ensure participants were determined to be eligible prior to issuing payments and did not establish segregation of duties. The Department stated insufficient staffing was the primary reason for the lack of a secondary review.

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

The Department issued payments to ineligible participants because eligibility determinations were not processed and monitored appropriately. Because a statistical sampling method was used to select the payments we examined, we estimate the amount of likely questioned costs to be \$60,830.

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 payments.

## **Recommendation**

We recommend the Department establish and follow written policies and procedures, including appropriate supervisory review procedures, sufficient to ensure that participants are eligible prior to issuing TRA benefit payments.

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

## **Agency's Response**

*The following actions will be taken to improve the program and to ensure that only eligible participants receive services and benefits:*

- *UI Policy unit will review current TRA policies, procedures and internal controls to ensure TRA staff are operating the program correctly.*
- *Department will implement a new process to ensure that only eligible participants receive the benefits.*
- *Department will increase managerial oversight to ensure program compliance.*
- *The department will create and implement internal control procedures that will be reviewed and monitored by management on an ongoing basis.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

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

- ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

Subpart B – Trade Readjustment Allowances (TRA)

Section 617.11– Qualifying requirements for TRA

- (2) (vii) Participant in training. (A) The individual must –
  - (1) Be enrolled in or participating in a training program approved pursuant to § 617.22(a), or
  - (2) Have completed a training program approved under § 617.22(a), after a total or partial separation from adversely affected employment within the certification period of a certification issued under the Act, or
  - (3) Have received from the State agency a written statement under § 617.19 waiving the participation in training requirement for the individual.

**2015-008 The Employment Security Department made unsupported payments to Trade Readjustment Allowance program participants.**

**Federal Awarding Agency:** U.S. Department of Labor  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 17.225 Unemployment Insurance  
**Federal Award Number:** UI-25237-14-55-A-53  
UI-26568-15-55-A-53  
**Applicable Compliance Component:** Activities Allowed or Unallowed,  
Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$4,772  
**Likely Questioned Cost Amount:** \$1,539,738

### **Background**

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

The Unemployment Insurance program may provide additional benefits under several other programs including Trade Readjustment Allowance (TRA). Trade Readjustment Allowances are income support payments to participants who have exhausted Unemployment Compensation and whose jobs were affected by foreign imports as determined by the Department of Labor.

Once determined eligible, a claimant must submit a weekly claim form to the Department to receive TRA benefit payments. Department staff will review the form to ensure that the payment is allowable.

In fiscal year 2015, Employment Security spent approximately \$1.1 billion in program funds, 92 percent of which was paid for benefits to workers. Approximately \$11 million of these program funds were TRA program funds.

### **Description of Condition**

We examined \$30,611 in payments made to 59 TRA participants who received benefit payments during fiscal year 2015. We reviewed each payment to determine if the Department received the weekly TRA benefit claim form prior to making payments.

The Department could not provide the weekly TRA benefit claim forms for nine payments totaling \$4,722. Without the proper support, we could not verify whether these payments were accurate or allowable.

### **Cause of Condition**

The Department did not have written policies and procedures in place to ensure supporting documentation was retained in accordance with state law. Additionally, management did not sufficiently monitor or review the work of Department staff to ensure the payments were accurate, allowable and adequately supported.

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

The Department risks making unallowable payments with federal funds when adequate support is not retained and claims are not reviewed. The Department paid \$4,722 to participants that was either unallowable or unsupported. Because a statistical sampling method was used to select the payments examined, we estimate the amount of likely questioned costs to be \$1,539,738.

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 payments.

## **Recommendation**

We recommend the Department establish and follow written policies and procedures, including appropriate supervisory review procedures, sufficient to ensure that payments are supported prior to issuing payment and that supporting documentation is retained in accordance with state and federal laws and regulations.

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

## **Agency's Response**

*The Employment Security Department appreciates the feedback received from the State Auditor's Office and agrees with their recommendations.*

*The following actions have already been taken to improve the program and to ensure that only eligible participants receive services and benefits:*

- *A process for document retention has been implemented. All supporting payment documentation will be scanned and documented to meet the Federal and State's record retention guidelines.*
- *UI and WCDD Divisions are working on a plan to locate TRA functions to increase accuracy and efficiency.*

*The following actions will be taken to improve the program and to ensure that transportation payments to participants are accurate and allowable:*

- *The UI Division will be implementing TRA payments in the new unemployment payment system which is expected to be executed in October 2016.*
- *The department will create internal control procedures that will be reviewed and monitored by UI Policy and WCDD Management on an ongoing basis.*
- *Policies and procedures will be reviewed and updated to ensure TRA staff are operating the program correctly.*

## **Auditor's Concluding Remarks**

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A – General Principles for Determining Allowable Costs; Section C – Basic Guidelines states in part:

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

## Revised Code of Washington (RCW)

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

- (1) Any destruction of official public records shall be pursuant to a schedule approved under RCW 40.14.050. Official public records shall not be destroyed unless:
  - (a) Except as provided under RCW 40.14.070(2)(b), the records are six or more years old; or
  - (c) The originals of official public records less than six years old have been copied or reproduced by any photographic or other process approved by the state archivist which accurately reproduces or forms a durable medium for so reproducing the original.

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

### 3.4 GRANTS MANAGEMENT

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

## DESCRIPTION OF RECORDS

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

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

### Retention and Disposition Action

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

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

#### Subpart B – Trade Readjustment Allowances (TRA)

##### Section 617.12 – Evidence of Qualification

- (a) State agency action. When an individual applies for TRA, the State agency having jurisdiction under §617.50(a) shall obtain information necessary to establish:
  - (1) Whether the individual meets the qualifying requirements in §617.11;
  - (2) The individual's average weekly wage; and
  - (3) For an individual claiming to be partially separated, the average weekly hours and average weekly wage in adversely affected employment.
- (b) Insufficient data. If information specifically in paragraph (a) of this section is not available from State agency records or from any employer, the State agency shall require the individual to submit a signed statement setting forth such information as may be required for the State agency to make the determinations required by paragraph (a) of this section.
- (c) Verification. A statement made under paragraph (b) of this section shall be certified by the individual to be true to the best of the individual's knowledge and belief and shall be supported by evidence such as Forms W-2, paycheck stubs, union records, income tax returns, or statements of fellow workers, and shall be verified by the employer.

##### Section 617.19 – Requirement for participation in training.

- (a) In general-(1) Basic requirement.
  - (i) All individuals otherwise entitled to basic TRA, for all weeks beginning on and after November 21, 1988, must either be enrolled in or participating in a training program approved under §617.22(a), or have completed a training program approved under §617.22(a), as provided in §617.11(a)(2)(vii), in order to be entitled to basic TRA payments for any such week.



**2015-009 The Employment Security Department did not have adequate internal controls to ensure only eligible participants of the Trade Adjustment Assistance program received benefits.**

**Federal Awarding Agency:** U.S. Department of Labor  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 17.245 Trade Adjustment Assistance  
**Federal Award Number:** TA-22690-12-55-A-53  
 TA-24376-13-55-A-53  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** None

**Background**

The Employment Security Department (Department) administers the Trade Adjustment Assistance grant to assist eligible workers who are unemployed because of international trade. The United States Department of Labor certifies companies where foreign trade was a cause of the worker’s job loss or threat of job loss. Once a company is certified, the Department is responsible for determining what training and education benefits each employee is eligible for, how long they are eligible to receive the benefits and how much they are allowed to receive.

To be determined eligible to receive benefits an employee must meet specific requirements. Applicants can submit a request for determination form to be considered for participation. These forms are sent to Department headquarters where an employee reviews them, makes a determination as to whether the applicant is eligible and enters the information into the participant management system. Once a participant is determined to be eligible to receive Trade Adjustment Assistance they can apply to receive benefits. Individual work source counselors rely on the initial information entered at headquarters to determine what benefits applicants can receive and for how long.

The Department spent approximately \$7.9 million in federal program funds in fiscal year 2015 with approximately \$5.3 million paid for client benefits.

For the fiscal year 2014 audit period we reported the Department did not have adequate internal controls in place to ensure only eligible participants of the Trade Adjustment Assistance program receive benefits. The prior finding number was 2014-009.

**Description of Condition**

The Department did not have adequate internal controls to ensure only eligible participants received Trade Adjustment Assistance. One employee had the authority to determine eligibility of all applicants and was also responsible for entering all client information into the participant management system. There was no secondary review of the information that was entered into the system to verify the accuracy of the information and to ensure that participants met all eligibility requirements.

The Department received a finding during the 2014 audit for the same issues and identified four specific actions they would take to address the identified weaknesses. None of the four actions were completed during fiscal year 2015.

We consider these control weaknesses to be a significant deficiency.

### **Cause of Condition**

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

### **Effect of Condition**

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

The internal controls over the Trade Adjustment Assistance program are also relied on to ensure payments issued for trade readjustment assistance income support are only made to eligible participants. Trade readjustment assistance income support is paid using Unemployment Insurance program funds.

We found the Department paid \$5,530 in Unemployment Insurance funds to participants that were not eligible for benefit payments. We used a valid statistical sampling method to select the payments examined in the audit. We estimate likely and known questioned costs to be \$60,830. Because the funds are not part of the Trade Adjustment Assistance program the questioned costs will not be included in this finding, but will be reported as finding 2015-007 for the Unemployment Insurance program.

### **Recommendation**

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

### **Agency's Response**

*The following actions have already been taken to improve the program and to ensure that only eligible participants receive services and benefits:*

- *Added additional staff to increase support and initiated separation of duties, by establishing one individual to determine the eligibility for benefits using the General Unemployment Insurance Design Effort (GUIDE) system with second individual entering information into the Case Management System.*
- *UI Policy unit provided training to all TRA staff to ensure proper processes are followed.*
- *Increased managerial oversight to ensure program compliance.*
- *UI and WCDD Divisions are working on a plan to locate TRA functions to increase accuracy and efficiency.*

*The following actions will be taken to improve the program and to ensure that only eligible participants receive services and benefits:*

- *The department will create new internal control procedures that will be reviewed and monitored by UI Policy and WCDD Management on an ongoing basis.*
- *Policies and procedures will be reviewed and updated to ensure TRA staff are operating the program correctly.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Section 20.15.40

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

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

**2015-010 The Employment Security Department did not have support for transportation reimbursement payments to Trade Adjustment Assistance program participants.**

<b>Federal Awarding Agency:</b>	U.S. Department of Labor
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	17.245 Trade Adjustment Assistance
<b>Federal Award Number:</b>	TA-22690-12-55-A-53 TA-24376-13-55-A-53
<b>Applicable Compliance Component:</b>	Activities Allowed or Unallowed Allowable Costs/ Cost Principles
<b>Questioned Cost Amount:</b>	\$643
<b>Likely Questioned Cost Amount</b>	\$24,127

**Background**

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

The Department reimburses participants for transportation costs associated with training or job searches. Participants must be preapproved to be reimbursed for travel costs. This preapproval is calculated based on the actual distance the participant travels and must be documented on a request for transportation/subsistence allowance form. Once they are determined eligible and begin training, the participants must submit weekly transportation/subsistence allowance forms to receive payments.

The Department spent approximately \$7.9 million in federal program funds in fiscal year 2015 with approximately \$375,000 paid directly to participants for transportation costs.

We reported a finding in our fiscal year 2014 audit for the Department paying \$1,544 that was either not allowable or unsupported with an estimated likely questioned cost amount of \$159,560. This was reported as finding number 2014-008.

**Description of Condition**

We examined 58 transportation reimbursement payments totaling \$11,155 to determine if the Department received the weekly transportation/subsistence allowance form prior to payment and were calculating each payment correctly. The Department could not provide the weekly transportation/subsistence allowance forms for five reimbursements totaling \$612. These payments could not be verified as accurate or allowable.

We also found one transportation payment was calculated incorrectly resulting in an overpayment of \$31.

## **Cause of Condition**

The Department did not consistently retain supporting documentation for transportation payments until February of 2015. Additionally, Department staff did not adequately review all payments for accuracy prior to approving them.

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

We identified \$643 in questioned costs during our examination of payments. Because a statistical sampling method was used to select the payments we examined, we estimate the amount of likely questioned costs to be \$24,127.

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 payments.

## **Recommendation**

We recommend the Department ensure payments are supported and adequately reviewed prior to reimbursing participants. We also recommend that supporting documentation is retained in accordance with state and federal laws and regulations.

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

## **Agency's Response**

*The following actions will be taken to improve the program and to ensure that transportation payments to participants are accurate and allowable:*

- *A process for document retention has been implemented. All payment supporting documentation will be scanned and documented to meet the Federal and State's record retention guidelines.*
- *Claim forms will be redesigned to ensure approval of payment. Additional review of calculation for accuracy by field and second review by central office staff.*
- *One individual will enter the payment information and another individual will verify the payment before delivering payment batch to vendor payment unit.*
- *Establishing written policies and procedures to address changes to new payment process.*
- *The department will create new internal control procedures that will be reviewed and monitored by management on an ongoing basis.*

## **Auditor's Concluding Remarks**

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A – General Principles for Determining Allowable Costs; Section C – Basic Guidelines states in part:

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

RCW 40.14.060: Destruction, disposition of official public records or office files and memoranda – Record retention schedules, states in part:

- (1) Any destruction of official public records shall be pursuant to a schedule approved under RCW 40.14.050.

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

### 3.4 GRANTS MANAGEMENT

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

#### DESCRIPTION OF RECORDS

Grants Received by State Agencies (GS 23004 Rev. 0)

Documentation of grant projects and funds received and expended by state agencies. May include copies of Requests for Proposals (RFPs), applications, notifications of grant awards, fiscal reports and supporting documentation, reports and correspondence

related to grant monitoring, audit reports, status reports, compliance reports, grants modifications requests, progress reports and final reports.

#### Retention and Disposition Action

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



**2015-011 The Department of Health did not have adequate internal controls to ensure compliance with the earmarking requirements for the Drinking Water State Revolving Funds program.**

**Federal Awarding Agency:** U.S. Environmental Protection Agency  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 66.468 Capitalization Grants for Drinking Water State Revolving Funds  
**Federal Award Number:** FS-99083913-0; FS-99083914-0  
**Applicable Compliance Component:** Earmarking  
**Questioned Cost Amount:** None

**Background**

The Department of Health administers the Capitalization Grants for Drinking Water State Revolving Fund (DWSRF). The Department’s Public Works Board and the Department of Commerce jointly manage the program. The Department uses grant funds to provide loans and financial assistance to community water systems to achieve or maintain compliance with Safe Drinking Water Act requirements.

The DWSRF grant requires the Department to use a specific percentage of grant funds to provide subsidies to community water systems. Specifically, the federal year 2013 and 2014 appropriations include the following requirements:

- No less than 20 percent and no more than 30 percent of the grant can be used for subsidies.
- Subsidies can be provided in the form of grants, principal forgiveness, or negative interest rate loans.
- Subsidies can be provided to communities meeting the state’s definition of disadvantaged or communities the state expects to become disadvantaged as a result of the project.

The grantor strongly encourages the minimum subsidy amounts to be met within the federal fiscal year of the award and requires they be met by the end of the following fiscal year. If the Department is unable to meet the minimum subsidy requirement they are required to provide the grantor, in an annual or biannual report, a complete explanation of the reasons for the delay and provide a plan that identifies the projects that will use the remaining subsidy funds. The grantor has also informed states that they can ensure enough qualified projects are available to fund by revising their subsidy distribution methods if they are too narrow to solicit enough projects to meet the minimum subsidy requirement.

The Department spent almost \$26 million in grant funds during fiscal year 2015.

**Description of Condition**

The Department did not have adequate internal controls in place to ensure it complied with the subsidy requirements. We determined the Department did not meet the 20 percent minimum subsidy requirement for the federal year 2013 and 2014 awards. The Department used approximately 15 percent of the 2013 award for subsidies by the end of the second year, which was September 30, 2014. The Department did not inform the grantor of the shortfall and did not provide a plan to the

grantor as required. The Department used approximately 17 percent of the 2014 award by the end of the second year, which was September 30, 2015. We also determined the Department did not inform the grantor they did not meet the requirement.

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

### **Cause of Condition**

The Department did not monitor the minimum subsidy requirement because staff did not have a thorough understanding of the grant requirements and thought compliance could be met by averaging cumulative subsidies distributed since federal year 2009. Additionally, the Department does not have a process in place to ensure enough qualified projects are available to fund or that the requirement will be met before the grants close.

### **Effect of Condition**

As a result of this condition the Department did not provide enough subsidies for the 2013 and 2014 grants. Grant awards cannot be closed until the minimum subsidy requirement is met. Without a process to ensure that the minimum required subsidies are provided in a timely manner, the Department cannot ensure it will meet all earmarking requirements before grant awards are closed. Additionally, the Department will be required to provide a plan that identifies how the necessary funds will be used for subsidized projects.

### **Recommendation**

We recommend the Department establish internal controls sufficient to ensure the monitoring and documentation of earmarking requirements are performed.

The Department should also monitor subsidy spending to ensure it spends at least the minimum required amount each year for the grant. If the Department determines it will not meet one of the requirements, it should contact its federal grantor to determine an appropriate course of action.

### **Agency's Response**

*Beginning immediately, Subsidy dollars will be tracked by our Loans and Grants Program Supervisor. We will also verify and document subsidy dollars on an ongoing basis in our DWSRF team meetings to ensure accuracy of the dollars reported. If we determine that we are not able to meet the minimum requirement of 20% subsidy, we will notify the Grantor prior to year-end.*

*Confusion was caused partly by a conflicting email received from Rick Green at EPA who stated; "My understanding is that a state can, if they have subsidy shortfall in one year, use any overages in a newer grant period, to make up for a previous years subsidy shortfall. Assuming that is the case, a state with a \$200,000 subsidy shortfall for their 2013 grant, could use \$200,000 worth of subsidy from a 2014 project to make up the difference."*

*In addition, the Department is providing subsidy in the form of principal loan forgiveness as well as waiving loan fees and lowering interest rates to those applicants that qualify. The criteria we are using is based on an affordability index that takes into consideration a percentage of Median Household Income (MHI) that the average water bill will be after funding the proposed loan project.*

*Those projects where the average monthly water rate will exceed 2 percent of the MHI for that service area will qualify.*

*We are also offering principal loan forgiveness for qualifying water system consolidation projects. Those projects that qualify will receive up to 50% loan forgiveness upon project completion along with a reduction in interest rate and waiving loan fees.*

*As we cannot control the number of loan applications we receive or those that may qualify for subsidy we will be adding a 3<sup>rd</sup> tier of application screening in order to qualify additional requests for subsidy that in previous years did not qualify.*

*We will be doing this during our underwriting process by identifying those applicants who have a Debt Service Coverage Ratio less than 1.20:1. Those applicants will be identified and placed on a list for consideration for subsidy dollars if they have not been utilized using our first 2 screening methodologies described above.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

Programmatic Conditions for FS-99083913-0, 2013 DWSRF Grant Conditions states:

1.Preamble:

The FY 2013 Appropriation to the DWSRF programs requires that a portion of the capitalization grant funds be used to provide additional subsidization, while relying on the purposes of the Funds in its underlying act. The application of the additional subsidies – in the form in which they are authorized in the FY 2013 Appropriations Act – to the base SRF

programs raises important issues for the underlying SRF programs. While the DWSRF program has since its inception offered discretion to States to provide additional subsidization, that authority was closely circumscribed by requirements that communities assisted meet the State's definition of "disadvantaged," and that the subsidies provided in any year could not exceed 30 percent of the capitalization grant. In contrast, the FY 2013 Appropriations Act requires States to provide not less than 20 percent and not more than 30 percent of the amount of their DWSRF capitalization grants as additional subsidies. Additional subsidies can be provided to any eligible recipient of SRF assistance, although priority for additional subsidies should be given to communities that could not otherwise afford eligible projects or which are defined by the State as disadvantaged consistent with Section IV.B. of the 2013 procedures. Under these circumstances, in which a large amount of base program capitalization grant funds will not revolve, it is prudent to include additional guidance in the capitalization agreements with States that ensure that the subsidies are funding infrastructure that is sustainable (not enabling the expansion of centralized infrastructure to accommodate growth while failing to adequately repair, replace, and upgrade infrastructure in existing communities which are not otherwise able to afford such projects). Section 1452(a)(3)(A)(i) of SDWA gives the authority to add such specifications to the capitalization grant. SDWA Section 1452(g)(3)(A) authorizes EPA to publish guidance "to ensure that each state commits and expends funds allotted to the State under this section as efficiently as possible." Therefore, EPA is adding a grant condition to all FY 2013 DWSRF capitalization grants:

- a. The recipient agrees to use funds provided by this grant to provide additional subsidization in the form of principal forgiveness, negative interest rate loans, or grants, in accordance with P.L. 113-6 as follows: Drinking Water State Revolving Fund capitalization grant recipients agree to use between 20 and 30 percent of the funds provided by this grant to provide additional subsidization.
- b. Priority for additional subsidies should be given to communities that could not otherwise afford such projects or that are defined by the State as disadvantaged. To further ensure sustainability of eligible projects receiving additional subsidies, these subsidies should be directed to: 1) repair, replacement, and upgrade of infrastructure in existing communities; 2) investigations, studies, or plans that improve the technical, financial and managerial capacity of the assistance recipient to operate, maintain, and replace financed infrastructure; and/or 3) preliminary planning, alternatives assessment and eligible capital projects that reflect the full life cycle costs of infrastructure assets, conservation of natural resources, and alternative approaches to integrate natural or "green" systems into the built environment. The recipient agrees to provide in its Annual Report an explanation as to how they did or did not address this provision.

**2015-012 The Office of Superintendent of Public Instruction did not have adequate internal controls over and did not comply with federal suspension and debarment requirements for the Grants for State Assessments and Related Activities program.**

**Federal Awarding Agency:** U.S. Department of Education  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 84.369 Grants for State Assessments and Related Activities  
**Federal Award Number:** S369A130049, S369A140049  
**Applicable Compliance Component:** Suspension and Debarment  
**Questioned Cost Amount:** None

## **Background**

The Office of Superintendent of Public Instruction administers the Grants for State Assessments and Related Activities. The program supports the development of standards-based state academic assessments in reading or language arts, mathematics and science. When the state has met all assessment requirements the funds may be used to improve standards, alignment, reporting or expanded use of test accommodations.

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

Grantees can meet this requirement by:

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

During fiscal year 2015 the program executed three contracts totaling almost \$89 million in state and federal funds.

## **Description of Condition**

The Office has procedures in place, however, they were not effective in ensuring compliance. We found the Office executed a contract without first verifying whether the entity was suspended or debarred. The value of this contract was \$17,242,155, which accounted for approximately 20 percent of total contracts executed. We were able to verify the vendor had not been suspended or debarred, therefore, we are not questioning costs.

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

## **Cause of Condition**

The Office relies on a certification that is included in its standard contract to meet the suspension and debarment requirements. For the contract in question the Office did not use its standard contract template and the certification regarding suspension and debarment was not included. The Office did not check the federal Excluded Parties List System or collect a certification from the entity to ensure they were in compliance with the suspension and debarment requirement.

## **Effect of Condition**

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

## **Recommendation**

We recommend the Office ensure vendors are not suspended or debarred prior to entering into contracts that include more than \$25,000 in federal funds. We also recommend the Office ensure there is sufficient supervisory oversight to ensure federal requirements are met prior to contracts being executed.

## **Agency's Response**

*The auditors did not include the following information that is necessary to provide proper perspective of this issue. The vendor in question is the University of California Los Angeles (UCLA). OSPI, based on direction from the U.S. Department of Education, entered into a required contract with UCLA as part of the Smarter Balanced Assessment Consortium grant agreement. This is not a material weakness, but rather a unique set of circumstances for which OSPI had full federal approval. Because of these circumstances, OSPI did not use the standard contract template (which includes suspension and debarment language). Therefore, we believe this isolated issue is being misreported by the auditors.*

## **Auditor's Concluding Remarks**

We thank the Office for its response and its cooperation throughout the audit. The State Auditor's Office agrees that this appears to be an isolated incident. However, the \$17 million amount is material to the grant. As such, federal regulations require us to report the issue as a finding. Even though the Office did not use the standard contract for this grant, it could have used one of the other two methods described in the background section of this finding.

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

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

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

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

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

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

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



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

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

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

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

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

Title 2, Code of Federal Regulation, part 180

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.

**2015-013 The Office of Superintendent of Public Instruction did not maintain required documentation for payroll costs charged to the Grants for State Assessments and Related Activities program.**

**Federal Awarding Agency:** U.S. Department of Education  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 84.369 Grants for State Assessments and Related Activities  
**Federal Award Number:** S369A130049, S369A140049  
**Applicable Compliance Component:** Activities Allowed or Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$196,904

**Background**

The Office of Superintendent of Public Instruction administers the Grants for State Assessments and Related Activities. The program supports the development of standards-based state academic assessments in reading or language arts, mathematics and science. When the state has met all assessment requirements, the funds may be used to improve standards, alignment, reporting or expanded use of test accommodations.

The Office may use grant money only for costs that are allowable and related to the grant’s purpose. Federal regulations specify what documentation must be kept to support employee compensation charged to federal grants. If employees are expected to work solely on a single federal award or cost objective, charges for their salaries and wages will be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification. These certifications will be prepared at least semi-annually and will be signed by the employee or supervisory official having firsthand knowledge of the work performed by the employee.

In fiscal year 2015, the Office spent approximately \$9 million in federal funds on the program, approximately \$1.4 million was for payroll expenses.

**Description of Condition**

We determined 62 certifications were required to be completed for fiscal year 2015. We examined all 62 and found that in 12 instances the Office was not compliant with federal requirements.

Specifically:

- Ten certifications were missing.
- An employee completed one certification for two half-year periods (i.e., July 2014 - June 2015).
- One employee completed a certification three months prior to the end of the period covered by the certification.

## **Cause of Condition**

The Office relied on the employees and/or their supervisors to submit the certifications, but did not enforce the submission deadlines. Additionally, the Office did not adequately track which certifications had been submitted to ensure compliance with the requirement.

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

We found \$196,904 in direct payroll and benefit charges to the Grants for State Assessments and Related Activities that were not supported by documentation required by federal regulations and Office policies.

In accordance with federal audit requirements, we question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support a payment. The federal grantor could disallow these charges and require the Office to pay back the money.

## **Recommendation**

We recommend the Office establish sufficient procedures to ensure payroll costs charged to a federal grant are supported by required documentation. We also recommend Office management ensure certifications are received and reviewed.

The Office should consult with the U.S. Department of Education to determine what, if any, of the questioned costs should be repaid.

## **Agency's Response**

*OSPI acknowledges that it did not ensure all semi-annual certifications were received in a timely manner. However, we will provide documentation to the U.S. Department of Education to support the questioned payroll costs. Specifically, we will provide copies of semi-annual certifications that we received during the audit, which were deemed "missing" by the auditor. We will also provide a copy of the semi-annual certification that covered two half-year periods, which resulted in the auditor questioning the employee's payroll costs for half of the year – we agree it was not timely yet believe it supports the payroll costs.*

## **Auditor's Concluding Remarks**

We thank the Office for its response and its cooperation throughout the audit. We agree that documentation supporting two of the ten certificates referred to as missing in the finding was provided during the audit. However, the two certifications were signed by the employee after we requested them - almost four months after the end of the year. We therefore concluded the required certifications were missing for the audit period.

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

### Appendix B, Section 8(h):

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

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

**2015-014 The Department of Health did not follow established internal controls over and did not comply with Federal Financial Reporting requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness programs.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.069 Public Health Emergency Preparedness  
93.889 National Bioterrorism Hospital Preparedness Program  
**Federal Award Number:** U90TP000559  
**Applicable Compliance Component:** Reporting  
**Questioned Cost Amount:** None

### **Background**

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

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and others. These entities oversee training, meetings, purchasing of supplies and equipment and generate reports for the program. The Department spent approximately \$11.9 million in Public Health Emergency Preparedness funds and \$6.5 million in Hospital Preparedness Program funds in fiscal year 2015.

In a five year period, the Department receives five amendments that all fall under the same grant award project period. The Department submits a final financial report when it has completed spending on an amendment to the original award. Staff collect supporting documentation and prepare the report. A manager then reviews the report and compares it to the supporting documentation to ensure it is accurate. One line item the Department must submit on the final report is the total amount of state funds spent on the program.

### **Description of Condition**

The Department has procedures in place but they were not effective in ensuring compliance. We found the final report submitted for the fiscal year 2013 amendment contained a material error. The Department overstated the state funds spent by \$29.8 million.

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

### **Cause of Condition**

The Department did not follow its own procedures to ensure federal reports are submitted accurately. We verified a manager did sign and date the report as having been reviewed, but the review did not detect the material error.

## **Effect of Condition**

By not correctly submitting the required financial report, the federal government's ability to monitor grant funds is diminished. Grant conditions allow the grantor to penalize the Department for noncompliance, suspending or terminating the award and withholding future awards.

## **Recommendation**

We recommend the Department follow its written policies and procedures and perform an adequate review to ensure federal reports are submitted accurately.

## **Agency's Response**

*As stated in the write-up by the State Auditor's Office, the Department does have written policies and procedures for reviewing all Federal Financial Report submissions. These internal controls include separation of duties by having agency fiscal staff prepare the Federal Financial Report. The agency fiscal staff then reviews the draft report with agency program staff. Finally, the report and associated backup documentation is then given to the Grants Manager or Grants Supervisor for review, approval and submission to the federal government. The error discovered by the State Auditor's Office did occur and has been corrected. The Department strives to accurately submit all Federal Financial Reports and will continue to do so in the future.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

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

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

agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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

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

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

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

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

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

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

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

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

Federal grant award 5U90TP000559-02, page 9, states:

NOTE 14.f: ANNUAL FEDERAL FINANCIAL REPORT (FFR): The Annual Federal Financial Report (FFR) SF-425 is required and must be submitted through eRA Commons within 90 days after the end of each budget period. The FFR for this budget period is due to the Grants Management Specialist by September 30, 2014. Reporting timeframe is July 1, 2013 through June 30, 2014. The website to access eRA Commons is: <http://era.nih.gov/>

The FFR should only include those funds authorized and disbursed during the timeframe covered by the report. If the FFR is not finalized by the due date, an interim FFR must be submitted, marked NOT FINAL, and an amount of un-liquidated obligations should be annotated to reflect unpaid expenses.



**2015-015 The Department of Health did not have adequate internal controls over federal level of effort requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness programs and did not comply with federal level of effort requirements for the National Bioterrorism Hospital Preparedness Program.**

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

## **Background**

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

The Department distributes money to hospitals, outpatient facilities, tribes, health centers, poison control centers, emergency management services and others. These entities oversee training, meetings, purchasing of supplies and equipment and generate reports on the program. The Department spent approximately \$11.9 million in Public Health Emergency Preparedness funds and \$6.5 million in Hospital Preparedness Program funds in fiscal year 2015.

Under the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness grants, the Department is required to maintain state-funded healthcare preparedness spending at a level that is at least equal to the average of the previous two years spending. The recipient of grant funds acknowledges acceptance of the award terms and conditions when it draws funds through the grant payment system. If the recipient does not agree with the terms of the award, they are required to notify the Grants Management Officer.

The Department has established written procedures to guide how it will ensure state spending requirements are met for the programs. Funds are budgeted at the beginning of the year and each quarter the Department logs and tracks current spending amounts and compares them to the amounts needed to meet federal requirements.

We reported findings in our fiscal year 2011, 2012, 2013 and 2014 audits that noted the Department did not have adequate internal controls to ensure it complied with level of effort requirements for either grant program. These were previously reported as finding numbers 11-20, 12-21, 2013-012, and 2014-016.

## **Description of Condition**

We found the Department followed its established procedures during the audit period. However, when it became known the Department would be noncompliant with the level of effort requirements

for the National Bioterrorism Hospital Preparedness program, it did not correct the shortfall or inform the grantor as required by the grant terms and conditions. Therefore the controls were not effective in ensuring compliance.

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

### **Cause of Condition**

The Department budgeted a sufficient amount of state funding to meet the requirements, but did not spend the full amount that was budgeted for the National Bioterrorism Preparedness program. The Department's written procedures do not specify what staff are to do if the level of effort requirement is not going to be met. The staff member tracking expenditures informed management the Department did not meet the spending requirement, but no further action was taken.

### **Effect of Condition**

The Department spent \$3,390 under the required level for the National Bioterrorism Hospital Preparedness program. Additionally, by not contacting the federal grantor and informing them the Department would not meet its level of effort requirement, the Department did not comply with the grant agreement.

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

### **Recommendation**

We recommend the Department update its written procedures to specify what actions should be taken by staff when it becomes known the Department will be noncompliant with state spending requirements. We also recommend the Department inform the grantor when it becomes aware it will be noncompliant with grant requirements.

### **Agency's Response**

*The Department concurs with the finding. The Department established, and now follows, written policies and procedures for tracking, documenting, and reporting the level of effort.*

*The Department communicated with its federal grantor to determine the best method for how and when to provide notification in the event that the required level of effort will not be met. We will be communicating with our federal partners on a quarterly basis.*

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

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

Section 510, states in part:

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

...

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

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

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

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

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

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

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

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

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

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

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

The Cooperative Agreement number 5U90TP000559-03 Terms and Conditions states, in:

Section III – Terms and Conditions-5U90TP000559-03

This award is based on the application submitted to, and as approved by, CDC on the above titled project and is subject to the terms and conditions incorporated either directly or by reference in the following:

- c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.

Section IV-TP Special Terms and Conditions-5U90TP000559-03

ACCEPTANCE OF THE TERMS OF AN AWARD:

By drawing or otherwise obtaining funds from the grant Payment Management Services, the grantee acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. If the recipient cannot accept the terms, the recipient should notify the Grants Management Officer within thirty (30) days of receipt of this award notice.

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

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

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

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

## 45 Code of Federal Regulations Part 92

### Subpart C--Post-award Requirements

#### Reports, Record Retention, and Enforcement

##### Sec. 92.43 Enforcement.

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

**2015-016 The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional 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:** 2B08TI010056-13; 2B08TI010056-14;  
2B08TI010056-15; 1H79SM061705-01;  
5H79SM060196-04; 1H79TI025342-01;  
1U79TI023477-01; 1U79TI024265-01;  
1U79SP020155-01; 5H79TI023425-02  
**Applicable Compliance Component:** Subrecipient Monitoring  
**Questioned Cost Amount:** None

## **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent over \$38 million in grant funds during fiscal year 2015. Of this amount, almost \$12 million was passed through to 68 subrecipients.

The Department also administers the Substance Abuse and Mental Health Services Projects of Regional Significance. This federal grant program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent approximately \$7.9 million in grant funds during fiscal year 2015. Of this amount, approximately \$2.8 million was passed through to 38 counties, school districts and nonprofit organizations as subrecipients.

Federal regulations require the Department to monitor the grant-funded activities of subrecipients. This includes ensuring organizations that spend \$500,000 or more in federal grant money during a fiscal year receive an audit of expenditures and related internal controls, in accordance with the federal Office of Management and Budget Circular A-133. The Department is also required to follow up on any findings a subrecipient receives that may affect the federal program. These requirements help ensure grant money is used for authorized purposes and within the provisions of contracts or grant agreements. Grant recipients must submit the results of these audits to a federal clearinghouse within nine months of their fiscal year-end.

We reported a finding in the fiscal year 2014 audit for the Department not having adequate controls over and not complying with requirements to ensure their subrecipients received audits when required. This was reported as finding number 2014-019.

## **Description of Condition**

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

- Subrecipients received required audits
- Findings are followed-up on
- Funds received are being reported for audit purposes.

During the audit period we found no evidence that the Department monitored or verified whether any subrecipients obtained a required audit.

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

## **Cause of Condition**

The Department did not have policies or procedures in place to ensure subrecipients received required audits. The Department's corrective action plan for the previous finding stated in April of 2015 the Department's Behavioral Health and Services Integration Administration's accounting section began tracking subrecipients requiring audits, including tribal subrecipients. We determined this was not the case and the responsibility to perform this function was not clearly assigned to a specific unit or individual. Additionally, management did not provide sufficient oversight to ensure the requirement was met.

## **Effect of Condition**

Without establishing adequate internal controls, the Department cannot be certain all subrecipients who met the threshold for an A-133 audit complied with federal grant requirements and therefore cannot ensure it has met the monitoring requirements of its federal grantor.

## **Recommendation**

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

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

## **Agency's Response**

*The Department concurs with this finding.*

*The Department will establish policies and procedures to ensure that subrecipients report when they are required to receive audits and that they have received them when appropriate. The Department originally had a dedicated staff person to do this work that was not replaced due to downsizing. The Department did reassign this work to the accounting unit who also had staff turnover and insufficient staffing to cover this as well as other accounting functions. The Department will re-evaluate where this workload should be and establish roles and responsibilities to ensure that subrecipient tracking of audits is completed.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

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

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

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

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

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



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

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

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

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

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

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

OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, Section 510, Audit findings, states in part:

- (a) *Audit findings reported.* The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - (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 §\_\_.315(b) materially misrepresents the status of any prior audit finding.

U.S. Office of Management and Budget Circular A-133, *Compliance Supplement 2015*, Part 3 – Compliance Requirements states in part:

#### Section M. Subrecipient Monitoring

##### Compliance Requirements

A pass-through entity is responsible for: ...

- *Subrecipient Audits* – (1) Ensuring that subrecipients expending \$500,000 or more in Federal awards during the subrecipient’s fiscal year for fiscal years ending after December 31, 2003 as provided in OMB Circular A-133 have met the audit requirements of OMB Circular A-133 and that the required audits are completed within 9 months of the end of the subrecipient’s audit period; (2) issuing a management decision on audit findings within 6 months after receipt of the subrecipient’s audit report; and (3) ensuring that the subrecipient takes timely and

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

**2015-017 The Department of Social and Health Services did not have adequate internal controls over and was not compliant with its required collection of Data Universal Numbering System (DUNS) numbers from subrecipients under the Substance Abuse and Mental Health Services Projects of Regional Significance and Block Grants for Prevention and Treatment of Substance Abuse programs.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.243 Substance Abuse and Mental Health Services  
Projects of Regional and National Significance  
93.959 Block Grants for Prevention and Treatment of  
Substance Abuse  
**Federal Award Number:** 2B08TI010056-13; 2B08TI010056-14;  
2B08TI010056-15; 1H79SM061705-01; 5H79SM060196-  
04; 1H79TI025342-01; 1U79TI023477-01;  
1U79TI024265-01;  
1U79SP020155-01; 5H79TI023425-02  
**Applicable Compliance Component:** Subrecipient Monitoring  
**Questioned Cost Amount:** None

## **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent over \$38 million in grant funds during fiscal year 2015. Of this amount, almost \$12 million was passed through to 68 subrecipients.

The Department also administers the Substance Abuse and Mental Health Services Projects of Regional Significance. This federal grant program is designed to address priority substance abuse treatment, prevention and mental health needs of regional and national significance. The Department spent approximately \$7.9 million in grant funds during fiscal year 2015. Of this amount, approximately \$2.8 million was passed through to 38 counties, school districts and nonprofit organizations as subrecipients.

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

We reported a finding in the fiscal year 2014 audit for the Department not having adequate internal controls over and not being compliant with collecting DUNS numbers from their subrecipients. This was reported as finding number 2014-020.

## **Description of Condition**

The Department's Block Grants for Prevention and Treatment of Substance Abuse program executed 27 subawards after July 1, 2014. Funds awarded for these contracts totaled \$1,018,405. The Department did not collect DUNS numbers from any of these subrecipients.

The Department's Substance Abuse and Mental Health Services Projects of Regional Significance program executed five subawards with four subrecipients after July 1, 2014. Funds awarded for these contracts totaled \$538,767. The Department did not collect DUNS numbers from any of these subrecipients.

We consider this control deficiency to be a material weakness.

## **Cause of Condition**

Department management was not aware of the requirement to collect DUNS numbers prior to making subawards until we conducted our 2014 audit. The Department implemented policies and procedures and other internal controls during state fiscal year 2015 to ensure the federal requirement was met, but these changes were made after the subawards had already been executed.

## **Effect of Condition**

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

## **Recommendation**

We recommend the Department ensure new policies and procedures are followed and monitor the collection of the DUNS numbers to ensure compliance with this requirement.

## **Agency's Response**

*The Department concurs with this finding.*

*The Department implemented a new policy, procedures and internal controls to ensure DUNS numbers were obtained from sub-recipients prior to making sub-awards in accordance to 2 CFR, Appendix A to Part 25. DUNS numbers will be recorded in the Special Terms and Conditions of all applicable contracts.*

## **Auditor's Concluding Remarks**

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**2015-018 The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to sanction Temporary Assistance for Needy Families program participants who were not cooperative with the Department regarding child support issues.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.558 Temporary Assistance for Needy Families
<b>Federal Award Number:</b>	1502WATANF; 1502WATAN3; 1402WATANF
<b>Applicable Compliance Component:</b>	Special Tests and Provisions – Child Support Non-Cooperation
<b>Questioned Cost Amount</b>	\$943
<b>Likely Questioned Cost Amount:</b>	\$115,669 \$60,830

## **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. The Department spent over \$326 million in grant funds during fiscal year 2015.

The Division of Child Support (DCS) within the Department of Social and Health Services provides child support services including paternity establishment, child support order establishment and child support collection services. TANF parents are required to cooperate with the DCS in order 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 where monitoring of TANF clients takes place. Federal regulations require the Department to reduce benefits if a parent is non-cooperative with DCS.

## **Description of Condition**

During the audit period the Department did not have adequate internal controls in place to ensure it complied with child support noncooperation requirements. For clients with an inactive TANF claim at time of noncooperation, the Department's process was not designed to ensure benefits were reduced if the client reapplied. After child support noncooperation was determined, the Department did not monitor sufficiently to ensure benefits were reduced.

We examined documentation for 59 TANF recipients who had received a noncooperation notice to determine whether the Department complied with federal requirements and found:

- Benefits were not properly reduced for five clients who were not cooperative.
- A record of noncooperation was not documented in three other client files. Two of the clients received improper payments after the end of the audit period.

We consider these control deficiencies to be a material weakness.

## **Cause of Condition**

The Department was unaware some non-cooperative clients' benefits were not being reduced or denied. Additionally, management did not adequately monitor to ensure the Department complied with federal requirements.

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

By not monitoring to ensure non-cooperative clients had their benefits reduced or denied, the Department issued \$943 in improper payments to clients. Because a statistical sampling method was used to select the payments we examined, we estimate the amount of likely questioned costs to be \$115,669.

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 payments.

## **Recommendation**

We recommend the Department establish policies and procedures sufficient to ensure participants who are non-cooperative with DCS have their TANF benefits reduced or denied as required by federal law. We further recommend management monitor to ensure the requirements for imposing sanctions are being met.

The Department should consult with the Department of Health and Human Services to determine what, if any, of the questioned costs should be repaid.

## **Agency's Response**

*The Department concurs with the audit finding.*

*The Department recognizes that benefits were not properly reduced for five clients who were not cooperative with child support requirements, and that a record of noncompliance was not documented in three other client files. Two clients received improper payments after the end of the audit period.*

*The Department took immediate action to correct this audit finding. The Division of Child Support (DCS) and the Community Services Division (CSD) collaborated to identify and resolve the technical issue (CSD & DCS IT systems not communicating) that led to non-compliance. CSD is reviewing each individual case identified by the SAO, and will establish overpayments as appropriate.*

*In addition to the individual exceptions identified by the SAO, and to ensure compliance with noncooperation requirements, CSD is reviewing and will take appropriate action on all cases with noncompliance sanctions during the audit period.*

*CSD leadership will remind staff to review each case record for non-cooperation notices prior to approving TANF cash while working towards a long-term, automated solution to ensure all cases in non-cooperation status are properly sanctioned.*



*In addition to the immediate corrections, CSD and DCS will work together to proactively identify and resolve any further potential gaps in communication between CSD and DCS relative to sanctioning a shared client in noncooperation status.*

*To further prevent another technical glitch, DCS made improvements to their release planning and implementation process, including a quality assurance process to be engaged prior to new release implementation.*

*CSD has commissioned a workgroup to develop and recommend an automated solution for updating and/or flagging closed cases in noncooperation status to ensure these cases will be handled appropriately if the case is reopened.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

- (b) Maintain internal control over Federal programs that provides reasonable assurance that the auditee is managing Federal awards in compliance with laws, regulations, and the provisions of contracts or grant agreements that could have a material effect on each of its Federal programs.
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Material noncompliance. In the absence of a definition of material noncompliance in the governmental audit requirement, a failure to follow compliance requirements or a violation of prohibitions included in the applicable compliance requirements that results in noncompliance that is quantitatively or qualitatively material, either individually or when aggregated with other noncompliance, to the affected government program.

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

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

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

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

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

Title 45, Code of Federal Regulations, Section 264.30 and 264.31-child support non-cooperation:

§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?

- (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.

**2015-019 The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements of its Temporary Assistance for Needy Families grant work verification plan.**

**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:** 1502WATANF; 1502WATAN3; 1402WATANF  
**Applicable Compliance Component:** Special Tests and Provisions – Penalty for Failure to Comply with Work Verification Plan  
**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. In order to receive TANF benefits participants must be engaged in entering the work force through the WorkFirst program, with limited exceptions. The Department spent over \$326 million in grant funds during fiscal year 2015.

Federal Regulations require states to report actual hours of work participation of the participants and be able to show reported activities were countable, supervised, documented and verified in accordance with a federally approved work verification plan. Within the work verification plan the state identifies the internal controls designed to ensure established work verification procedures are properly being followed. One of the primary internal controls the Department specified was contract monitoring of entities who directly administer and supervise WorkFirst participation. There are three state agencies that provide these services and must be monitored by the Department. These agencies received approximately \$44 million in grant funds during fiscal year 2015.

### **Description of Condition**

During the audit period the Department did not conduct the contract monitoring required by its work verification plan. The Department was supposed to conduct monitoring by receiving supporting documentation from each of the three agencies that provided services. The Department received partial support from one agency and no supporting documentation from the other two.

We consider these internal control weaknesses to constitute a material weakness

### **Cause of Condition**

Department management stated that while they were aware of the requirement they did not request the required documentation and did not conduct any of the required monitoring. The Department added that insufficient staffing was the primary reason for the lack of monitoring. Additionally, management did not adequately monitor to ensure the Department complied with the federal requirements.

## **Effect of Condition**

Without monitoring the contracted agencies, the Department was not able to ensure the accuracy of the data used in calculating work participation rates and was not in compliance with the requirements of its work verification plan. Federal law allows the grantor to penalize the state between one and five percent of the grant award amount for violation of these requirements.

## **Recommendation**

We recommend the Department follow its federally approved work verification plan, by adequately monitoring its contracts with other state agencies.

## **Agency's Response**

*The Department concurs with the audit finding.*

*The Department will take swift action to correct this audit finding. As an immediate fix, the responsible Community Services Division (CSD) staff will create automated, electronic reminders to request the partner agencies monitoring reports and schedules as appropriate.*

*CSD will initiate a workgroup that will develop effective monitoring tools and schedules to ensure all contract monitoring obligations are met. The schedule will include retroactively monitoring and taking appropriate action on the partner contracts for the audit period. This workgroup will also recommend additional staffing to remedy workload issues, if warranted. CSD leadership will ensure the tools and schedules are effectively implemented.*

*CSD will create an internal quality assurance process to further ensure staff continue to adequately monitor the contracts.*

*While the Department concurs with the audit finding and will swiftly initiate and implement corrective action to resolve the finding, the Department would also like to note that inadequate contract monitoring is not the sole activity quantifying the accuracy of the data used in calculating the work participation rates. Section IV (B1) of the Work Verification Plan describes multiple internal controls Washington employs to ensure accuracy of the data used to calculate the work participation rate.*

*These internal controls include an extensive Quality Assurance (QA) process that the Department conducts on an annual basis for each of the three contracted agencies. Through the QA process, the integrity and accuracy of the data provided for the work participation rate are reviewed and verified. Therefore, the Department asserts that the reliability and accuracy of actual hour reporting is verified through multiple processes, not just through contract 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

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

### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

Title 45, Code of Federal Regulations, which states in part:

§261.61 How must a State document a work-eligible individual's hours of participation?

- (a) A State must support each individual's hours of participation through documentation in the case file. In accordance with § 261.62, a State must describe in its Work Verification Plan the documentation it uses to verify hours of participation in each activity.
- (b) For an employed individual, the documentation may consist of, but is not limited to pay stubs, employer reports, or time and attendance records substantiating hours of participation. A State may presume that an employed individual participated for the total number of hours for which that individual was paid.
- (c) The State must document all hours of participation in an activity; however, if a State is reporting projected hours of actual employment in accordance with § 261.60(c), it need only document the hours on which it bases the projection.
- (d) For an individual who is self-employed, the documentation must comport with standards set forth in the State's approved Work Verification Plan. Self-reporting by a participant without additional verification is not sufficient documentation.
- (e) For an individual who is not employed, the documentation for substantiating hours of participation may consist of, but is not limited to, time sheets, service provider attendance records, or school attendance records. For homework time, the State must also document the homework or study expectations of the educational program.

§261.62 What must a State do to verify the accuracy of its work participation information?, states in part:

- (a) To ensure accuracy in the reporting of work activities by work-eligible individuals on the TANF Data Report and, if applicable, the SSP-MOE Data Report, each State must:
  - (1) Establish and employ procedures for determining whether its work activities may count for participation rate purposes;
  - (2) Establish and employ procedures for determining how to count and verify reported hours of work;

- (3) Establish and employ procedures for identifying who is a work-eligible individual;
  - (4) Establish and employ internal controls to ensure compliance with the procedures; and
  - (5) Submit to the Secretary for approval the State's Work Verification Plan in accordance with paragraph (b) of this section.
- (b) A State's Work Verification Plan must include the following:
- (5) A description of the internal controls that the State has implemented to ensure a consistent measurement of the work participation rates, including the quality assurance processes and sampling specifications it uses to monitor adherence to the established work verification procedures by State staff, local staff, and contractors.

§261.65 Under what circumstances will we impose a work verification penalty?

- (a) We will take action to impose a penalty under §262.1(a)(15) of this chapter if:
  - (2) We determine that the State has not maintained adequate documentation, verification, or internal control procedures to ensure the accuracy of the data used in calculating the work participation rates.



**2015-020 The Department of Social and Health Services did not have adequate internal controls in place to ensure compliance with the maintenance of effort requirements for the Temporary Assistance for Needy Families grant program.**

**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:** 1502WATANF; 1502WATAN3; 1402WATANF  
**Applicable Compliance Component:** Level of Effort  
**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. The Department spent over \$326 million in grant funds during fiscal year 2015.

Federal regulations require the Department to maintain state spending at certain levels in order to meet federal grant requirements. This is referred to as maintenance of effort (MOE) and includes:

- Maintain qualified state expenditures for eligible families at a level that is at least 80 percent of historic state expenditures. Qualified expenditures with respect to eligible families may come from all programs, such as the state's TANF program as well as programs separate from the state's TANF program.
- Maintain qualified state expenditures at a level that is more than 100 percent of its historic state expenditures for fiscal year 1994 in order to keep any of the federal contingency funding it received.
- A state's records must show all the costs are verifiable.

During fiscal year 2015, the Department claimed almost \$123 million of their own spending as well as \$429 million in MOE expenditures from ten programs, including six other state agencies and one non-profit organization. These expenditures were not part of the State's TANF program.

## **Description of Condition**

The Department did not adequately monitor expenditures throughout the year to ensure it would meet the MOE requirements. Instead, the Department waited until the end of the year to determine whether it spent enough state funds. Additionally, the staff responsible for submitting and approving the reports were unable to provide sufficient documentation to support that the amounts they reported were accurate and for allowable purposes.

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

## **Cause of Condition**

The Department did not have written policies or procedures in place to ensure it complied with maintenance of effort requirements. Additionally, management did not adequately monitor to ensure the Department complied with the federal requirements. Until we requested records, Department staff were not aware adequate supporting documentation for expenditures was not used when reporting the MOE expenditures to the federal government.

## **Effect of Condition**

By not monitoring to ensure MOE requirements are being met, the Department did not know if it would be compliant until after the year had ended. Additionally, by not reviewing adequate supporting documentation prior to reporting the MOE amount to the grantor, the report preparer and approver did not know whether the amounts reported were allowable and not used as MOE for any other federal programs.

We determined the Department met the MOE requirement for fiscal year 2015. However, if the Department does not improve internal controls and the state does not meet the basic MOE requirement in the future, the grantor can reduce future grants in the amount of the shortage.

## **Recommendation**

We recommend the Department establish policies and procedures and improve other internal controls sufficient to ensure it collects and reviews adequate documentation to support all MOE expenditures. We also recommend that management monitor throughout the year to ensure that the federal requirements are met.

## **Agency's Response**

*The Department concurs with the finding.*

*The Department agrees that its written policies and procedures are not well-organized or structured, and that internal controls need to be improved.*

*The majority of the reported MOE was provided by other state agencies and one non-profit entity, the same as in previous years. The Department maintains that there is a low risk that these entities would not provide the agreed upon MOE. This assertion is based on the historical performance and relationship between the Department and these entities.*

*Department data, research and information technology staff worked closely with their counterparts from the source entities during the year to ensure that the data reported at the end of the year would be accurate and that only allowable expenditures were reported to the Department.*

*In addition, the Economic Services Administration's Division of Finance and Financial Recovery (DFFR) accounting staff work with appropriate Community Services Division (CSD) staff continuously throughout the year to verify MOE expenditures and monitor state policy changes that may affect expenditures.*

*The Department agrees that these policies and procedures need to be better documented, organized, available in writing, and accessible. The Department will more fully document internal controls,*

*policies and procedures specific to monitoring expenditures throughout the year (minimum of quarterly), in order to ensure that the minimum MOE requirements will be met. These policies and/or procedures will also identify the steps and processes for staff to ensure that the MOE claim is accurate and allowable. The Department will document and follow the specific steps required for management to appropriately monitor compliance with federal reporting requirements.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

performing the control does not possess the necessary authority or competence to perform the control effectively.

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

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

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

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

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

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

45 CFR 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.

**2015-021 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:** 1502WATANF; 1502WATAN3; 1402WATANF  
**Applicable Compliance Component:** Reporting  
**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. In order to receive TANF benefits participants must be engaged in entering the work force through the WorkFirst program, with limited exceptions. The Department spent over \$326 million in grant funds during fiscal year 2015.

Federal regulations require the Department to file quarterly financial reports that includes spending data on the use of federal TANF funds as well as state TANF funds. The state TANF spending is required to be maintained at a specific level in order to meet federal maintenance of effort requirements. The Department is required to file an annual report containing information on the TANF program and the state's maintenance of effort spending for that year. The Department must maintain records that show all costs are allowable and verifiable.

### **Description of Condition**

The Department did not have adequate internal controls in place to ensure it complied with grant reporting requirements for financial reports or its annual report. The Department reported \$551,697,292 in state spending for federal fiscal year 2014, but the documentation used by the preparer and reviewer only supported \$122,741,657. The other \$428,955,636 consisted of spending by other state agencies and one nonprofit organization. Each of these entities told the Department how much they spent, but the staff submitting the reports did not verify the amounts were accurate, allowable and adequately supported before reporting them to the federal government.

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

### **Cause of Condition**

The Department did not have written policies or procedures in place to ensure it complied with reporting requirements. The staff who prepared the reports relied on emails received from other state agencies and one non-profit entity for support and believed this was sufficient. Additionally, management did not adequately monitor to ensure the Department complied with the federal requirements.

## **Effect of Condition**

By not ensuring the accuracy of the required quarterly and annual reports, the federal government's ability to monitor grant funds is diminished. Additionally, grant conditions 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.

## **Recommendation**

We recommend the Department:

- Improve internal controls sufficient to ensure reporting requirements are met.
- Verify expenditures reported as state maintenance of effort to ensure they are allowable and adequately supported.
- Maintain adequate documentation to support reports filed with its federal grantor.

## **Department's Response**

*The Department concurs with the overall findings of the State Auditor's Office and appreciates the State Auditor's Office acknowledgement that they have verified the amounts reported by the Department were materially correct.*

*The Department asserts that staff completing the reports reviewed documentation and analyzed costs to confirm that reported MOE was allowable per federal regulations. This documentation, which includes a comprehensive matrix that identifies services and confirms allowability, was reviewed prior to the MOE being reported to the federal government.*

*The Department confirmed that expenditures were not used by the source entities to match other federal dollars. The Department's research and data unit and information technology staff worked closely with data research and information technology staff from the source entities throughout the year to ensure that the data reported at the end of the year would be accurate and that only allowable expenditures were reported. The Department has obtained certifications from the source entities for the audit period in question and will continue to do so for future reporting.*

*The preparer, reviewer, and approver are aware that the supporting data exist. This awareness, in addition to ongoing communication with data research and information technology staff and between the Department and the source entities, provided confidence that the reported MOE expenditures were accurate and allowable per federal guidelines.*

*The Department agrees that documentation should be immediately available, well-organized, and updated as appropriate. The Department will develop written procedures and policies requiring yearly certifications for the MOE prior to reporting to the federal government. These items will identify the steps and processes for staff to ensure that the MOE is accurate and allowable. The Department will also develop and implement additional controls to ensure reporting requirements are met.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

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

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

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

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



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

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

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

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

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

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

## Title 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:

(d) 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.

**2015-022** The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure only eligible refugees of the Refugee and Entrant Assistance program received cash assistance.

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.566 Refugee and Entrant Assistance – State Administered Programs
<b>Federal Award Number:</b>	1401WARCMA 1501WARCMA
<b>Applicable Compliance Component:</b>	Eligibility
<b>Questioned Cost Amount:</b>	\$23,213
<b>Likely Questioned Cost Amount</b>	\$134,655

## **Background**

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

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

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

The Department is responsible for determining eligibility for all applicants. Department staff at Community Service Offices enter applicant's information into an automated eligibility system that assists in determining what federal programs applicants are eligible for, including Refugee Cash Assistance (RCA). As a condition for receipt of RCA, a refugee must (with very few exemptions), register and participate in employment services.

The Department contracts with employment providers to ensure that employability services are available. Case notes are required to be entered in the Department's case management system indicating whether the client adequately met the work and training requirements. Failure to participate in the work and training activities results in the client being ineligible to receive cash assistance.

In fiscal year 2015, the Department spent approximately \$12 million in grant funds, with almost \$1.5 million paid as cash assistance to 838 clients.

We reported a finding in the fiscal year 2014 audit that the Department did not have adequate internal controls over and was not compliant with ensuring only eligible refugees received cash assistance. This was reported as finding number 2014-021.

## **Description of Condition**

We found the Department did not have adequate internal controls to ensure only eligible refugees received cash assistance and to ensure that refugees receiving RCA met the minimum requirements. We randomly selected and examined records for 83 clients and found:

- Thirteen (16 percent) applicant files lacked required documentation to evidence they participated in required employment services. These applicants received improper payments totaling \$12,361.
- Two clients were eligible for TANF. Therefore, making them ineligible to receive RCA. These applicants received improper payments totaling \$976.

Additionally, we examined records for 30 minor clients and found:

- Twenty-six minors were part of 11 households eligible for TANF. Therefore, the minors were ineligible for RCA. These applicants received improper payments totaling \$9,876.

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

## **Cause of Condition**

The Department lacked an adequate process for staff to consistently track RCA recipients to ensure their registration and participation with employment and training providers.

Management did not sufficiently monitor staff to ensure they were verifying client participation in work and training activities and input information accurately in the Department's automated eligibility system. If the information had been input properly, the 11 households would have been deemed eligible for TANF, prior to being authorized as eligible for refugee cash assistance.

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

Without having adequate internal controls in place, the Department is at a higher risk for approving cash assistance benefits for ineligible clients. This resulted in the Department making improper payments with federal funds. A statistical sampling method was used to randomly select clients examined in the audit. We estimate the amount of likely questioned costs to be \$134,655.

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 payments.

## **Recommendation**

We recommend the Department establish adequate internal controls to ensure only eligible clients receive refugee cash assistance. The Department should establish procedures to track work and training activities for eligible clients.

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

## Agency's Response

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

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

*The Department also agrees that for part of the audit period, it lacked the ability to ensure that refugees receiving RCA registered and participated in employability services. It is important to note that, unlike the two applicants identified in the report as being improperly approved for RCA because they were eligible to receive TANF, the thirteen applicants identified as lacking documentation were ineligible for TANF and eligible for and properly enrolled in RCA. The Department considers these clients to be potentially ineligible because of a lack of documentation.*

*The Department takes seriously its responsibility to provide strong program oversight through appropriate internal controls. Immediately following receipt of the recommendations articulated in the SFY2014 SWSA audit, ORIA implemented many action items aimed at resolving the findings. Unfortunately, the timing of the audit and subsequent findings allowed only three months (April, May, and June 2015) for the corrective action plan to be fully effective. The majority of the clients identified as not referred to Work and Training (W&T) in the current audit were enrolled prior to the full implementation of the corrective action plan items.*

*For the FY14 audit, the SAO sampled 57 clients and determined that four applicants (about seven percent of the sample) were improperly approved for RCA benefits because they were eligible to receive TANF, and 10 applicants (about 17% of the sample) lacked required documentation.*

*The Department's accuracy rate increased and questioned costs decreased (despite the increased sample size) in both areas (eligibility and documentation) during the FY15 audit. For this audit, the SAO sampled a larger selection of clients (83) and determined that two applicants (about two percent of the sample) were improperly approved for RCA benefits because they were eligible to receive TANF, and 13 applicants (about 16% of the sample) lacked required documentation.*

<b>FY2014 Audit</b>		<b>FY2015 Audit</b>	
Sample Size = 57		Sample Size = 83	
<i>Ineligible</i>	<i>Lacked Documentation</i>	<i>Ineligible</i>	<i>Lacked Documentation</i>
4	10	2	13
Accuracy Rate = 93%	Accuracy Rate = 82%	Accuracy Rate = 98%	Accuracy Rate = 84%
Questioned Costs = \$2,420	Questioned Costs = \$12,870	Questioned Costs = \$976	Questioned Costs = \$12,361

*In January 2015, prior to receipt of the SWSA14 audit findings, the Community Services Division (CSD) introduced an RCA referral tool in the electronic Jobs Automated System (eJAS). The tool requires CSD staff to complete an employability screening for eligible clients and to create a referral to an authorized employment provider. With the introduction of the RCA referral tool in eJAS there now exists a system to refer and track RCA recipients. This has significantly increased appropriate referrals, and the Department will ensure continued staff training and monitoring is provided to*

*ensure that this new automated system is functioning and that all eligible refugees are referred to W&T programs.*

*CSD will continue to ensure all CSO staff receive annual training to facilitate accurate RCA eligibility determination and W & T referrals. To complement the annual training, ORIA program managers will regularly visit local offices across the state to provide outreach and onsite technical assistance to ensure staff are appropriately trained and able to make accurate RCA eligibility determinations and W & T referrals.*

*ORIA will continue to review, track, and monitor RCA enrollments and employment referrals through a monthly report from the ESA Management Accountability and Performance Statistics unit. For those clients not referred to a W&T program, ORIA will work with CSD Operations staff to correct errors in eligibility determination and employment referrals.*

*ORIA will work with ESA's Information Technology Solutions team to explore the feasibility of implementing a system edit, or "hard stop" to prevent financial workers from inappropriately enrolling a minor into an RCA (in the Automated Client Eligibility System).*

*In addition to the newly implemented controls, the Department employs the following efforts to ensure that only eligible clients are enrolled in the RCA program:*

- *When processing client eligibility, Community Service Division (CSD) staff first determine eligibility for TANF. Refugees who are age 65 or older and are ineligible for TANF can be authorized for RCA immediately at the same time that they are referred to receive assistance with applying for Social Security Administration benefits (SSI). If ineligible for TANF or SSI, refugees are eligible to receive up to eight months of RCA from the date of arrival in the U.S.*
- *Supervisors audit staff work monthly. These audits consist of full case reviews of probationary staff for which 100% of their case work is audited, as well as ongoing, periodic full case reviews of permanent (non-probationary) staff.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

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

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

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

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

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

Material weakness in internal control over compliance. A deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable

possibility that material noncompliance with a compliance requirement will not be prevented, or detected and corrected, on a timely basis. In this section, a reasonable possibility exists when the likelihood of the event is either reasonably possible or probable as defined as follows:

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

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

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

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

45 CFR section 400.53 General eligibility requirements states in part:

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

45 CFR section 400.75 Registration for employment services, participation in employability service programs and targeted assistance programs, going to job interviews, and acceptance of appropriate offers of employment , states in part:

- (a) As a condition for receipt of refugee cash assistance, a refugee who is not exempt under § 400.76 of this subpart must, except for good cause shown—
  - (1) Register with an “appropriate agency providing employment services,” as defined in § 400.71, and within 30 days of receipt of aid participate in the employment services provided by such agency, as defined in § 400.154(a) of this part.
  - (2) Go to a job interview which is arranged by the State agency or its designee.
  - (3) Accept at any time, from any source, an offer of employment, as determined to be appropriate by the State agency or its designee.
  - (4) Participate in any employability service program which provides job or language training in the area in which the refugee resides, which is funded under section 412(c) of the Act, and which is determined to be available and appropriate for that refugee; or if such a program funded under section 412(c) is not available or appropriate in the area in which the refugee resides, any other available and appropriate program in such area.
  - (5) Participate in any targeted assistance program in the area in which the refugee resides, which is funded under section 412(c) of the Act, and which is determined to be available and appropriate for that refugee.
  - (6) (i) Accept an offer of employment which is determined to be appropriate by the local resettlement agency which was responsible for the initial resettlement of the refugee or by the appropriate State or local employment service;
    - (ii) Go to a job interview which is arranged through such agency or service; and

- (ii) Participate in a social service or targeted assistance program which such agency or service determines to be available or appropriate.

WAC 388.466.0150 Refugee employment and training services, states:

- (1) What are refugee employment and training services?  
Refugee employment and training services provided to eligible refugees may include information and referral, employment oriented case management, job development, job placement, job retention, wage progression, skills training, on-the-job training, counseling and orientation, English as a second language, and vocational English training.
- (2) Am I required to participate in refugee employment and training services?  
If you are receiving refugee cash assistance (RCA) you are required to participate in refugee employment and training services, unless you are exempt.
- (3) How do I know if I am exempt from mandatory employment and training requirements?
  - (a) You may be exempt from participation in employment and training requirements if:
    - (i) You are needed in the home to personally provide care for your child under three months of age (see WAC388-310-0300);
    - (ii) You are sixty years of age or older.
  - (b) You can not be exempt from work and training requirements solely because of an inability to communicate in English.
- (4) If I am required to participate, what do I have to do?  
You are required to:
  - (a) Register with your employment service provider;
  - (b) Accept and participate in all employment opportunities, training or referrals, determined appropriate by the department.
- (5) What happens if I do not follow these requirements?  
If you refuse without good reason to cooperate with the requirements, you are subject to the following penalties:
  - (a) If you are applying for refugee cash assistance, you will be ineligible for thirty days from the date of your refusal to accept work or training opportunity; or
  - (b) If you are already receiving refugee cash assistance, your cash benefits will be subject to financial penalties.
  - (c) The department will notify your voluntary agency (VOLAG) if financial penalties take place.
- (6) What are the penalties to my grant?  
The penalties to your grant are:
  - (a) If the assistance unit includes other individuals as well as yourself, the cash grant is reduced by the sanctioned refugee's amount for three months after the first occurrence. For the second occurrence the financial penalty continues for the remainder of the sanctioned refugee's eight-month eligibility period.
  - (b) If you are the only person in the assistance unit your cash grant is terminated for three months after the first occurrence. For the second occurrence, your grant is terminated for the remainder of your eight-month eligibility period.
- (7) How can I avoid the penalties?  
You can avoid the penalties, if you accept employment or training before the last day of the month in which your cash grant is closed.
- (8) What is considered a good reason for not being able to follow the requirements?



You have a good reason for not following the requirements if it was not possible for you to stay on the job or to follow through on a required activity due to an event outside of your control. See WAC 388-310-1600 (3) for examples.

**2015-023 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:** G1401WACCDF; G1501WACCDF  
**Applicable Compliance Component:** Activities Allowed or Unallowed and Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$64,802  
**Likely Questioned Cost Amount:** \$85,239,118

**Background**

The Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. Child care providers consist of licensed centers, licensed in-home providers and friends, family or neighbors (FFNs).

DEL is responsible for establishing adequate policies and procedures to ensure payments are allowable. In fiscal year 2015, the Department made an estimated 96,000 payments to providers consisting of over 626,000 monthly child care subsidy payments. These payments totaled approximately \$200 million in federal grant funds, as well as \$51.5 million in state funds.

*Authorizations for child care*

To be authorized for child care services, parents must be determined eligible based on their income, residency and demonstrated need based on their work schedules. Once parents are determined eligible, DSHS authorizes one of two service levels. For licensed providers, the service levels are generally either 23 full-day units (up to ten 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).

The authorized service level is based on the parent’s work schedule, which is also required to be documented and updated with DSHS when it changes significantly. Payments for child care are only allowable if they are properly approved, adequately documented and for actual worked hours.

*Attendance records*

According to state rules, child care providers must maintain attendance records to support their requests for payment. At a minimum, the records must include the children’s names, date(s) child care was provided and authorized signatures 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 requested to submit attendance records and other supporting documentation, which are reconciled to paid invoices.

DEL subsidy auditors completed 1,072 reconciliations during the audit period. DEL auditors identified 701 instances (65 percent) of provider overpayments during their reconciliations and assessed overpayments that totaled \$536,000. The identified overpayments represented 12.5 percent of the total payments reviewed.

The most common reasons DEL's reconciliations determined overpayments occurred were:

- Providers overbilled because child care was not provided.
- Providers did not maintain required attendance records.
- Providers billed and were paid for the maximum amount of authorized childcare, regardless if services aligned with the family's established work schedule.
- Providers made billing errors relating to absence days.

### *Prior audit results*

Since fiscal year 2005, we have reported the Departments have not established adequate internal controls to prevent unallowable payments. During fiscal years 2010 and 2011, we found DSHS did not adequately reconcile attendance records with child care payments. In fiscal year 2012 DEL assumed this process, but only reconciled one month of child care payments to attendance records. In fiscal year 2013, we found no reconciliations of fiscal year 2013 months of service were performed. In 2014, reconciliations were initiated for three months of the fiscal year and the rest of the reconciliations were for services months in prior fiscal years. The most recent audit finding numbers were 2014-023, 2013-016, 12-28, 11-23, 10-31, 9-12, and 8-13.

In October 2012, our Office issued an accountability audit report titled, "Audit of State Payments to Child Care Providers," covering the period from July 1, 2010 to June 30, 2011. Using a statistical sample of 153 providers, the audit identified actual overpayments of \$1.6 million and total estimated overpayments of \$73.9 million. The audit also identified \$2.9 million in payments supported by questionable documentation, with estimated questionable payments that totaled of \$34.9 million. The payments examined in the audit were funded by both state and federal grants.

### **Description of Condition**

We found the Departments continue to lack adequate internal controls to prevent and detect significant unallowable payments to child care providers. In response to the most recent audit finding, DEL said it would work to address the internal control weaknesses by having dedicated staff perform payment reconciliations. DEL also said it would seek timely reimbursements from providers for overpayments.

DEL has a desk manual that contains steps for subsidy auditors to follow when performing reconciliations. However, management instructed subsidy auditors to disregard some of the desk

manual criteria during the audit period. For the audit period, DEL's reconciliation steps used included the following:

- Determine if submitted provider attendance records are complete and contact the provider if records are incomplete.
- Examine attendance records for reasonability and allow for partial parental/guardian signatures and/or names of children without signatures.
- Determine allowable region rates for the provider by region and child's age, and compare this to the billed invoice.
- Allow unlimited absence days per month as long as the child attended for one day of the month.
- Determine any allowable holidays providers were allowed to bill.

The criteria that was disregarded included key internal control components such as comparing attendance records and provider billings to the approved child care schedule and not limiting absences as required by state regulations.

We randomly selected and examined 399 payments for child care totaling \$155,846 in federal funds to determine if they were allowable. Of the 399 payments, 133 were selected from each of three provider types: licensed centers, licensed in-home providers and FFNs. With assistance from DEL, we requested attendance records from providers that supported the payments. We also compared the providers' records to the case files to determine if the payments were allowed by federal and state regulations, as well as DEL's internal policies.

We found 263 payments were partially or completely unallowable with questioned costs totaling \$64,802. For the payments we examined, overpayments were found for 94 percent of FFNs, 57 percent for licensed in-home care providers and 47 percent for licensed centers.

The reasons we found that overpayments occurred were:

- Some providers billed the maximum childcare authorized regardless of the amount of actual services performed, or required by the parent's work schedules.
- Providers overbilled for services not performed.
- Attendance records were not provided upon request or were inadequate to support payments.

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

### **Cause of Condition**

Sufficient preventative 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 or hours. Childcare providers are not required to submit any supporting documentation before payments are made. The authorization maximums also do not prevent clients from using child care when they are not working.

While DEL subsidy auditors reviewed some payments (1.6 percent), they specifically did not consider certain components required by state regulations, such as comparing attendance records with payments and the documented working schedule for the parents. Therefore, while the DEL auditors' reconciliations identified overpayments 65 percent of the time, they likely did not detect

all overpayments during their reviews. Audits for providers with overpayments were not expanded to determine if the issues were systemic.

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

By not having adequate internal controls in place, the state is at a higher risk of making improper payments for child care services. Additionally, by not considering all criteria required by state regulations, DEL auditors may not detect all improper payments when performing reconciliations. By not expanding its audits when overpayments are found, DEL may not be identifying providers with systemic billing issues.

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 questioned costs to be \$85,239,118. The statistical sample that was used for testing was also used to test compliance with eligibility and period of performance requirements. Because some payments we examined were unallowable for violating multiple federal compliance requirements, some of the questioned costs reported here may also be reported in findings number 2015-026 and 2015-027.

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 payments.

Many of the improper payments were partially funded by state dollars. Specifically, we found \$18,667 of improper state payments, which projects to a likely improper payment amount of \$24,956,886. This amount is not included in the federal questioned costs.

### **Recommendation**

We recommend the Departments implement preventative internal controls over payments to providers to reduce the rate of unallowable payments.

Further, we also recommend DEL continue to improve its reconciliation process by following Departmental policies, testing to all federal and state regulations when reviewing provider payments, and reviewing payments more timely.

Finally, when significant provider overpayments are found, DEL auditors should expand their examinations to determine if the issue is isolated or systemic.

### **Agency's Response**

*DEL concurs with this finding and recommendations.*

*DEL is actively taking steps to reduce overpayments including changes to the program rules, policy clarifications, provider feedback and training, record keeping templates, improved communication between DEL and DSHS, assigned audit caseloads, auditor training, and risk-based auditing techniques. DEL has moved to a system of auditing providers based on month of payment rather than month of service in an effort to improve the timeliness of audit reviews.*

*DEL's efforts to reduce overpayments and identify fraud are undertaken in the context of a manual, paper-based attendance and billing system not conducive to accurate billing or fraud detection. DEL has and will continue to request funding for an electronic time and attendance billing system whereby attendance data for all providers is available and reconciled to billing before payment is*

*made. In addition to preventing provider error, such a system would eliminate many forms of potential fraud.*

*DEL believes addressing the root causes of the high level of unintentional errors will result in greater decreases in improper payments. In addition, DEL will undertake expanded record review in cases where DEL has information to suggest it is likely to uncover additional types of billing errors, return substantial sums to the grant, or assist with fraud investigations.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

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

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

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

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

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

Title 45 Code of Federal Regulations, Section 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.

Title 45 Code of Federal Regulations, section 98.50 - Child care services, states in part:

- (a) Of the funds remaining after applying the provisions of paragraphs (c), (d) and (e) of this section the Lead Agency shall spend a substantial portion to provide child care services to low-income working families.
- (b) Child care services shall be provided:
  - (1) To eligible children, as described in § 98.20;
  - (2) Using a sliding fee scale, as described in § 98.42;
  - (3) Using funding methods provided for in § 98.30; and
  - (4) Based on the priorities in § 98.44.

Title 45 Code of Federal Regulation, Section 98.54 - Restrictions on the use of funds, states in part:

- (a) General.
  - (1) Funds authorized under section 418 of the Social Security Act and section 658B of the Child Care and Development Block Grant Act, and all funds transferred to the Lead Agency pursuant to section 404(d) of the Social Security Act, shall be expended consistent with these regulations. Funds transferred pursuant to section 404(d) of the Social Security Act shall be treated as Discretionary Funds;



- (2) Funds shall be expended in accordance with applicable State and local laws, except as superseded by § 98.3.

Title 45 Code of Federal Regulations, Section 98.67 - Fiscal requirements, states:

- (a) Lead Agencies shall expend and account for CCDF funds in accordance with their own laws and procedures for expending and accounting for their own funds.
- (b) Unless otherwise specified in this part, contracts that entail the expenditure of CCDF funds shall comply with the laws and procedures generally applicable to expenditures by the contracting agency of its own funds.
- (c) Fiscal control and accounting procedures shall be sufficient to permit:
  - (1) Preparation of reports required by the Secretary under this subpart and under subpart H; and
  - (2) The tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the provisions of this part.

WAC 170-290-0005 Eligibility, states:

- (1) Parents. To be eligible for WCCC, the person applying for benefits 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 two hundred percent of the FPG;
  - (g) Not have a monthly copayment that is higher than the state will pay for all eligible children in care;
  - (h) Complete the WCCC application and DSHS verification process regardless of other program benefits or services received; and
  - (i) 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 age thirteen; or
  - (ii) Less than age nineteen, and:
    - (A) Have a verified special need, according WAC [170-290-0220](#); or
    - (B) Be under court supervision.

WAC 170-290-0012 Verifying consumers' information, states:

- (1) A consumer must complete the DSHS application for WCCC benefits and provide all required information to DSHS to determine eligibility when:
  - (a) The consumer initially applies for benefits; or
  - (b) The consumer reapplies for benefits.
- (2) A consumer must provide verification to DSHS to determine if he or she continues to qualify for benefits during his or her eligibility period when there is a change of circumstances under WAC [170-290-0031](#).
- (3) 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.
- (4) 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\(9\)](#).
- (5) The verification that the consumer gives to DSHS includes, but is not limited to, the following:
  - (a) A current WorkFirst IRP for consumers receiving TANF;
  - (b) Employer name, address, and phone number;
  - (c) State business registration and license, if self-employed;
  - (d) Work, school, or training schedule (when requesting child care for non-TANF activities);
  - (e) Hourly wage or salary;
  - (f) Either the:
    - (i) Gross income for the last three months;
    - (ii) Federal income tax return for the preceding calendar year; or
    - (iii) DSHS employment verification form;
  - (g) Monthly unearned income the consumer receives, such as child support or supplemental security income (SSI) benefits;
  - (h) If the other parent is in the household, the same information for them;
  - (i) 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](#);
- (j) Name and phone number of the licensed child care provider; and
- (k) For the in-home/relative child care provider, a:
  - (i) Completed and signed criminal background check form;
  - (ii) Legible copy of the proposed provider's photo identification, such as a driver's license, Washington state identification, or passport;
  - (iii) Legible copy of the proposed providers' valid Social Security card; and
  - (iv) All other information required by WAC [170-290-0135](#).
- (6) If DSHS requires verification from a consumer that costs money, DSHS must pay for the consumer's reasonable costs.
- (7) DSHS does not pay for a self-employed consumer's state business registration or license, which is a cost of doing business.
- (8) If a consumer does not provide all of the verification requested, DSHS will determine if a consumer is eligible based information already available to DSHS.

WAC 170-290-0020 Eligibility—Special circumstances, states:

- (1) Child care provided at the consumer's place of work. A consumer is not eligible for WCCC benefits for his or her children when child care is provided at the same location where the consumer works.
- (2) Consumer's child care employment.
  - (a) A consumer may be eligible for WCCC benefits during the time she or he works in a child care center but does not provide direct care in the same classroom to his or her children during work hours.
  - (b) A consumer is not eligible for WCCC benefits during the time she or he works in a family home child care where his or her children are also receiving subsidized child care.
  - (c) In-home/relative providers who are paid child care subsidies to care for children receiving WCCC benefits may not receive those benefits for their own children during the hours in which they provide subsidized child care.
  - (d) A child care provider who receives TANF benefits on behalf of a dependent child may not bill the state for subsidized child care for that same child.
- (3) Two-parent family.
  - (a) A consumer may be eligible for WCCC if he or she is a parent in a two-parent family and one parent is not able or available as defined in WAC [170-290-0003](#) to provide care for the children while the other parent is working or participating in approved activities.
  - (b) If a consumer claims one parent is not able to care for the children the consumer must provide written documentation from a licensed professional (see WAC [388-448-0020](#)) that states the:
    - (i) Reason the parent is not able to care for the children;
    - (ii) Expected duration and severity of the condition that keeps the parent from caring for the children; and
    - (iii) Treatment plan if the parent is expected to improve enough to be able to care for the children. The parent must provide evidence from a medical professional showing he or she is cooperating with treatment and is still not able to care for the children.

- (4) Single-parent family. A consumer is not eligible for WCCC benefits when he or she is the only parent in the family and will be away from the home for more than thirty days in a row.
- (5) Legal guardians.
  - (a) A legal guardian under WAC [170-290-0005](#) may receive WCCC benefits for his or her work or approved activities without his or her spouse or live-in partner's availability to provide care being considered unless his or her spouse or live-in partner is also named on the permanent custody order.
  - (b) Eligibility for WCCC benefits is based on the consumer's work or approved activities schedule, the child's need for care, and the child's income eligibility and family size of one.
  - (c) The consumer's spouse or live-in partner is not eligible to receive subsidized child care payments as a child care provider for the child.
- (6) In loco parentis custodians.
  - (a) An in loco parentis custodian may be eligible for WCCC benefits when he or she cares for an eligible child in the absence of the child's legal guardian or biological, adoptive or step-parents.
  - (b) An in loco parentis custodian who is not related to the child as described in WAC [170-290-0005](#)(1) may be eligible for WCCC benefits if he or she has:
    - (i) A written, signed agreement between the parent and the caregiver assuming custodial responsibility; or
    - (ii) Receives a TANF grant on behalf of the eligible child.
  - (c) Eligibility for WCCC benefits is based on his or her work schedule, the child's need for care, and the child's income eligibility and family size of one.
  - (d) The consumer's spouse or live-in partner is not eligible to receive subsidized child care payments as a child care provider for the child.
- (7) WorkFirst sanction.
  - (a) A consumer may be eligible for WCCC if he or she is a sanctioned WorkFirst participant and participating in an activity needed to remove a sanction penalty or to reopen his or her WorkFirst case.
  - (b) A WorkFirst participant who loses his or her TANF grant due to exceeding the federal time limit for receiving TANF may still be eligible for WCCC benefits under WAC [170-290-0055](#).

WAC 170-290-0031 Notification of changes, states:

When a consumer applies for or receives WCCC benefits, he or she must:

- (1) Notify DSHS, within five days, of any change in providers;
- (2) Notify the consumer's provider within ten days when DSHS changes his or her child care authorization;
- (3) Notify DSHS within ten days of any significant change related to the consumer's copayment or eligibility, including:
  - (a) The number of child care hours the consumer needs (more or less hours);
  - (b) The consumer's countable income, including any TANF grant or child support increases or decreases, only if the change would cause the consumer's countable income to exceed the maximum eligibility limit as provided in WAC [170-290-0005](#). A consumer may notify DSHS at any time of a decrease in the consumer's household income, which may lower the consumer's copayment under WAC [170-290-0085](#);
  - (c) The consumer's household size such as any family member moving in or out of his or her home;

- (d) Employment, school or approved TANF activity (starting, stopping or changing);
  - (e) The address and telephone number of the consumer's in-home/relative provider;
  - (f) The consumer's home address and telephone number; and
  - (g) The consumer's legal obligation to pay child support;
- (4) Report to DSHS, within twenty-four hours, any pending charges or conviction information the consumer learns about his or her in-home/relative provider; and
  - (5) Report to DSHS, within twenty-four hours, any pending charges or conviction information the consumer learns about anyone sixteen years of age and older who lives with the provider when care occurs outside of the child's home.

WAC 170-290-0095, When WCCC benefits start, states:

- (1) WCCC benefits for an eligible consumer may begin when the following conditions are met:
  - (a) The consumer has completed the required WCCC application and verification process as described under WAC [170-290-0012](#) within thirty days of the date DSHS received the consumer's application or reapplication for WCCC benefits;
  - (b) The consumer is working or participating in an approved activity under WAC [170-290-0040](#), [170-290-0045](#), [170-290-0050](#) or [170-290-0055](#);
  - (c) The consumer needs child care for work or approved activities within at least thirty days of the date of application for WCCC benefits; and
  - (d) The consumer's eligible provider (under WAC [170-290-0125](#)) is caring for his or her children.
- (2) If a consumer fails to turn in all information within thirty days from his or her application date, the consumer must restart the application process.
- (3) The consumer's application date is whichever is earlier:
  - (a) The date the consumer's application is entered into DSHS's automated system; or
  - (b) The date the consumer's application is date stamped as received.

WAC 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.

WAC 170-290-0271, Payment discrepancies—Consumer overpayments, states:

- (1) DSHS establishes overpayments for past or current consumers when the consumer:
  - (a) Received benefits when he or she was not eligible;
  - (b) Used care for an unapproved activity or for children not in his or her WCCC household;
  - (c) Failed to report information 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](#); or
- (e) Received benefits for a child who was not eligible per WAC [170-290-0015](#) or [170-290-0020](#).
- (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 [170-290-0032](#) and the provider has billed correctly, the consumer is responsible for the entire overpayment, including any absent days.

WAC 170-290-0275, Payment discrepancies—Providers covered under collective bargaining, states:

- (1) This section applies to any provider covered under the collective bargaining agreement.
- (2) For in-home/relative and licensed family home child care providers, disputes regarding underpayments shall be grievable.
- (3) Beginning July 1, 2007, there are different time frames for how far back a payment discrepancy may be corrected. The time frames, as provided in this subsection are based on:
  - (a) When services were provided;
  - (b) When the request for the underpayment was made; and
  - (c) The type of provider: Family home or in-home/relative provider.
- (4) Family home and in-home/relative providers must submit a claim for payment no later than twelve months after the date of service. "Submitting a claim for payment" means turning the original invoice in to DSHS for services no later than twelve months after the date of service. If the claim for payment is made within the twelve-month period, the time limits for correcting payment errors are:
  - (a) Two years back if the error is on rates paid by age and/or region, unless discovered by a federal audit. This means the provider has up to two years after the date of service to ask for a corrected payment; or
  - (b) Three years back if the error was for any other reason, including those discovered by a federal audit. This means the provider has up to three years after the date of service to ask for a corrected payment.

WAC 388-410-0001, What is a cash assistance overpayment?, states:

- (1) An overpayment is any cash assistance paid that is more than the assistance unit was eligible to receive.
- (2) There are two types of cash overpayments:
  - (a) Intentional overpayments, presumed to exist if you willfully or knowingly:
    - (i) Fail to report a change you must tell us about under WAC [388-418-0005](#) within the time frames under WAC [388-418-0007](#); or
    - (ii) Misstate or fail to reveal a fact affecting eligibility as specified in WAC [388-446-0001](#).
  - (b) Unintentional overpayments, which includes all other client-caused and all department-caused overpayments.
- (3) If you request a fair hearing and the fair hearing decision is in favor of the department, then:
  - (a) Some or all of the continued assistance you get before the fair hearing decision must be paid back to the department (see WAC [388-418-0020](#)); and
  - (b) The amount of assistance you must pay back will be limited to sixty days of assistance, starting with the day after the department receives your hearing request.
- (4) If you receive child support payments directly from the noncustodial parent, you must turn these payments over to the division of child support (DCS). These payments are not cash assistance overpayments.

**2015-024 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:** G1501WACCDF; G1401WACCDF  
**Applicable Compliance Component:** Special Tests and Provisions - Health and Safety Requirements  
**Questioned Cost Amount:** None

## **Background**

The Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. In fiscal year 2015, approximately \$200 million was paid to child care providers. DEL is the lead agency responsible for ensuring providers meet licensing standards, including ensuring background checks are performed for all staff with direct access to children.

As the lead agency, DEL monitors and enforces licensing rules for child care providers. The Department conducts unannounced, annual on-site inspections of licensed providers to verify if required safety and health standards are being met and require providers to address any identified issues. Department staff (licensors) document inspections using a checklist. When safety and health 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 to their licensor a corrective action plan or resolution activity to the Department. If an attempt was made for an inspection, and the provider was not present, the licensor must follow-up and conduct their inspection within 30 days of the due date. If a follow-up inspection cannot be conducted, the licensor consults with their supervisor for a decision on conducting any further inspection attempts.

When any licensing health, safety, or well-being of children non-compliance issues are identified the Department must ensure the non-compliance issues have been resolved. This often requires additional, unannounced inspections. Examples of issues include:

- Providers that exceed the required staff to child ratios
- Providers that did not maintain accurate or complete attendance logs
- Provider supervision was not sufficient to ensure the safety of children
- Health and safety hazards

If the provider does not resolve a noncompliance issue the Department has the authority to impose sanctions, issue fines, or suspend or revoke the provider's license.



The Department conducts additional unannounced inspections for other reasons including, but not limited to:

- Receipt of health or safety complaints.
- Receipt of complaints regarding verbal, physical, or sexual abuse.
- When accidents resulting in physical harm to a child, including, but not limited to unintentional accidents, and allegations of intentional acts of violence to a child are reported.

### **Description of Condition**

In state fiscal year 2015, DEL regulated 5,642 licensed providers. Department staff informed us that 935 (17 percent) of all licensed providers were overdue on their yearly inspections (licensors had attempted visits on 152 of those providers).

We reviewed records for 22 licensed providers for internal control testing to determine if required background checks were performed and monitoring inspections were conducted as required. We found:

- One monitoring inspection was performed two months late.
- Two required monitoring inspections were not conducted and were over-due by two and six months, as of June 30, 2015.

We also randomly selected 58 child care providers (including the 22 listed above) for compliance testing and performed tests to determine if inspections were conducted on time, included all licensing requirements, and ensured that the Department addressed non-compliance according to the severity of the issue identified. We found:

- Two inspections were conducted between two and 20 months late.
- Four inspections had not been conducted as of June 30, 2015.
  - All four providers who were not inspected were identified as having health, safety, or well-being of children non-compliance issues during their last inspection.
- For the inspections that occurred, the Department provided us with evidence showing all licensing requirements were examined by the licensor.

For violations that may immediately impact the health, safety, and well-being of children within the provider's care, licensors are required to follow-up with an on-site visit within 10 business days. We examined the Department's response to violations documented during inspections and found 14 cases (24 percent) identified health, safety, and well-being of children violations, but were not appropriately followed-up on per Department policy to ensure they were corrected. Some examples of these serious violations were:

- Inadequate supervision of children
- Use of inappropriate disciplinary methods
- Exceeding the maximum licensed capacity
- Exceeding the staff to child ratio
- General health and safety hazards to the children

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

## **Cause of Condition**

Management stated there were times when reduced staffing and significant turnover made conducting timely inspections difficult to complete. We found one instance when supervisors were not aware providers were overdue for inspections by two years.

Management also stated there have been circumstances when some licensed family home providers refused licensors access during their scheduled inspection, or were repeatedly not home during regular business hours for an inspection. These types of refusals, or provider un-availabilities should, by policy, be followed up by another licensor monitoring attempt within 30 days, and follow-up communication and results should be shared with the licensor's supervisor as necessary.

Finally, while the policies and procedures in place require a second inspection for serious health and safety violations, licensors sometimes rely on attestations in place of on-site inspections to resolve issues.

## **Effect of Condition**

The Department's activities resulted in inconsistent monitoring and enforcement actions for providers. When inspections are not conducted, or are conducted late, it increases the likelihood that the Department would not detect health and safety violations in a timely manner.

Further, we found 17 percent of inspection records 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 in a timely manner, the Department cannot be sure these issues have been corrected. Health and safety, supervision, discipline, and over-capacity/over-ratio violations may put children in jeopardy for harm, neglect, and unhealthy emotional and cognitive development environments.

## **Recommendation**

We recommend the Department ensure staff follow all policies related to health and safety requirements. This includes ensuring management oversight is sufficient to ensure compliance with state rules and policies and procedures and that child care providers are meeting all applicable health and safety requirements.

## **Agency's Response**

*The Department of Early Learning (DEL) concurs with this finding and recommendation, and is strongly committed to ensuring the health, safety and well-being of all children in licensed care.*

*To quickly address these deficiencies in our monitoring efforts DEL is:*

- *Reassigning licensing staff from regions where work is being completed timely to regions where staff are behind.*
- *Undertaking emergency rulemaking to clarify when licensors should not inspect licensees that have become inactive.*
- *Recently created a licensing background unit that will allow staff to better manage fingerprint requirements.*

*As a longer-term, more permanent resolution, DEL will continue to request funding to develop an integrated licensing management system. The current fractured and disjointed licensing system tools require too much time from licensors both in the field and at their office, leaving insufficient time to adequately manage their caseloads. Replacing the inefficient licensing IT system staff use now should better allow them to make timely updates, improve data integrity, and streamline their work processes, resulting in time savings to reinvest in the higher caseload and additional state and federal licensing requirements.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

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

agreements that has a material effect on the audit; and (4) abuse that has a material effect on the audit.

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

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

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

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

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

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

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

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

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

45 CFR 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 CFR 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.
  - (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.

WAC 170-296A-0001, Authority, states:

The department of early learning was established under chapter 265, Laws of 2006. Chapter [43.215](#) RCW establishes the department's responsibility and authority to set and enforce licensing requirements and standards for licensed child care agencies in Washington state, including the authority to adopt rules to implement chapter [43.215](#) RCW.

WAC 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.

WAC 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.

WAC 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.

WAC 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.

WAC 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.

WAC 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.

WAC 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.

WAC 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, 10.1.3 Compliance Agreement Procedure state in part:

#### Completing the Compliance Agreement

1. The licensor must use 10.9.1.1 Compliance Agreement 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.
7. If there is an immediate health and safety issue, the issue will be corrected immediately or as soon as possible to ensure child safety but no later than 10 business days to ensure child health and safety.

#### Monitoring the Compliance Agreement

10. The licensor must monitor the compliance agreement based on the nature and severity of WAC violations.
11. The licensor must make a site visit within 10 business days to verify correction of licensing non-compliance that could immediately impact the health, safety and well-being of children in care. The site visit must be documented in FamLink using the health and safety re-check code. The licensor must request supervisor approval if unable to meet this time frame and this must be documented in FamLink provider notes. Examples may include but are not limited to:
  - a. Health and safety hazards
  - b. Behavior management
  - c. Supervision

- d. Staff/child interaction
  - e. Group size/capacity
  - f. Medication management
  - g. Nap and sleep equipment to include SIDS prevention
  - h. Window blind cords that form a loop
12. 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 compliance. 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. Health Care Plan
  - g. Fire Drill record

**2015-025 The Department of Early Learning did not have adequate internal controls over child care fraud detection and repayments.**

**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:** G1401WACCDF; G1501WACCDF;  
**Applicable Compliance Component:** Special Tests and Provisions – Fraud Detection and Repayment  
**Questioned Cost Amount:** none

**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 child care. In fiscal year 2015, child care providers were paid approximately \$200 million in federal grant funds. The Department of Early Learning is the lead agency for the CCDF program and is responsible for recovering child care payments as the result of fraud. However, in Washington, the Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) has delegated authority to conduct investigations related to allegations of fraud within the CCDF program.

Both DEL and DSHS have a place to refer suspected fraud on their websites and all staff who work at either agency can refer suspected fraud to a hotline. DEL staff perform case reviews to identify payment errors. Overpayments are sent for collection to DSHS, and could lead to a referral to OFA for suspected fraudulent activity.

State and federal law require DEL to refer all suspected incidents of child care subsidy fraud to OFA for appropriate investigation and action and to recover child care payments.

DEL randomly selects provider payments to review based on a given month of service. When a provider is selected for review, child care subsidy auditors request attendance records for all payments to that provider for the month and compare the records to paid invoices. If an error is found, the subsidy auditor establishes an overpayment and refers the case to a supervisor for further examination if fraud is suspected. The supervisor determines whether to forward the case to a manager for a final fraud referral determination, prior to referring the case to OFA for fraud investigation.

In fiscal year 2015 the Department made an estimated 96,000 payments to providers consisting of over 626,000 monthly child care subsidy payments. DEL reviewed records for 1,072 provider billing months, which totaled approximately \$4.29 million in payments. The reviews identified overpayments in 701 (65 percent) of those months, totaling approximately \$536,000.

**Description of Condition**

The Department did not have adequate internal controls to ensure it referred all suspected client or provider child care fraud to OFA for examination and determination.

Despite identifying potential overpayments in 65 percent of the payment records examined during the year, only one case was referred to OFA for investigation of suspected fraud. The Department did not expand its review for any of the cases that resulted in significant overpayments, which could have led to support for a fraud investigation.

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

### **Cause of Condition**

The Department does not have written policies and procedures related to the identification of suspected fraud for use by staff performing and supervising the payment review process.

The determination of whether a case is referred to OFA as suspected fraud is made on a judgment basis by staff. However, management explained that staff do not receive training specific to identify suspected fraud. Managers stated that DEL staff are directed to refer anything that appears to represent fraudulent activities to supervisors.

### **Effect of Condition**

DEL is at higher risk of not detecting fraudulent billing activities by not expanding its examination of records when significant overpayments are detected.

Further, as a result of the Department's lack of established guidance and training for identifying suspected fraud, staff may not be properly referring cases to OFA.

### **Recommendation**

We recommend DEL:

- Establish written policies and procedures for staff to follow when potential fraud is suspected.
- Consider expanding its review of provider records when significant overpayments are discovered during payment reviews.
- Provide training for staff responsible for reviewing provider records and who make decisions about whether to refer cases of suspected fraud to OFA.
- Ensure that all suspected incidents of child care subsidy fraud are referred to OFA, as required by state law.

### **Agency's Response**

*DEL concurs with this finding and recommendations.*

*DEL concurs that written policies and written procedures for staff to follow when potential fraud is suspected, and auditor training in the elements of fraud, would be beneficial. DEL will take these and other steps to refer more suspected fraud cases.*

*DEL's efforts to reduce overpayments and identify fraud are undertaken in the context of a manual, paper-based attendance and billing system not conducive to accurate billing or fraud detection. DEL has and will continue to request funding for an electronic time and attendance billing system whereby attendance data for all providers is available and reconciled to billing before payment is*

*made. In addition to preventing provider error, such a system would eliminate many forms of potential fraud.*

*DEL is actively taking steps to reduce overpayments including changes to the program rules, policy clarifications, provider feedback and training, record keeping templates, improved communication between DEL and DSHS, assigned audit caseloads, auditor training, and risk-based auditing techniques. Since beginning to take these active steps, the number of suspected incidents of fraud have also increased (DEL recently referred three cases identified by DEL Subsidy Audit to OFA). DEL will continue to refer all suspected cases of fraud to OFA and will provide OFA the documentation necessary to support the investigation, including expanded review of provider records where necessary to support the investigation. Under the current systems, most instances of provider overpayment cases will not benefit from expanded record review, as additional records will simply support the conclusion that the provider regularly bills in error unintentionally (not intentionally, which constitutes fraud). DEL believes addressing the root causes of the high level of unintentional errors will result in greater decreases in improper payments.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

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

45 CFR, 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.

Child care subsidy fraud - Referral - Collection of overpayments.

- (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.

**2015-026 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:** G1401WACCDF; G1501WACCDF;  
**Applicable Compliance Component:** Eligibility  
**Questioned Cost Amount:** \$12,967  
**Likely Questioned Costs:** \$22,680,872

**Background**

The Department of Early Learning (DEL) administers the federal Child Care and Development grant to assist eligible working families in paying for child care. The Department of Social and Health Services (DSHS) determines client eligibility and pays child care providers under an agreement with DEL. In fiscal year 2015, child care providers were paid approximately \$200 million in federal grant funds.

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

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

In addition to the requirements above, the state has established the following rules that must be followed when determining eligibility:

- All verification of client information must be from a reliable source, accurate, complete and consistent. This includes, but is not limited to, employer and hourly wage information and the parent’s work schedule.
- Determination of family household size and composition.
- The eligibility determination must be completed within 30 days, or the application process must be restarted.

If an ineligible client receives assistance, the payment made to the child care provider is not allowable by federal regulations.

In the past three annual statewide single audits for Washington, we reported in findings that DSHS did not have adequate internal controls over the eligibility process for child care subsidy recipients. These were reported as finding numbers 2014-026, 2013-017 and 12-30.



## Description of Condition

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

We found:

- In most cases, a DSHS caseworker processes client eligibility information and authorizes services without a secondary review or approval.
- Caseworkers can authorize services in the Department's eligibility system without verifying client household income or employment activity.
- Caseworkers who establish authorizations for child care can also make changes to increase these authorizations to exceed full time care without supervisory review.
- DSHS reviews at least one percent of open authorizations for child care eligibility determinations, which does not provide adequate coverage to compensate for the internal control weaknesses to prevent improper payments. As part of these reviews, the Department identified incorrect eligibility determinations regarding parent income, authorizations, co-payments and missing or incomplete documentation.

For authorizations requiring more than standard full-time care, Department policy requires staff to use a special authorization code. The code does not become active until a supervisor has reviewed and approved the request. The system, however, allows a worker to authorize additional care without using the special code, thereby avoiding supervisory approval.

We randomly selected and examined 399 payments totaling \$155,846 in federal funds to determine if the Department properly assessed client eligibility. The examination was designed to determine if the client's eligibility was supported by required documentation and aligned with state rules. We found 34 payments (8.5 percent) were made to child care providers when clients were not properly determined eligible for the program.

We found:

- Fourteen clients were not determined to be eligible within the 30 day window as required by state regulations, and as disclosed within the CCDF federal grant agreement.
- Seven clients were not participating in an approved activity, and were still authorized for benefits.
- Four clients were determined eligible when parental income determinations were made improperly or were incomplete.
- Income information for three clients was not verified properly. In these cases inadequate information was accepted to determine eligibility.
- Three clients were determined eligible when self-employment determinations were made improperly or were incomplete.
- Three clients were improperly determined eligible for other reasons.

In total we identified \$12,967 of provider overpayments due to improper client eligibility determinations.

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

## **Cause of Condition**

DSHS supervisors made eligibility determinations which conflicted with state regulations and the federally approved state plan for the program. When we discussed staff not meeting the 30 day limit for determining eligibility, the Department asserted that income verification could be performed after the 30 day period. State regulations and the approved state plan require these verifications to be performed within 30 days and state regulations require the client must reapply for the program if eligibility verification is not complete after 30 days.

Other incorrect eligibility determinations were a result of required documents, such as birth certificates or work schedule verifications, not being collected before approving and authorizing child care. In some of these instances the documents were never collected.

The Department's eligibility system is designed with an alert function that reminds staff when an issue is outstanding and needs to be addressed. The alerts can be dismissed without confirming outstanding issues were addressed.

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

By not having adequate internal controls in place, the state is at a higher risk of paying providers for child care services when clients are ineligible. This resulted in the Department making improper payments with federal funds.

A statistical sampling method was used to randomly select the payments examined in the audit. We estimate the amount of likely federal questioned costs to be \$22,680,872. The statistical sample that was used for testing was also used to test compliance with eligibility and period of performance requirements. Because some payments tested were unallowable for violating multiple requirements, some of the questioned costs reported here are also reported in finding numbers 2015-023 and 2015-027.

Further, many of the improper payments were partially funded by state dollars. Specifically, we found \$4,518 of improper state payments, which projects to a likely improper payment amount of \$7,720,039. 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 payments.

## **Recommendation**

We recommend DSHS improve its internal controls over determining eligibility to ensure:

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

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

## 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 governments accountable for the use of public resources.*

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

*The Department strongly disagrees with the SAO's statement that "34 payments were made to child care providers when clients were not properly determined eligible for the program." The Department thoroughly reviewed each of the 34 cases in question, and maintains Department staff correctly determined eligibility in every single case.*

*The Department must make "point in time" eligibility determinations based on the information available at the time of application. In fact, if a consumer does not provide all of the verification requested, DSHS is required to determine eligibility based on the information already available to DSHS per [WAC 170-290-0012\(8\)](#).*

*While the Department made accurate initial eligibility determinations in 100% of the 399 cases reviewed by the SAO, the Department concurs that it is likely that in six cases, improper payments were made to child care providers. In five of the six cases in question, the clients failed to accurately report information at application or failed to report changes in their circumstances as required by rule ([WAC 170-290-0031](#)). The Department became aware of this information after making the initial, accurate eligibility determinations. In the sixth case, the Department had appropriately terminated the client's eligibility, however, a minor procedural error allowed child care to briefly continue.*

*In all six cases, the Department was already aware of and actively addressing the client's change in circumstances prior to the SAO's review of the cases and associated payments. It is important to note that changes in clients' circumstances do not necessarily result in changes to a client's eligibility status – minor changes may result in a slight fluctuation of co-payment or hours of care approved.*

*The Department's calculation of total questioned costs is \$2,919 – not \$12,967 as proposed by the State Auditor's Office. The Department has reviewed the cases in question, and is pursuing overpayments as appropriate.*

*These results are consistent with previous audits (SWSA 13, SWSA 14), during which the SAO found the Department correctly determined child care eligibility in all the cases sampled.*

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

**SAO Description of Weakness** - *In most cases, a DSHS caseworker processes client eligibility information and authorizes services without a secondary review or approval.*

*The Department of Social and Health Services partially concurs with this description. Childcare program policy, as established and maintained by the Department of Early Learning, does not*

*require secondary review or approval when determining eligibility and authorizing benefits and payment.*

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

- The Department’s “universal caseload model” utilizes analytics to prioritize and randomly assign work activities to staff. This provides a process where case actions, (such as eligibility determination and authorization for care) are highly likely to be completed by different workers. The assigned worker will conduct a review of the case (essentially a secondary review) each time they receive an assignment. This allows the worker to familiarize themselves with the case and confirm eligibility and payment information prior to completing the required case action. The worker will correct any errors they find prior to completing the assignment. Approximately 140 line staff process child care cases, and the probability of the same case being assigned to the same worker for two case actions in a row is less than one percent.*
- A supervisory review is required for payment requests that exceed certain parameters. The supervisor reviews the need for the additional payment and either approves the payment by submitting the authorization to SSPS or denies the payment if the consumer is not eligible. All special authorizations require supervisor review for approval.*
- New workers have 100% of their work audited by Leadworkers; these audits may be conducted either pre or post-authorization.*

*Also, the federal fiscal year 2014 Improper Payments Information Act (IPIA) audit required by the Federal Office of Child Care and conducted by the Department of Early Learning found that less than one percent of the total amount of payments for the sampled cases were made in error.*

**SAO Description of Weakness** - *Caseworkers can authorize services in the Department’s eligibility system without verifying client household income or employment activity.*

*The Department of Social and Health Services partially concurs with this description. Washington Administrative Code, established and maintained by the Department of Early Learning, requires workers to request verification if not provided by the consumer. Eligibility workers must verify a consumer’s activity and income prior to making eligibility determinations. Childcare program training reinforces these requirements. DEL WAC 170-290-0012 requires a consumer to provide verification of employment or employment activity including income, hours of work and work schedule to receive childcare subsidy payments, however, if a consumer does not provide all of the verification requested, DEL WAC ([WAC 170-290-0012 \(8\).](#)) requires DSHS to determine eligibility based on the information provided to DSHS.*

**SAO Description of Weakness** - *Caseworkers who establish authorizations for child care can also make changes to increase these authorizations to exceed full time care without supervisory review.*

*The Department of Social and Health Services partially concurs with this description. It is true that caseworkers have access to create authorizations, including those that exceed full time care, without supervisory review. This is consistent with childcare program policy, established and maintained by the Department of Early Learning, which allows staff to approve benefits, authorize payment and make changes to authorizations without supervisory approval. The Department has consistent monitoring protocols to maintain payment integrity including:*

- An Integrity Report (identifying cases where the same staff member has authorized four or more payments in a 15 month period without authorization activity from other staff members)*

is reviewed by regional staff periodically. To date, the report has not identified any cases resulting in a finding of improper authorization activities.

- The Department has instituted a separation of duties protocol that does not allow a staff member who activates a license-exempt provider to make any authorizations for that provider.
- Staff activating or reactivating a provider's SSPS number are electronically linked to that provider number and are not able to create or alter authorizations on behalf of that provider number. The activation of a license-exempt provider's file occurs when the provider's SSPS number is created, and reactivation occurs when the provider has had no payment authorizations for the previous 90 days. Staff must manually activate, or reactivate, a license-exempt provider's SSPS number prior to authorizations/payments being submitted through SSPS.

**SAO Description of Weakness** - DSHS reviews at least one percent of open authorizations for child care eligibility determinations, which does not provide adequate coverage to compensate for the internal control weaknesses to prevent improper payments. As part of these reviews, the Department identified incorrect eligibility determinations regarding parent income, authorizations, co-payments and missing or incomplete documentation.

The Department of Social and Health Services concurs with the description that DSHS conducts monthly audits of at least one percent of the caseload. DSHS does not concur with the description that this does not provide adequate coverage to address the internal control weaknesses to prevent improper payments. When errors are found they are corrected. In instances of improper payments, overpayments are established when appropriate. In addition to auditing at least 1% of applications and eligibility reviews, DSHS takes the following steps to ensure program integrity:

- Requires exceptional payment authorizations to be reviewed and approved by a supervisor before payment can be made. An example of an exceptional payment is when a child requires and is eligible for care six days per week due to parent work activity.
- Works with data provided by the Health Care Authority to audit additional childcare payments. The Health Care Authority (HCA) has developed and runs algorithms which identify billing anomalies. Providers who over-bill or are paid an incorrect rate are identified and overpayments are established. All paid authorizations are reviewed on a scheduled basis.
- Performs 100% pre/post authorization audits for all new childcare workers.
- Reviews provider payment authorizations and validates billing records when potential payment discrepancies are identified.
- Reviews potential overpayments and requests attendance records to reconcile these with corresponding payments to determine provider billing accuracy. In appropriate cases, staff establish an overpayment and the DSHS Office of Financial Recovery (OFR) initiates collection action.

**SAO Cause of Weakness** – DSHS supervisors made eligibility determinations which conflicted with state regulations and the federally approved state plan for the program. When we discussed staff not meeting the 30 day limit for determining eligibility, the Department asserted that income verification could be performed after the 30 day period. State regulations and the approved state plan require

*these verifications to be performed within 30 days and state regulations require the client must reapply for the program if eligibility verification is not complete after 30 days.*

*The Department of Social and Health Services does not concur with the SAO description of the cause of internal control weakness, specifically, that “The Department made eligibility determinations which conflicted with state regulations and the federally approved state plan.”*

*[WAC 170-290-0065 \(1\) \(b\)](#) allows DSHS to use the best available estimate of income when a client begins new employment. A WCCC applicant providing self-attestation of new employment wages or salary and work schedule is the best available estimate and constitutes verification when the employer’s statement is unavailable. Therefore, so long as the applicant makes the statement within the 30 day window (per [WAC 170-290-0095 \(1\)](#)), the application has been completed timely. Benefits may be awarded or continued despite the fact that the applicant’s further corroboration (through pay stubs, employer statement, etc.) of the verification occurs after initial approval of the application or change. Benefits begin when a client has met all of the eligibility requirements as defined in [WAC 170-290-0005](#). There is no rule stating or suggesting that the Department’s request for additional information indicates the original verification supplied by the consumer was incomplete or insufficient for eligibility determination purposes.*

**SAO Cause of Weakness** - *Other incorrect eligibility determinations were a result of required documents, such as birth certificates or work schedule verifications, not being collected. In some of these instances the documents were never collected.*

*The Department of Social and Health Services does not concur that required documentation was not collected. DSHS does not concur that when documentation was not received prior to issuing benefits that benefits were issued to clients who were not eligible to receive them.*

*In the examples provided by SAO, DSHS did not find a single instance where an ineligible client was inappropriately determined eligible to receive benefits.*

**SAO Cause of Weakness** - *The Department’s eligibility system is designed with an alert function that reminds staff when an issue is outstanding and needs to be addressed. The alerts can be dismissed without confirming outstanding issues were addressed.*

*The Department of Social and Health Services concurs that alerts can be dismissed without confirming outstanding issues have been addressed. The Department does not concur that this constitutes a weakness or contributes to improper payments. Staff are trained to process electronic alerts and to take appropriate action to address the outstanding issues. The system is programmed to show the date/time alerts are completed and by whom. Any outstanding issues are addressed by the next worker processing the case.*

### **Auditor’s Concluding Remarks**

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

We believe the Department has not adequately designed its process to ensure that only eligible clients are authorized. We also found several instances where, had established procedures been followed as required in WAC and the state plan, clients would not have been determined eligible because of incomplete document verification, including lack of birth certificate, income verification, or self-employment supported earnings and expense receipts.

The Department asserts it is permissible to determine clients eligible when they have not provided all of the verifications requested, including verification of income. The Child Care and Development Plan submitted by Washington state to the federal grantor says applicant statements are allowed for some information, such as household composition or the relationship of the applicant to the child. However, it specifies that the state requires documentation of income and lists the methods the state will use to “document and verify applicant information”. These are listed as “an Employment Verification Form (DSHS # 14-252); cross match using electronic TALX program; paystubs; phone verification with employer. For self-employment: tax documents, business records and receipts. Child support paid or received is verified by court documentation, receipts, pay stubs, and cross-matched with SEMS.” The Employment Verification Form mentioned is required to be filled out by the employer and therefore none of the methods the state says it will use include relying on self-verification by the client. Additionally, WAC 170-290-0095 states if a parent does not complete all required application and verification documentation within 30 days the application process must start over.

While the Department has established procedures when making initial eligibility determinations, there were many instances where incomplete eligibility determinations created unallowable payments. Some of the more notable issues identified led to eventual client terminations, fraud referrals and overpayment assessments. We determined the Department’s processes were ineffective and led to inappropriate client payments.

Additionally, the Department acknowledges in six cases improper payments were likely made based on the Department receiving improper data yet asserts this does not indicate a weakness in internal controls. Had the Department met the requirements of the state plan and WAC 170-290-0095 it is likely these cases would have been identified as ineligible prior to being approved and payments being issued. We reaffirm that without receiving all required verifications, including from the employer or other reliable income data, within 30 days the client cannot be determined eligible to receive benefits and must reapply.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are

those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

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

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

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

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

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

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



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

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

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

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

45 CFR 98.20 A child's eligibility for child care services, states:

- (a) In order to be eligible for services under § 98.50, a child shall:
  - (1) (i) Be under 13 years of age; or,
    - (ii) At the option of the Lead Agency, be under age 19 and physically or mentally incapable of caring for himself or herself, or under court supervision;
  - (2) Reside with a family whose income does not exceed 85 percent of the State's median income for a family of the same size; and
  - (3) (i) Reside with a parent or parents (as defined in § 98.2) who are working or attending a job training or educational program; or
    - (ii) Receive, or need to receive, protective services and reside with a parent or parents (as defined in § 98.2) other than the parent(s) described in paragraph (a)(3)(i) of this section.
      - (A) At grantee option, the requirements in paragraph (a)(2) of this section and in § 98.42 may be waived for families eligible for child care pursuant to this paragraph, if determined to be necessary on a case-by-case basis by, or in consultation with, an appropriate protective services worker.
      - (B) At grantee option, the provisions in (A) apply to children in foster care when defined in the Plan, pursuant to § 98.16(f)(7).
- (b) Pursuant to § 98.16(g)(5), a grantee or other administering agency may establish eligibility conditions or priority rules in addition to those specified in this section and §98.44 so long as they do not:
  - (1) Discriminate against children on the basis of race, national origin, ethnic background, sex, religious affiliation, or disability;
  - (2) Limit parental rights provided under Subpart D; or
  - (3) Violate the provisions of this section, § 98.44, or the Plan. In particular, such conditions or priority rules may not be based on a parent's preference for a category of care or type of provider. In addition, such additional conditions or rules may not be based on a parent's choice of a child care certificate.

WAC 170-290-0005 Eligibility, states:

- (1) Parents. To be eligible for WCCC, the person applying for benefits 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;
    - (ii) 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 two hundred percent of the FPG;
  - (g) Not have a monthly copayment that is higher than the state will pay for all eligible children in care;
  - (h) Complete the WCCC application and DSHS verification process regardless of other program benefits or services received; and
    - (i) 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 age thirteen; or
    - (ii) Less than age nineteen, and:
      - (A) Have a verified special need, according WAC [170-290-0220](#); or
      - (B) Be under court supervision.

WAC 170-290-0012 Verifying consumers' information, states:

- (1) A consumer must complete the DSHS application for WCCC benefits and provide all required information to DSHS to determine eligibility when:
  - (a) The consumer initially applies for benefits; or
  - (b) The consumer reapplies for benefits.
- (2) A consumer must provide verification to DSHS to determine if he or she continues to qualify for benefits during his or her eligibility period when there is a change of circumstances under WAC [170-290-0031](#).
- (3) 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.
- (4) 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).
- (5) The verification that the consumer gives to DSHS includes, but is not limited to, the following:
- (a) A current WorkFirst IRP for consumers receiving TANF;
  - (b) Employer name, address, and phone number;
  - (c) State business registration and license, if self-employed;
  - (d) Work, school, or training schedule (when requesting child care for non-TANF activities);
  - (e) Hourly wage or salary;
  - (f) Either the:
    - (i) Gross income for the last three months;
    - (ii) Federal income tax return for the preceding calendar year; or
    - (iii) DSHS employment verification form;
  - (g) Monthly unearned income the consumer receives, such as child support or supplemental security income (SSI) benefits;
  - (h) If the other parent is in the household, the same information for them;
  - (i) 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;
    - (iv) A qualified alien; or
    - (iv) A nonqualified alien who meets the Washington state residency requirements as listed in WAC [388-468-0005](#);
  - (j) Name and phone number of the licensed child care provider; and
  - (k) For the in-home/relative child care provider, a:
    - (i) Completed and signed criminal background check form;
    - (ii) Legible copy of the proposed provider's photo identification, such as a driver's license, Washington state identification, or passport;
    - (iii) Legible copy of the proposed providers' valid Social Security card; and
    - (iv) All other information required by WAC [170-290-0135](#).
- (6) If DSHS requires verification from a consumer that costs money, DSHS must pay for the consumer's reasonable costs.
- (7) DSHS does not pay for a self-employed consumer's state business registration or license, which is a cost of doing business.
- (8) If a consumer does not provide all of the verification requested, DSHS will determine if a consumer is eligible based information already available to DSHS.

WAC 170-290-0020 Eligibility—Special circumstances, states:

- (1) Child care provided at the consumer's place of work. A consumer is not eligible for WCCC benefits for his or her children when child care is provided at the same location where the consumer works.
- (2) Consumer's child care employment.

- (a) A consumer may be eligible for WCCC benefits during the time she or he works in a child care center but does not provide direct care in the same classroom to his or her children during work hours.
  - (b) A consumer is not eligible for WCCC benefits during the time she or he works in a family home child care where his or her children are also receiving subsidized child care.
  - (c) In-home/relative providers who are paid child care subsidies to care for children receiving WCCC benefits may not receive those benefits for their own children during the hours in which they provide subsidized child care.
  - (d) A child care provider who receives TANF benefits on behalf of a dependent child may not bill the state for subsidized child care for that same child.
- (3) Two-parent family.
- (a) A consumer may be eligible for WCCC if he or she is a parent in a two-parent family and one parent is not able or available as defined in WAC [170-290-0003](#) to provide care for the children while the other parent is working or participating in approved activities.
  - (b) If a consumer claims one parent is not able to care for the children the consumer must provide written documentation from a licensed professional (see WAC [388-448-0020](#)) that states the:
    - (i) Reason the parent is not able to care for the children;
    - (ii) Expected duration and severity of the condition that keeps the parent from caring for the children; and
    - (iii) Treatment plan if the parent is expected to improve enough to be able to care for the children. The parent must provide evidence from a medical professional showing he or she is cooperating with treatment and is still not able to care for the children.
- (4) Single-parent family. A consumer is not eligible for WCCC benefits when he or she is the only parent in the family and will be away from the home for more than thirty days in a row.
- (5) Legal guardians.
- (a) A legal guardian under WAC [170-290-0005](#) may receive WCCC benefits for his or her work or approved activities without his or her spouse or live-in partner's availability to provide care being considered unless his or her spouse or live-in partner is also named on the permanent custody order.
  - (b) Eligibility for WCCC benefits is based on the consumer's work or approved activities schedule, the child's need for care, and the child's income eligibility and family size of one.
  - (c) The consumer's spouse or live-in partner is not eligible to receive subsidized child care payments as a child care provider for the child.
- (6) In loco parentis custodians.
- (a) An in loco parentis custodian may be eligible for WCCC benefits when he or she cares for an eligible child in the absence of the child's legal guardian or biological, adoptive or step-parents.
  - (b) An in loco parentis custodian who is not related to the child as described in WAC [170-290-0005](#)(1) may be eligible for WCCC benefits if he or she has:
    - (i) A written, signed agreement between the parent and the caregiver assuming custodial responsibility; or
    - (ii) Receives a TANF grant on behalf of the eligible child.
  - (c) Eligibility for WCCC benefits is based on his or her work schedule, the child's need for care, and the child's income eligibility and family size of one.

- (d) The consumer's spouse or live-in partner is not eligible to receive subsidized child care payments as a child care provider for the child.
- (7) WorkFirst sanction.
  - (a) A consumer may be eligible for WCCC if he or she is a sanctioned WorkFirst participant and participating in an activity needed to remove a sanction penalty or to reopen his or her WorkFirst case.
  - (b) A WorkFirst participant who loses his or her TANF grant due to exceeding the federal time limit for receiving TANF may still be eligible for WCCC benefits under WAC [170-290-0055](#).

WAC 170-290-0031 Notification of changes, states:

When a consumer applies for or receives WCCC benefits, he or she must:

- (1) Notify DSHS, within five days, of any change in providers;
- (2) Notify the consumer's provider within ten days when DSHS changes his or her child care authorization;
- (3) Notify DSHS within ten days of any significant change related to the consumer's copayment or eligibility, including:
  - (a) The number of child care hours the consumer needs (more or less hours);
  - (b) The consumer's countable income, including any TANF grant or child support increases or decreases, only if the change would cause the consumer's countable income to exceed the maximum eligibility limit as provided in WAC [170-290-0005](#). A consumer may notify DSHS at any time of a decrease in the consumer's household income, which may lower the consumer's copayment under WAC [170-290-0085](#);
  - (c) The consumer's household size such as any family member moving in or out of his or her home;
  - (d) Employment, school or approved TANF activity (starting, stopping or changing);
  - (e) The address and telephone number of the consumer's in-home/relative provider;
  - (f) The consumer's home address and telephone number; and
  - (g) The consumer's legal obligation to pay child support;
- (4) Report to DSHS, within twenty-four hours, any pending charges or conviction information the consumer learns about his or her in-home/relative provider; and
- (5) Report to DSHS, within twenty-four hours, any pending charges or conviction information the consumer learns about anyone sixteen years of age and older who lives with the provider when care occurs outside of the child's home.

WAC 170-290-0082, Eligibility period, states:

- (1) A consumer who meets all of the requirements of part II of this chapter is eligible to receive WCCC subsidies for twelve months before having to redetermine his or her income eligibility. The twelve-month eligibility period in this subsection applies only if enrollments in the WCCC program are capped as provided in WAC [170-290-0001](#)(1). Regardless of the length of eligibility, consumers are still required to report changes of circumstances to DSHS as provided in WAC [170-290-0031](#).
- (2) A consumer's eligibility may be for less than twelve months if:
  - (a) Requested by the consumer; or
  - (b) A TANF consumer's individual responsibility plan indicates child care is needed for less than twelve months.
- (3) A consumer's eligibility may end sooner than twelve months if:
  - (a) The consumer no longer wishes to participate in WCCC; or
  - (b) DSHS terminates the consumer's eligibility as stated in WAC [170-290-0110](#).

- (4) All children in the consumer's household under WAC [170-290-0015](#) are eligible for the twelve-month eligibility period.
- (5) The twelve-month eligibility period begins:
  - (a) When benefits begin under WAC [170-290-0095](#); or
  - (b) Upon reapplication under WAC [170-290-0109](#)(4).

WAC 170-290-0095, When WCCC benefits start, states:

- (1) WCCC benefits for an eligible consumer may begin when the following conditions are met:
  - (a) The consumer has completed the required WCCC application and verification process as described under WAC [170-290-0012](#) within thirty days of the date DSHS received the consumer's application or reapplication for WCCC benefits;
  - (b) The consumer is working or participating in an approved activity under WAC [170-290-0040](#), [170-290-0045](#), [170-290-0050](#) or [170-290-0055](#);
  - (c) The consumer needs child care for work or approved activities within at least thirty days of the date of application for WCCC benefits; and
  - (d) The consumer's eligible provider (under WAC [170-290-0125](#)) is caring for his or her children.
- (2) If a consumer fails to turn in all information within thirty days from his or her application date, the consumer must restart the application process.
- (3) The consumer's application date is whichever is earlier:
  - (a) The date the consumer's application is entered into DSHS's automated system; or
  - (b) The date the consumer's application is date stamped as received.

WAC 170-290-0109, New eligibility period, states:

- (1) If a consumer wants to receive child care benefits for another eligibility period, he or she must reapply for WCCC benefits before the end of the current eligibility period. To determine if a consumer is eligible, DSHS:
  - (a) Requests reapplication information before the end date of the consumer's current WCCC eligibility period; and
  - (b) Verifies the requested information for completeness and accuracy.
- (2) A consumer may be eligible for WCCC benefits for a new eligibility period if:
  - (a) DSHS receives the consumer's reapplication information no later than the last day of the current eligibility period;
  - (b) The consumer's provider is eligible for payment under WAC [170-290-0125](#); and
  - (c) The consumer meets all WCCC eligibility requirements.
- (3) If DSHS determines that a consumer is eligible for WCCC benefits based on his or her reapplication information, DSHS notifies the consumer of the new eligibility period and copayment.
- (4) When a consumer submits a reapplication after the last day of his or her current eligibility period, the consumer's benefits begin:
  - (a) On the date that the consumer's reapplication is date-stamped as received in DSHS's community service office or entered into the DSHS automated system, whichever date is earlier;
  - (b) When the consumer is working or participating in an approved WorkFirst activity; and
  - (c) The consumer's child is being cared for by his or her eligible WCCC provider.

**2015-027 The Departments of Early Learning and Social and Health Services did not establish adequate internal controls over and did not comply with period of availability requirements for the Child Care and Development Fund program.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.575 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
<b>Federal Award Number:</b>	G1401WACCDF; G1501WACCDF
<b>Applicable Compliance Component:</b>	Period of Availability
<b>Questioned Cost Amount:</b>	\$21,320,595
<b>Likely Questioned Cost Amount:</b>	\$7,209,569

## **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 child care. The Department of Social and Health Services (DSHS) pays child care providers under an agreement with DEL. The Departments are responsible for ensuring grant money is used only for costs that are allowable and related to each grant's purpose. The federal grants specify a period when program costs may be obligated. Payments for costs obligated prior to the beginning date of a grant are not allowed without prior approval by the grantor.

In fiscal year 2015, child care providers were paid approximately \$200 million in federal grant funds.

## **Description of Condition**

The Departments did not have adequate internal controls in place to ensure federal period of availability requirements were met.

The CCDF grant awards have a fiscal year 2015 grant period that began on October 1, 2014. We found DSHS obligated \$21,317,679 of program expenditures in September 2014, but the costs were charged to the fiscal year 2015 grants.

We also examined 399 payments for child care services to determine whether they met federal requirements. We found nine payments, totaling \$2,916, were charged to the fiscal year 2015 grant, but were for child care services provided before the grant period began.

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

## **Cause of Condition**

We confirmed with DEL and DSHS that, during the audit period, no staff were assigned to track or monitor period of availability requirements for the CCDF grant. Both Departments confirmed that they did not collaborate or jointly review the expenditures and period of performance requirements relating to the CCDF grant. Neither Department had formal written policies or procedures in place related to period of availability requirements.

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

Without having adequate internal controls in place, the Department is at a higher risk for using federal grant funds outside a grant's period of availability. This resulted in the Department making improper payments with federal funds.

A statistical sampling method was used to randomly select the 399 payments examined in the audit. We estimate the amount of likely federal questioned costs to be \$7,209,569. The statistical sample that was used for testing was also used to test compliance with eligibility and period of performance requirements. Because some payments tested were unallowable for violating multiple requirements, some of the questioned costs reported here are also reported in findings number 2015-023 and 2015-026.

We are also questioning improperly charged grant expenditures, or known questioned costs, of \$21,320,595 made before the start of the grant's period of availability.

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

## **Recommendation**

We recommend the Departments:

- Establish written policies and procedures that are adequate to ensure compliance with grant requirements.
- Assign staff to monitor period of availability requirements and coordinate their efforts to ensure grant requirements are met.
- Only charge expenditures to federal grants if they are obligated during the period of availability.

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

## **Agency's Response**

*The Department concurs with this finding.*

*The Department's Economic Services Administration (ESA), Division of Finance and Financial Recovery will establish, sponsor and lead a cross-agency committee comprised of ESA, Financial Services Administration, Department of Early Learning (DEL), Office of Financial Management and Washington Technology Solutions staff. This committee will review the processes involved and recommend implementation of changes to the existing Cost Allocation System (CAS) methodology. These changes will ensure that federal grant-related accruals are accounted for in the appropriate period of performance (grant year).*

*As an immediate fix to rectify the existing issue (including questioned costs), ESA and DEL will develop, coordinate, and utilize a manual process (journal vouchers) to ensure full compliance until the revised CAS methodology is implemented.*

*The committee will also work with the appropriate Federal agencies to discuss changing and/or updating the compliance supplement to better align with the State's business practices for cash*



*draws and reporting of the federal grants. We will continue discussions with our Federal partners regarding what, if any, of the questioned costs should be repaid and acceptance of our prospective corrections*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

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

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

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

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

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

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

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

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

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

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

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

45 CFR 98.60 Availability of funds, states, in part:

- (d) The following obligation and liquidation provisions apply to States and Territories:
- (1) Discretionary Fund allotments shall be obligated in the fiscal year in which funds are awarded or in the succeeding fiscal year. Unliquidated obligations as of the end of the succeeding fiscal year shall be liquidated within one year.
  - (2) (i) Mandatory Funds for States requesting Matching Funds per § 98.53 shall be obligated in the fiscal year in which the funds are granted and are available until expended.

- (ii) Mandatory Funds for States that do not request Matching Funds are available until expended.
- (3) Both the Federal and non-Federal share of the Matching Fund shall be obligated in the fiscal year in which the funds are granted and liquidated no later than the end of the succeeding fiscal year.
- (4) Except for paragraph (d)(5) of this section, determination of whether funds have been obligated and liquidated will be based on:
  - (i) State or local law; or,
  - (ii) If there is no applicable State or local law, the regulation at 45 CFR 92.3, Obligations and Outlays (expenditures).
- (5) Obligations may include subgrants or contracts that require the payment of funds to a third party (e.g., subgrantee or contractor). However, the following are not considered third party subgrantees or contractors:
  - (i) A local office of the Lead Agency;
  - (ii) Another entity at the same level of government as the Lead Agency; or
  - (iii) A local office of another entity at the same level of government as the Lead Agency.
- (6) For purposes of the CCDF, funds for child care services provided through a child care certificate will be considered obligated when a child care certificate is issued to a family in writing that indicates:
  - (i) The amount of funds that will be paid to a child care provider or family, and
  - (ii) The specific length of time covered by the certificate, which is limited to the date established for redetermination of the family's eligibility, but shall be no later than the end of the liquidation period.
- (7) Any funds not obligated during the obligation period specified in paragraph (d) of this section will revert to the Federal government. Any funds not liquidated by the end of the applicable liquidation period specified in paragraph (d) of this section will also revert to the Federal government.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2015, Part 3 – Compliance Requirements, states in part:

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

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

**2015-028 The Department of Social and Health Services did not have adequate internal controls over and did not comply with foster care payment rate setting and application requirements for the Foster Care program.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.658 Foster Care – Title IV-E  
**Federal Award Number:** 1401WA1401; 1501WAFOST  
**Applicable Compliance Component:** Special Tests and Provisions – Payment Rate Setting and Application  
**Questioned Cost Amount:** None

**Background**

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

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

During fiscal year 2015 the Department spent approximately \$83 million in federal grant funds with more than \$23 million being paid to eligible foster care recipients and their guardians.

For the fiscal year 2014 audit period we reported the Department did not have adequate internal controls in place to ensure the Department performed a periodic review of basic maintenance payment rates for their continued appropriateness, as required by federal regulations. The Department was not compliant with foster care payment rate setting and application requirements for the Foster Care program. The prior finding number was 2014-027.

**Description of Condition**

For the fiscal year 2015 audit period, we sought to determine if basic maintenance rates established by the Department were reviewed for their continued appropriateness and if the review was conducted in accordance with the Department’s approved Title IV-E state plan. We found the Department’s Title IV-E plan did not specifically address the frequency of its periodic review of

payment rates. We also found the Department had continued to pay the same maintenance payment rates to eligible foster care recipients and had not performed a review of basic maintenance payment rates for continued appropriateness for at least six years.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

Because the Department's IV-E state plan was approved by the grantor, the Department had previously felt its plan was sufficient to ensure the Department met all federal program requirements.

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

During the audit period, the Department agreed to a settlement, provided the Department receive a budget increase of \$33 million to cover the costs of reimbursement to foster care providers applied over the next four years. The final settlement agreement requires the Department to calculate the amount it reimburses foster care providers based on the actual costs of raising a child in the state of Washington. This would result in a significant increase in the basic maintenance payment rates paid to eligible recipients, and require the Department to establish a process for conducting a review of basic maintenance payment rates for continued appropriateness.

The Department included this request in its budget proposal to the Legislature for the 2015-2017 biennium. However, the additional funding was not approved until after July 1, 2015, which occurred outside the audit period. As a result, the Department's basic maintenance payment rates remained unchanged from the previous year.

### **Effect of Condition**

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

### **Recommendation**

We recommend the Department:

- Perform a review of its maintenance payment rates, as required by federal regulations.
- Establish a process for evaluating basic maintenance payment rates for its continued appropriateness, specifying the methodology and periodicity of required review.
- Ensure the established process is included in its approved Title IV-E plan as required.

### **Agency's Response**

*The Department concurs with this finding.*

*The settlement of the Foster Parents Association of Washington State lawsuit and subsequent funding by the legislature beginning State Fiscal Year 2016, increased the basic maintenance rate paid to licensed foster care homes. The increase in the maintenance rate is tied to an economic analysis of the cost of raising a child. Per the settlement agreement, Children's Administration (CA) will review the maintenance payment in 2019 to see if it needs adjustment. If an increase is indicated by the economic analysis, CA will submit a decision package for additional funding. CA will periodically review the maintenance payment after 2019 to see if it is adequate under changing economic conditions and include this process in the Title IV-E State Plan.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

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

Except as noted otherwise, these Terms and Conditions apply to all mandatory grant programs administered by the Administration for Children and Families (see Appendix A). Please also review the separate program-specific Addendum to these Terms and Conditions applicable to each program.

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

45 CFR section 1356.21 (m) – Requirements Applicable to Title IV-E, Foster care maintenance payments program implementation requirements, states in part:

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

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

42 USC 671(a)(11) - State Plan for foster care and adoption assistance – Requisite features of State Plan states, in part:

In order for a state to be eligible for payments under this part, it shall have a plan approved by the Secretary which –

- (11) Provides for periodic review of the standards referred to in the preceding paragraph and amounts paid as foster care maintenance payments and adoption assistance to assure their continuing appropriateness;



**2015-029** The Department of Health did not ensure Medicaid hospital and home health agency surveys were performed with the frequency required by federal regulations and 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)  
93.778A Medical Assistance Program (Medicaid, Title XIX) –American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Test and Provisions – Provider Health and Safety Standards  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. Almost \$2.3 million was spent by the Department of Health.

In Washington there are 100 hospitals that fall into one of three categories:

- Acute care/general
- Chemical dependency
- Psychiatric

State law requires the Department of Health, or an accreditation agency, to survey all acute care/general hospitals on average at least every 18 months. Surveys for chemical dependency and psychiatric hospitals must be performed on 12 month intervals. Surveys focus on the hospital’s administration and patient services, as well as compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

The state has 64 Medicare certified home health agencies, which provide necessary support services to allow clients to get the care they need in their own home setting. Services provided by home health agencies can range from companion care provided by trained providers to advanced skilled

care provided by registered or licensed practical nurses. Federal regulations require the Department of Health, or accreditation agencies such as the Community Health Accreditation Program or the Joint Commission on Accreditation of Healthcare Organizations, to survey all home health agencies at least every 36.9 months to maintain Medicare certification and be eligible to accept Medicaid clients as stated in the Mission and Priority Statement issued by Centers for Medicare and Medicaid Services.

Federal regulations require states to ensure home health agencies and health care facilities, such as hospitals, to meet prescribed health and safety standards in order to be eligible for federal reimbursement.

In the past three years we have reported in audit findings that the Department has not completed required surveys in accordance with the frequency required by federal regulations and state law. Prior finding numbers 2014-028, 13-019, 12-33 and 11-25.

### **Description of Condition**

While the Department made significant improvements over its internal controls to perform surveys in a timely manner, it will take a period of 36 months for the Department to be in material compliance. We determined the internal control deficiency from the prior year finding is resolved.

#### *Hospitals*

In fiscal year 2015, we found surveys for 37 (39 percent) of the state's 95 acute/general hospitals were not performed within the required 18 month average frequency rate. Twenty-eight of the 37 were reported in the 2014 Medicaid finding. The surveys that exceeded the average ranged from 18.3 to 31.3 months. Twelve of the hospitals had their survey conducted by an accrediting organization; however, the Department was still responsible to ensure the surveys were completed timely.

#### *Home Health Agencies*

In fiscal year 2015, we found surveys for 5 (10 percent) of the state's 52 home health agencies were not performed within 36.9 months as required by law. Two of the 5 were reported in the 2014 Medicaid finding. Of the state's 12 home health agencies that were surveyed by an accrediting organization, two (17 percent) exceeded the required 36.9 month survey interval. One of these home health agencies was reported in the prior year's audit finding. Although the two surveys were conducted by an accrediting organization, the Department was still responsible to ensure the surveys were completed timely.

## **Cause of Condition**

### *Hospitals*

Since state law bases the timeliness on an average of 18 months between surveys, deficiencies reported in prior findings continued to impact the measurement of hospital surveys in fiscal year 2015.

### *Home Health Agencies*

Deficiencies we reported in prior findings continue to impact the measurement of home health agency surveys in fiscal year 2015.

## **Effect of Condition**

When surveys of hospitals and home health agencies are not performed as required, the state is paying the facilities for services provided to Medicaid clients without assurance they are compliance with required health standards and regulations.

## **Recommendation**

We recommend the Department conduct hospital and home health agency surveys in accordance with the frequency required by federal and state laws.

## **Department's Response**

*We concur with above findings and have implemented the necessary steps to ensure that both hospitals and home health agencies are surveyed in accordance with the applicable requirements.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

Title 42 Code of Federal Regulations, Section 430.10 The State plan, states:

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

RCW 70.41.120 Inspection of hospitals – Final report – Alterations or additions, new facilities – Coordination with state and local agencies – Notice of inspection, states in part:

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

RCW 70.41.122 Exemption from RCW 70.41.120 for hospitals accredited by other entities, states:

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

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

WAC 246-320-016 Department responsibilities – On-site survey and complaint investigation, states in part:

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

- (1) Surveys. The department will:
  - (a) Conduct on-site surveys of each hospital on average at least every eighteen months or more often using the health and safety standards in this chapter and chapter 70.41 RCW;
  - (f) Accept on-site surveys conducted by the Joint Commission or American Osteopathic Association as meeting the eighteen-month survey requirement in accordance with RCW 70.41.122.

WAC 246-322-020 Licensure – Initial, renewal, modifications, state in part:

- (1) A person shall have a current license issued by the department before operating or advertising a private psychiatric hospital.
- (3) The licensee shall apply for license renewal annually at least thirty days before the expiration (a) A completed application on forms provided by the department;

RCW 71.12.480 Examination of operation of establishment and premises before granting license

The department of health shall not grant any such license until it has made an examination of all phases of the operation of the establishment necessary to determine compliance with rules adopted under this chapter including the premises proposed to be licensed and is satisfied that the premises are substantially as described, and are otherwise fit and suitable for the purposes for which they are designed to be used, and that such license should be granted.

42 U.S.C. § 1395bbb. Conditions of participation for home health agencies; home health quality, states in part:

(c) Surveys of home health agencies

- (1) Any agreement entered into or renewed by the Secretary pursuant to section 1395aa of this title relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. . .
- (2) (A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 36 months after the date of the previous standard survey conducted under this paragraph. The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.

State Operations Manual: Chapter 2, Section 2195 - Guidelines for Determining Survey Frequency (Rev. 1, 05-21-04)

Section 1891(c)(2)(A) of the Act states that standard surveys will occur not later than 36 months after the previous standard survey, and that the Secretary shall establish a frequency for surveys within this 36-month interval commensurate with the need to assure the delivery of quality home health services.

**2015-030 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 Controls  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington state’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

It is common for Medicaid beneficiaries to have one or more additional sources of coverage for health care 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 “payor 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 requires health insurers to provide states with 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 RCW 74.09A in 2007 that 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 are required to use that information to identify Medicaid clients with third-party coverage and provide those results to the Authority. The law requires the exchange of data to occur not less than twice per year. The Authority was required to focus its implementation of the law on those health insurers with the highest probability of joint beneficiaries.

Since 2008, we have reported findings regarding lack of internal controls over and noncompliance with the federal Deficit Reduction Act of 2005 and the state law. Prior audit finding numbers were 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 required by state law.

The Centers for Medicare and Medicaid Services developed the Payer Initiated Eligibility/Benefits (PIE) Transaction, the national standard format for data sharing prescribed by the federal government. The Authority implemented this transaction format in July 2013. In October 2013, the Authority sent letters to ten major insurance carriers with the most Medicaid clients, inviting them to begin data sharing.

During the audit period, the Authority received 24 client data files from private health insurers and attempted to upload three that contained over 10,000 client policy records. The Authority was forced to stop after a three-day nonstop effort because its systems were unable to manage the large influx of data. The Authority ceased all future data exchanges with health insurers and is working with its Medicaid Management Information System vendor to resolve the capacity issue.

In response to the prior year finding, the Authority planned to work with the Office of the Insurance Commission and the Office of Financial Management by December 2015 to enhance direct insurer participation. As of June 30, 2015 the Authority had not discussed the issue with either agency.

RCW 74.09A.020 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. In practice, the data exchange is initiated by payers (health insurers) and the Authority will work to identify joint beneficiaries.

The U.S. Government Accountability Office (GAO) published an audit report in January 2015 that stated additional federal action is needed to 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.

We consider the condition described above to be material noncompliance with federal grant requirements and, as a result, a material weakness in internal controls.

## **Cause of Condition**

The client files received from health insurers were much larger than anticipated and the Authority could not manage the incoming information due to data processing and storage limitations. In addition, the Authority asserts it has no authority to compel private insurance carriers to participate in the data exchange.

## **Effect of Condition**

Without performing the data exchange and data match, the Authority is not able to timely identify Medicaid clients that have third party insurance coverage. This puts the Authority at a higher risk of paying claims that are not allowable. Additionally, the Authority is out of compliance with the federal Deficit Reduction Act of 2005 and state law (RCW 74.09A.020).

## **Recommendation**

We recommend the Authority:

- Work with the Office of Insurance Commissioner, the Office of Financial Management and the Legislature to bring Washington into compliance with state law.
- Continue its efforts to perform data-matches with private insurers.

## **Authority's Response**

*RCW 74.09A.020 requires HCA to provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information, and requires health insurers to use this information to identify joint beneficiaries. HCA [Health Care Authority] does not have legal authority to compel insurers to comply with this law.*

*The Authority meets the intent of the law by performing data matching with insurance carriers in the State of Washington on a regular basis. Data exchanges occur in real time using information and electronic data available to the State Medicaid program.*

*In addition, the Authority contracts with a vendor to provide supplemental identification of TPL [Third Party Liability] not previously identified by HCA. The vendor works closely with carriers to implement new data sharing agreements and expand the data they receive for data matching with the Washington Eligibility file to identify the legal liabilities of third parties. They receive carrier data as frequently as daily and weekly, and most carrier data exchanges occur monthly. This contract supplements the Authority's data matching capabilities and further ensures compliance with applicable state law.*

*The Authority will continue to encourage health insurers to develop systems capable of participating in the PIE data exchange, and will contact the Office of Insurance Commissioner and the Office of Financial Management to consider options for working with Legislature to align state law to the current practice.*



## **Auditor's Concluding Remarks**

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

We acknowledge the Authority has contracted with a vendor that performs data matches to provide supplemental identification of Third Party Liability. In our opinion, we do not believe this activity has brought the Authority into compliance with federal regulations and state law. We encourage the Authority to continue to work with health insurers and develop a system in which the PIE data exchange can take place.

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

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

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

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

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

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned

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

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

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

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

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

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

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

Title 42, United States Code, Part 1396a(a)(25) 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 1167(1) of U.S.C. Title 29), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--
- (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
  - (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims

processing and information retrieval systems required under section 1396b(r) of this title;

- (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 (RCW) 74.09A.005 states:

The legislature finds that:

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

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

RCW 74.09A.020 states:

Computerized information — Provision to health insurers.

1. The authority shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the authority. The authority shall use this information to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.
2. To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the authority. The authority shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the authority and its population's health insurance coverage information.
3. If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.

4. The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for authority programs.
5. The frequency of updates will be mutually agreed to by each health insurer and the authority based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.
6. The health insurers and the authority shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.
7. The authority shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

**2015-031 The Health Care Authority did not collect application fees from prospective or re-enrolling Medicaid providers, resulting in non-compliance with Affordable Care Act provisions.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Special Tests and Provisions - Provider Eligibility
<b>Likely Questioned Cost Amount:</b>	\$17,794

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures.

In March 2011, federal regulations began to require states (with some exceptions) to collect an application fee for newly enrolling or re-enrolling institutional provider who was not already enrolled in Medicare.

Application fees collected by states must be used to offset the state Medicaid agency’s provider screening and enrollment costs. If revenue from application fees exceeds the cost of conducting the required screening, states must return the portion of the application fees which exceed the state’s administrative costs to the federal government.

In fiscal year 2015, the Health Care Authority newly enrolled or re-enrolled more than 300 institutional providers. The application fee for calendar year 2015 was \$553. The fee has increased every year since 2011.

**Description of Condition**

The Authority did not collect application fees from any prospective or re-enrolling Medicaid provider.

## **Cause of Condition**

The Authority has not implemented a fee collection process because it asserts the cost of implementing the provisions of the federal regulation will exceed revenue collected from providers. The fee only applies to new and re-enrolling institutional providers who have not already paid an application fee to Medicare, the number of which the Authority believes is marginal.

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

Application fees collected by the Authority must be used to offset the Medicaid administrative provider screening and enrollment costs. By not collecting the application fees, the Authority does not offset any Medicaid administrative costs, resulting in a loss of federal and state resources.

In fiscal year 2015, the Authority newly enrolled or re-enrolled 325 institutional providers. Using information from the Centers for Medicare & Medicaid Services (CMS), we estimate 65 institutional providers<sup>1</sup> should have paid \$35,588 in application fees. We calculated this estimate by applying the average application fee of \$547.50 for calendar years 2014 and 2015 to 65 providers. The federal portion of this amount is \$17,794 for fiscal year 2015.

Federal regulations required Medicaid agencies to begin collecting the fees on or after March 25, 2011. The Authority has newly enrolled or re-enrolled 1,335 institutional providers since March 25, 2011. We estimate the Authority has failed to collect \$141,777 from 267 institutional providers since March 25, 2011. We calculated this amount by using the average application fee of \$531 for calendar years 2011 through 2015.

## **Recommendation**

We recommend the Authority establish an application fee collection process to be in compliance with the federal law.

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.

## **Authority's Response**

*The Authority concurs with the finding. The Authority has taken steps to establish and implement a process for collection of the provider application fee for institutional providers that are prospective or re-enrolling Medicaid providers. The Authority will have this process in place by May 31, 2016.*

## **Auditor's Concluding Remarks**

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<sup>1</sup> Centers for Medicare & Medicaid Services (CMS) estimates that 80 percent of Medicaid providers also participate in the Medicare program according to the CMS Final Rule outlining the implementation of the Affordable Care Act provider screening requirements posted on February 2, 2011. The CMS Final Rule can be found at Federal Register Vol 76 No 22. We estimated the total number of providers required to pay the application fee by multiplying the total number of newly enrolled or reenrolled institutional providers by 20 percent.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

42 Code of Federal Regulations (CFR) 455.460 states:

#### Application fee

- (a) Beginning on or after March 25, 2011, States must collect the applicable application fee prior to executing a provider agreement from a prospective or re-enrolling provider other than either of the following:
  - (1) Individual physicians or non-physician practitioners.
  - (2) (i) Providers who are enrolled in either of the following:
    - (A) Title XVIII of the Act.
    - (B) Another State's title XIX or XXI plan.
  - (ii) Providers that have paid the applicable application fee to
    - (A) A Medicare contractor; or
    - (B) Another State.
- (b) If the fees collected by a State agency in accordance with paragraph (a) of this section exceed the cost of the screening program, the State agency must return that portion of the fees to the Federal government.

**2015-032 The Health Care Authority did not have adequate internal controls over its Medicaid service verification process.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Controls  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) –American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Test and Provisions – Utilization Control and Program Integrity  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

Federal regulations require states to have a process in place to verify with Medicaid clients whether they actually received services billed by providers. The intent is to improve program integrity and identify potential fraud and abuse in the Medicaid program.

The Authority sends medical services verification surveys to a randomly selected number of clients asking if they received certain services. Staff review surveys that are returned and follow up when questions about the legitimacy of a claim arise. Regulations require the Authority to follow up on surveys when clients indicate that they did not receive the service or paid for the service listed out of their own pocket. The Authority must also conduct a preliminary investigation to determine if there is sufficient information to warrant a full investigation.

If credible suspicions of fraud or abuse are identified, the Authority is required to forward that information to the Attorney General’s Office Medicaid Fraud Control Unit for investigation.

In prior audits, we reported findings regarding service verification surveys. The prior finding numbers were: 11-39, 12-54, 13-031, and 2014-039.



We reviewed the Authority's corrective action plan to determine the status of the prior finding. The Authority's plan stated it made arrangements to use professional translation services to follow-up on negative survey responses written in a foreign language.

The completion date of the corrective action was listed as February 2015.

### **Description of Condition**

In fiscal year 2015, the Authority sent out 4,966 medical service verification surveys, of which 1,707 (34 percent) were returned. Three survey responses were received written in a foreign language. The Authority did not translate or review these responses.

In August 2014, we found that rather than translating returned surveys as its corrective action plan stated, the Authority stopped sending verifications to clients whose written language was other than English. We believe this affects the integrity of the Authority's method for performing beneficiary verifications.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

The Authority stated it did not implement the corrective action plan from the 2014 finding to use professional translation services to follow up on negative survey responses written in a foreign language. An Authority manager said the process to implement translation services is costly and involves obtaining approval from management.

### **Effect of Condition**

By not sending out surveys to non-English speaking clients and the lack of adequate follow-up on returned foreign language surveys increases the risk that Medicaid fraud may go undetected and cause the Authority to be out of compliance with federal requirements.

### **Recommendation**

We recommend the Authority strengthen its method for performing beneficiary verifications by surveying all clients and following-up when required by federal regulations.

### **Authority's Response**

*The Authority has resumed sending verifications to clients whose written language is other than English, and now uses professional translation services to follow up on negative survey responses.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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

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

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

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

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

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

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

OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, Section 510, Audit findings, states in part:

- (b) *Audit findings reported.* The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - (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 §\_\_.315(b) materially misrepresents the status of any prior audit finding.

Title 42, 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, 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.

42 CFR 455.20, Beneficiary verification procedure, states:

- (a) The agency must have a method for verifying with beneficiaries whether services billed by providers were received.
- (b) In States receiving Federal matching funds for a mechanized claims processing and information retrieval system under part 433, subpart C, of this subchapter, the agency must provide prompt written notice as required by §433.116 (e) and (f).

**2015-033 The Health Care Authority made improper Medicaid payments to Federally Qualified Health Centers and Rural Health Clinics.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$197,774

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures.

The Health Care Authority spent nearly \$7.6 billion in Medicaid funds in fiscal year 2015. The Authority paid more than \$237 million to Federally Qualified Health Centers and \$12 million to Rural Health Clinics.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are “safety net” providers that serve a range of populations, including the uninsured, publicly insured, and the underinsured low-income population, as well as special populations such as migrant seasonal farm workers and homeless people. Both FQHCs and RHCs are certified by Centers for Medicare and Medicaid Services and designed to provide medical help for people in medically-challenged areas.

RHCs are considered the essential source of outpatient care, emergency care and basic lab services in many rural areas. RHCs provide care in rural areas and places which are categorized as Health Professional Shortage Areas or Medically Underserved Areas.

FQHCs provide care for people in rural and urban areas that are classified as Medically Underserved Areas or Medically Underserved Populations. FQHCs offer similar services as RHCs, but with more

comprehensive services that must be made through formal arrangements. Services include; diagnostic and lab, pharmaceutical, behavioral and oral, hospital and specialty, after-hours care, case management, transportation, and interpretative services.

With few exceptions, FQHCs and RHCs are paid based on client encounters. An encounter is defined as a face-to-face visit between a client and a qualified FQHC/RHC that exercises independent judgment when providing services that qualify for an encounter rate. A fixed rate is paid by the Authority regardless of the number or type of procedures provided during the encounter.

When encounter rates are established for each FQHC/RHC, incidental services are factored into the encounter rate. 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 per client, per day except in the following circumstances:

- The client needs to be seen on the same day by different practitioners with different specialties; or
- The client needs to be seen multiple times on the same day due to unrelated diagnoses.

In prior audits, we found that the Authority made improper payments to Federally Qualified Health Centers due to lack of sufficient system edits within its ProviderOne system. Prior finding numbers are 2014-036, 2013-026 and 12-45.

### **Description of Condition**

Using computer assisted auditing techniques, we examined all \$250 million payments made to FQHCs and RHCs and found the Authority made improper payments to FQHC and RHC providers totaling \$303,716.

The following tables summarize the specific results by provider type:

*FQHCs*

Description	Total unallowable payments
Fee-for-service claims were paid in addition to encounter payments.	\$216,640
Encounter payments were made for encounter ineligible claims.	\$ 62,761
More than one encounter payment was made for the same client.	\$ 7,088
<b>Total</b>	<b>\$286,489</b>

*RHCs*

Description	Total unallowable payments
Fee-for-service claims were paid in addition to encounter payments.	\$ 8,569
Encounter payments were made for encounter ineligible claims.	\$ 8,658
<b>Total</b>	<b>\$ 17,227</b>

We also found 18,649 FQHC encounter eligible claims and 4,704 RHC encounter eligible claims were billed and paid at fee-for-service rates to providers. The Authority made underpayments to the providers because most fee-for-service rates are less than encounter rates.

**Cause of Condition**

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within its ProviderOne system, 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 stated that it worked on developing new system edits which would better prevent overpayments and improper billings by providers. The new system edits were not fully implemented during the audit period. The Authority informed us that the new edits were implemented in October 2015 which was outside of our audit period.

The unallowable payments represent less than 0.5 percent of total payments. We do not believe the weaknesses in the system represent a significant deficiency or material weakness in internal controls.

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

The Authority improperly claimed federal reimbursement for unallowable payments of \$303,716. We are questioning \$197,774, which is the federal portion of the unallowable costs. The federal share is calculated using the state's 2015 FMAP rate assigned per expenditure type.

## **Recommendation**

We recommend the Authority:

- Recoup the overpayments made to FQHCs and RHCs.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Authority's Response**

*As noted by the State Auditor's Office, the Authority has implemented new system edits which will eliminate duplicate payments, and will identify improper billings. The Authority is currently in the process of recouping the unallowable FQHC and RHC payments identified by the State Auditor's Office, with an estimated completion date of June 2016.*

*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**

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.



OMB Circular A-133 Compliance Supplement for 2013, *Part 3 – Compliance Requirements*, states in part:

#### Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment include the following:

1. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, such as overpayments or underpayments made to eligible recipients resulting from inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments.
2. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
3. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

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.

Washington Administrative Code 182-549-1400, Rural health clinics—Reimbursement and limitations, states in part:

- (8) The agency pays for one encounter, 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) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

**2015-034 The Health Care Authority did not have adequate internal controls to ensure it sought reimbursement for all eligible Medicaid outpatient drug rebate claims.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Known Questioned Cost Amount:</b>	\$97,425
<b>Likely Questioned Cost Amount:</b>	\$3,526,792

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington state's largest public assistance program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. The Health Care Authority spent more than \$7.6 billion of the Medicaid funds.

The Medicaid drug program, which began in 1991, is set forth in section 1927 of the Social Security Act. For federal payments to be available for covered outpatient drugs provided under Medicaid, drug manufacturers are required to enter into a rebate agreement with the Secretary of the U.S. Health and Human Services and pay quarterly rebates to states. Under these rebate agreements, manufacturers must provide the Center for Medicare and Medicaid Services (CMS) with the average manufacturer price by national drug code for each of their covered drugs. CMS uses the average manufacturer price and best price data to calculate the unit rebate amount for each national drug code included in the Medicaid drug rebate program and transmits this information to the states.

States calculate the total quarterly rebates that participating manufacturers owe by multiplying the unit rebate amount for a specific drug by the number of units of that drug for which the state reimbursed providers in that quarter. Within 60 days of the end of the quarter, states must invoice the manufacturers for the units reimbursed and indicate the total rebate due for each national drug code. The manufacturers process the invoices and pay the rebates to 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; other state-funded only programs; or
- Other federal non-Medicaid funded drug programs

In fiscal year 2015, the Authority invoiced drug manufacturers for drug rebates totaling more than \$406 million, of which \$67 million was for fee for service claims.

In the previous audit, we reported the Authority did not seek reimbursement of \$225,439 for eligible fee for service drug rebate claims, and \$1,048,530 in likely missed eligible claims. The prior finding number was 2014-031.

**Description of Condition**

We found the Authority’s internal controls were not effective to ensure it sought reimbursement for all eligible Medicaid outpatient drug rebate claims.

Using a statistical sampling method, we randomly selected 45 fee for service invoices from a population of 1,629 invoices, which were processed during the audit period to determine if they were accurately prepared. The total rebate amount for the 45 invoices was nearly \$4.7 million.

We identified 1,382 claims, totaling \$151,954 that were eligible for a drug rebate but not included in the 45 rebate invoices. As a result, the Authority failed to claim \$194,430 in owed rebates.

The following table summarizes the results of our review:

<b>Eligible claim types not invoiced</b>	<b>Number of claims</b>	<b>Paid amount</b>	<b>Rebate amount</b>
Medicare crossover claims	1,363	\$151,159	\$193,789
Family planning services	11	\$25	\$1
Pharmacy Claims	8	\$771	\$641
<b>Total</b>	<b>1,382</b>	<b>\$151,954</b>	<b>\$194,430</b>

Medicare Crossover Claims are claims submitted by Medicaid providers for Medicare/Medicaid dual eligible beneficiaries. Medicare pays the claim to the provider and applies a deductible/coinsurance or co-pay amount before submitting the claim to Medicaid.

Family Planning services are services relating to preventative health and contraceptive methods provided by Medicaid providers.

Pharmacy claims are claims submitted by pharmacy providers.

We found the Authority failed to claim \$194,430 in rebates for 1,382 claims. We are questioning the federal share of \$97,425, which is calculated using the state's Federal Medicaid Assistance (FMAP) rate.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

The Authority did not identify all eligible drug rebate claims when preparing invoices for the following reasons:

- When the requirement to include Medicare crossover claims took effect in 2008, the Authority intended to ask for a temporary delay in implementation until a new Medicaid Management Information System, ProviderOne, was fully implemented. However, the Authority did not request a formal waiver from CMS at that time and has since not included Medicare crossover claims in drug rebates invoices.
- The Authority incorrectly excluded all claims from Family Planning providers because a majority of the providers were also Public Health Service providers, which were not eligible for drug rebate in that role. In addition, the majority of the claims were for clinic or bulk packaged drugs, which were not eligible for drug rebate.
- The eight pharmacy claims were excluded because the claims were not reported in the drug rebate system timely due to system interface issues.

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

By not having adequate internal controls in place to ensure the Authority claims rebate amount for all drug rebate eligible claims, the Authority misses the opportunity to collect potential revenue. We used a statistical sampling method to randomly select the invoices we examined in the audit. When we project the results to the entire population of invoices, we estimate the likely questioned costs to be \$7,038,364.

The federal share of the estimated unclaimed rebates, or likely questioned costs, is \$3,526,792.

### **Recommendation**

We recommend the Authority:

- Implement adequate internal controls to ensure the Authority seeks reimbursement for all eligible professional and outpatient drug rebate claims.
- Review Medicare crossover and Family Planning claims to determine how much in drug rebates should be requested from manufacturers.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

## **Authority's Response**

*The Authority acknowledges that the State Auditor's Office identified groups of claims that were excluded from drug rebate invoicing in error, and appreciates SAO's identification of an issue that, when corrected, will increase Medicaid rebates.*

*To address the crossover claim oversight, staff have identified the steps necessary to include these claims for drug rebate invoicing. Target date for full implementation is July 2016.*

*The Authority developed and implemented an action plan that reversed the Family Planning provider claims exclusion identified in the previous and current audits. The plan was not fully implemented prior to the start of the current audit period, resulting in the questioned costs identified in this finding. This reconfiguration has since been completed, effective December 2015.*

*The eight pharmacy claims described above were identified by HCA during routine monitoring and review and were corrected. SAO reports this error because the identification and correction occurred after June 30. No additional corrective action is necessary.*

*The Authority will ensure that the U.S. Department of Health and Human Services receives a copy of this finding as soon as it is published so that they may begin their process to recover questioned costs.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

Section 510, states in part:

- (b) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

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

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

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

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

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

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

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

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

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

42 U.S. Code 1396r-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.

**2015-035 The Health Care Authority improperly claimed federal reimbursement for payments made on behalf of deceased Medicaid clients.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Controls  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
**Questioned Cost Amount:** \$310,091

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than \$11.3 billion in federal and state funds during fiscal year 2015, almost \$7.6 billion of which was spent by the Health Care Authority. Medicaid is Washington state’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures.

Medicaid providers may not be reimbursed for services provided after a beneficiary’s death. The Authority receives monthly death certificate information from the state Department of Health, which it uses to perform a quarterly cross-check with paid claims. When clients are determined to be deceased, but claims were paid, the Authority initiates a process to recover the overpayments and closes the client’s file.

In the previous audit, we reported the Authority paid providers \$130,980 for services that occurred after a client’s death. The prior finding number was 2014-030.

**Description of Condition**

We examined all Medicaid payments made by the Authority in fiscal year 2015 to determine if the Authority paid for services after a client died. We found 835 claims were paid for services provided after a client’s death.



## **Cause of Condition**

The Authority performs quarterly reviews to detect unallowable Medicaid payments for services provided after a client's death. However, due to timing, the reviews were not effective to detect all unallowable payments during the audit period.

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

When the state provides services to ineligible individuals, or the services are unallowable, the services cannot be claimed for federal reimbursement. We found \$347,221 in paid services that occurred after a client's death. We are questioning \$310,091, which is the federal share of the unallowable payments. The federal share is calculated using the state's Federal Medical Assistance Percentage (FMAP) rate. The federal share is 50.3 percent for some services, and 100 percent for others.

The unallowable payments described above includes \$259,865 the Authority processed after the audit period, the federal share of the unallowable expenditures was \$232,209. The Authority recovered the overpayments after June 30, 2015, and provided us with evidence showing adjustments for the unallowable claims have been processed. Because the recovery occurred after the end of the audit period we are reporting the full amount of unallowable payments identified of \$310,091.

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

## **Recommendation**

We recommend the Authority:

- Recover the remaining unallowable payments for services provided after the client's death.
- Consult with the U.S. Department of Health and Human Services to discuss if repayment of the questioned costs is required.

## **Authority's Response**

*The majority of the questioned costs identified by the State Auditor's Office (SAO) are routine monthly premiums paid in advance to the managed care organizations the clients were enrolled in. Once a client's death is verified, the Authority recoups the premiums through the normal recoupment process.*

*SAO conducted this test by comparing June 30, 2015 client data to October 2015 Social Security Administration Death Master File. The test was not a test of June 30 records to June 30 death records; it was a test of June 30 records to October death records. The result of the timing difference is that SAO's list of exceptions includes clients who died before June 30, but whose death was not*

*recorded in the Social Security Administration Death Master File until after June 30. SAO cannot determine which of the 835 client deaths were recorded before June 30, and which ones were recorded after June 30.*

*They are, however, holding the Authority responsible for identifying and collecting, before June 30, all payments made on behalf of these clients, including those whose death was recorded after June 30.*

*When provided the list of 835 clients, the Authority could quickly demonstrate that costs had already been recouped totaling \$259,865 for 549 clients. Recoupment was through the normal process. SAO acknowledges this in the finding, but continues to question the costs.*

*The Authority concurs costs had not yet been recouped for the remaining 286 clients. The Authority will recover those costs and will discuss repayment of these costs with the U.S. Department of Health and Human Services.*

*Clearly the Authority's process is working appropriately. We recognize that there will always be a lag in recouping costs resulting in the unavoidable situation where HCA is not able to recoup premiums for deceased clients before the client's death is recorded in state and national databases. The Authority remedies this condition by recouping costs as the death is recorded and therefore becomes known to staff.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor

shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-133 Compliance Supplement for 2015, *Part 3 – Compliance Requirements*, states in part:

#### Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment include the following:

4. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, such as overpayments or underpayments made to eligible recipients resulting from inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments.
5. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
6. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
  - f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
  - g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.

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

**2015-036 The Health Care Authority made improper Medicaid payments for clients whose Social Security numbers and citizenship status were not verified and for unallowable non-emergency services.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Eligibility Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$155,033
<b>Likely Questioned Costs:</b>	\$938,309

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion during fiscal year 2015, more than \$7.6 billion of which was spent by the Health Care Authority.

### *Social Security number requirements*

Federal regulations require the Authority to obtain a Social Security number from individuals, including children, who apply for Medicaid. A verification with the Social Security Administration must be performed to ensure the provided number was issued to the individual. The Authority must require individuals apply for a number if they do not have one unless the individual meets certain exemptions. The Authority must verify the age, citizenship or immigration status, and the identity of the applicant.

### *Undocumented individuals and non-emergency services*

Undocumented individuals over the age of 18 and who are not pregnant are not eligible to receive Medicaid benefits, unless they are eligible for care and services related to a qualifying or emergent medical condition. Social Security numbers are not required for undocumented individuals.

Federal law requires states to have an Alien Emergency Medical program that covers medical emergencies for undocumented individuals. The program defines emergency medical conditions as the sudden onset of a medical condition with acute and severe symptoms such that the absence of immediate medical attention could reasonably be expected to result in:

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

Under Washington's Alien Emergency Medical program, any visit or service not meeting the criteria of an emergency situation is considered unallowable. However, individuals who are in need of kidney dialysis, cancer or tumor treatment or take anti-rejection medication are considered to have met this requirement. This includes, but is not limited to:

- Physical, occupational, speech therapy or audiology services
- Hospital clinic services
- Office or clinic-based services rendered by a physician, an Advanced Registered Nurse Practitioner, or any other licensed practitioner
- Laboratory, radiology, and any other diagnostic testing
- Personal care services
- Waiver services
- Nursing facility services
- Home health services

States can choose to pay for non-emergency services for undocumented individuals using non-Medicaid funds. However, non-emergency related services for pregnant women who are undocumented individuals are covered under Title XXI, Children's Health Insurance Program (CHIP). Emergency related services for undocumented pregnant women, such as labor and delivery, are allowable Medicaid expenses.

### *Medicaid application process*

The Affordable Care Act and Washington's Medicaid State Plan allows applicants to self-attest to having a valid Social Security number and to their citizenship status. Applicants are allowed 90 days to provide evidence of a valid Social Security number, application for a valid Social Security number, proof of citizenship or their pending application for citizenship. The Authority may not

deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's Social Security number or citizenship status during this 90 day period.

In the previous audit, we reported the Authority improperly paid providers \$66,503 with Medicaid funds on behalf of clients who did not have a valid Social Security number. The prior finding number was 2014-029. Additionally, we reported the Authority improperly paid providers \$65,490 with Medicaid funds for non-emergency services provided to undocumented individuals. The prior finding number was 2014-030.

### **Description of Condition**

#### *No Social Security numbers*

Using data mining techniques, we identified and performed tests of payments for the following high-risk populations:

- Clients with no Social Security numbers recorded in ProviderOne, the state's Medicaid claims payment system.
- Clients with a citizenship status of "undocumented alien" in the Medicaid client eligibility system.

In fiscal year 2015, we found payments to providers were made for 8,638 clients who had no Social Security number. Of these clients:

- 515 were categorized as foster or adopted children
- 5,461 were categorized as undocumented individual in the Medicaid eligibility system
- 2,662 were categorized as a citizen, documented individual or another category

From the 515 clients categorized as foster or adopted children, we selected and reviewed a statistically valid sample of 43 to determine if the Authority ensured clients had valid Social Security numbers and properly paid for Medicaid services.

We found Social Security numbers for four clients were not verified when their Medicaid eligibility was initiated. All four clients were determined eligible for Medicaid prior to the Affordable Care Act's effective date of January 1, 2014. Prior to implementation of the Affordable Care Act, the Authority was required to ensure each applicant had a valid Social Security number or applied for one prior to Medicaid eligibility approval. The Authority paid providers \$3,106 for unallowable services provided to these clients during the audit period.

From the 5,461 clients categorized as undocumented individuals in the Medicaid eligibility system, we reviewed services provided for the clients and identified 431 individuals who may have received non-emergency services during the audit period. We selected and reviewed a statistically valid sample of 81 clients and found six instances when undocumented individuals received unallowable, non-emergency services. The Authority paid providers \$29,151 for these services.

For 48 clients, Medicaid eligibility was determined based on self-attested citizenship and Social Security numbers. We found that a verification of these individuals' citizenship and Social Security numbers was not performed in a timely manner. The number of days it took for a verification to take place ranged from 147 to 689 days before the clients were ultimately determined ineligible and removed from the Medicaid program.

Although clients have 90 days to provide evidence of their citizenship status, we used a conservative approach and identified the payments that were made after 120 days to allow for communication between the client and the Authority. We found \$137,241 of unallowable payments to providers for services that occurred more than 120 days after the Authority made eligibility determinations.

From the 2,662 individuals categorized as citizen, documented individual or another, we selected and reviewed a statistically valid sample of 87 clients to determine if the Authority ensured clients had valid Social Security numbers and properly paid for Medicaid services.

We found six clients' citizenship was incorrectly categorized and were undocumented individuals who received non-emergency services. The Authority improperly charged the Medicaid program \$5,421 for non-emergency services. Of this amount, the Authority paid \$2,841 for non-emergency pregnancy services. These expenditures should have been charged to Title XXI, CHIP program.

We also found 14 clients self-attested to their citizenship or Social Security number. We found that a verification of these individuals' citizenship and Social Security numbers was not performed in a timely manner. The number of days it took for a verification to take place ranged from 131 to 500 days before the clients were ultimately determined ineligible and removed from the Medicaid program.

Although clients have 90 days to provide evidence of their citizenship status, we used a conservative approach and identified the payments that were made after 120 days to allow for communication between the client and the Authority. We found \$11,895 of unallowable payments to providers for services that occurred over 120 days after the Authority made eligibility determinations.

#### *Social Security numbers belonging to deceased individuals*

We also matched information from the Social Security Administration with paid Medicaid claims and found 62 clients received Medicaid services under a deceased person's Social Security number in ProviderOne. We reviewed case files for all 62 clients and found most matches were due to input errors or were retained from historical non-Medicaid files. However, we found one undocumented individual received non-emergency services. The Authority improperly charged the Medicaid program \$4,384 for non-emergency services.

We also found Medicaid eligibility for 17 individuals was determined based on self-attested citizenship and Social Security numbers. We found that a verification for these individuals was not performed in a timely manner. The number of days it took for a verification to take place ranged from 158 to 640 days before the clients were ultimately determined ineligible and removed from the Medicaid program. We found \$30,886 of unallowable payments to providers for services that occurred over 120 days after the Authority made eligibility determinations.



## **Cause of Condition**

The Authority has continuously made improvements in its training and monitoring, and maintains adequate Social Security number and citizenship verification procedures. However, it is unable to prevent or detect all unallowable payments.

The Authority has procedures in place to detect unallowable Medicaid payments for services provided to nonqualified individuals. However, the reviews are not in time to prevent or detect all unallowable payments.

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

The Authority cannot claim federal reimbursement for unallowable costs provided to ineligible clients. We question costs when we find an agency has not complied with grant regulations and/or when it does not have adequate documentation to support expenditures.

In total, we found the Authority claimed \$222,082 for unallowable Medicaid claims. We are questioning the federal share of \$155,033, which is calculated using the state's Federal Medicaid Assistance (FMAP) rate.

When we project the results of our audit tests performed using statistical sampling to the entire population of payments, we estimate likely questioned costs to be \$1,461,240. The federal share of the likely questioned costs is \$938,309.

## **Recommendation**

We recommend the Authority consult with U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Authority's Response**

*The Authority has terminated eligibility for the 96 identified clients whose citizenship or social security numbers could not be verified.*

*The Authority will also 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

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

Title 42, Code of Federal Regulations, Section 435.910 Use of social security number, states in part:

- (a) [T]he agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN). . .
- (e) If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must—
  - (1) Assist the applicant in completing an application for an SSN;
  - (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
  - (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.
- (f) The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA.

- (g) The agency must verify the SSN furnished by an applicant or beneficiary to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

Title 42, Code of Federal Regulations, Section 435.916 Periodic renewal of Medicaid eligibility, states in part, (a)

[T]he eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months[.]

Title 42, Code of Federal Regulations, Section 435.920 Verification of SSNs states:

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

Title 45, Code of Federal Regulations, Section 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange, states in part:

- (b) Validation of Social Security number.
  - (1) For any individual who provides his or her Social Security number to the Exchange, the Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.
  - (2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

...

- (f) *Inconsistencies.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included

in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange:

- (1) Must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;
- (2) If unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, must—
  - (i) Provide notice to the applicant regarding the inconsistency; and
  - (ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in § 155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.
- (3) May extend the period described in paragraph (f)(2)(ii) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.
- (4) During the periods described in paragraphs (f)(1) and (f)(2)(ii) of this section, must:
  - (i) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified; and
  - (ii) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.
- (5) If, after the period described in paragraph (f)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph (g) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation.
- (6) When electronic data to support the verifications specified in § 155.315(d) or § 155.320(b) is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange must accept the applicant's attestation regarding the factor of eligibility for which the unavailable data source is relevant.

Washington State Medicaid State Plan-Medicaid MAGI Eligibility and Benefits, states in part:

Citizenship and Non-Citizen Eligibility

The state provides Medicaid eligibility to otherwise eligible individuals:

- Who are citizens or nationals of the United States; and
- Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and
- Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.
  - The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.
  - The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

**2015-037 The Health Care Authority overpaid Medicaid providers for dental services.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls
	93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
	93.778 Medical Assistance Program (Medicaid; Title XIX)
	93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$25,945

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington state's largest public assistance program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. The Health Care Authority spent more than \$7.6 billion of the Medicaid funds.

States are required to provide dental benefits to children covered by Medicaid, and choose whether to provide dental benefits for adults. Medicaid covers dental services for all child enrollees as part of a comprehensive set of benefits, referred to as the Early and Periodic Screening, Diagnostic and Treatment benefit. This benefit provides comprehensive and preventative health care services for children under age 21 and who are enrolled in Medicaid.

The Authority's Dental-related Services program provides quality dental and dental-related services to eligible Medicaid clients. At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. In fiscal year 2015, the Authority paid providers nearly \$319 million for dental claims.

The Medicaid claim adjudication and payment process is highly automated. The Authority relies heavily on internal controls within the ProviderOne payment system, Washington's Medicaid Management Information System, to identify and deny claims when charges are unallowable or billed improperly by dental providers.

In prior audits, we found the Authority overpaid dental providers for unallowable services and recommended the Authority align its Medicaid Dental Provider Guide with Washington Administrative Code (WAC). The Authority implemented changes in response to the audit finding, published in March 2014, which became effective on April 30, 2015. The WAC is now consistent with the Medicaid Provider Guide. The prior audit finding numbers are 2014-033 and 2013-027.

### **Description of Condition**

We selected five specific dental services and used data mining techniques to determine whether the payments made to providers were allowable, based on the requirements existing at the date of service.

#### Prophylaxis (dental cleanings)

In fiscal year 2015, \$16.5 million of Medicaid funds was paid to dental providers for cleanings.

We identified 427 claims totaling \$14,646 paid to providers for dental cleanings that exceeded the allowed number covered by Medicaid. We are questioning \$10,225, which is the federal portion of the unallowable payments.

#### Topical fluoride treatments

In fiscal year 2015, \$11 million of Medicaid funds was paid to dental providers for topical fluoride treatments.

We identified 287 claims totaling \$3,673 paid to providers for fluoride applications that exceeded the allowed number covered by Medicaid. We are questioning \$1,850, which is the federal portion of the unallowable payments.

#### Oral health evaluations

In fiscal year 2015, \$19.5 million of Medicaid funds was paid to dental providers for oral health evaluation services.

We identified 73 claims totaling \$1,802 paid to providers for oral health evaluations that exceeded the allowed number covered by Medicaid. We are questioning \$924, which is the federal portion of the unallowable payments.

#### Oral Hygiene Instruction

In fiscal year 2015, approximately \$273,500 of Medicaid funds was paid to dental providers for oral hygiene instruction services.

We identified 40 claims totaling \$839 paid to providers for oral hygiene instruction services that exceeded the allowed number covered by Medicaid. We are questioning \$260, which is the federal portion of the unallowable payments.

## Family Oral Health Education

In fiscal year 2015, \$2.9 million of Medicaid funds was paid to dental providers for family oral health education services.

We identified 922 claims totaling \$25,359 paid to providers for family oral health education services that exceeded the allowed number covered by Medicaid. We are questioning \$12,686, which is the federal portion of the unallowable payments.

### **Cause of Condition**

We found that some automated controls within ProviderOne did not operate effectively. However, we determined the deficiencies did not constitute a significant deficiency or material weakness in internal controls.

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

In total, we found the Authority paid \$46,320 for unallowable dental services. We are questioning \$25,945, which is the federal portion of the unallowable payments.

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

### **Recommendation**

We recommend the Authority:

- Recover the \$25,945 in unallowable claims paid to dental providers.
- Consult with the U.S. Department of Health and Human Services to determine what, if any, of the questioned costs should be repaid.

### **Authority's Response**

*The Authority has already begun recouping the unallowable claims paid to dental providers, with an estimated completion date of June 30, 2016.*

*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

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines, state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

The OMB Circular A-133 Compliance Supplement (June 2015), *Part 3 – Compliance Requirements*, states in part:

### Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal

awards for such payments, and, as applicable, reclaim improper payments. Improper payment means:

1. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments).
2. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
3. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

WAC 182-535-1079 Dental-related services -- General, states in part (effective 5/18/12-4/29/14):

- (1) . . . The agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:
  - (a) Are part of the client's dental benefit package;
  - (b) Are within the scope of an eligible client's medical care program;
  - (c) Are medically necessary;
  - (d) Meet the agency's prior authorization requirements, if any;
  - (e) Are documented in the client's record in accordance with chapter 182-502 WAC;
  - (f) Are within accepted dental or medical practice standards;
  - (g) Are consistent with a diagnosis of dental disease or condition;
  - (h) Are reasonable in amount and duration of care, treatment, or service; and
  - (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

WAC 182-535-1079 Dental-related services -- General, states in part (effective 4/30/14):

- (1) . . . The agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:
  - (a) Are part of the client's dental benefit package;
  - (b) Are within the scope of an eligible client's Washington apple health (WAH) program;
  - (c) Are medically necessary;
  - (d) Meet the agency's prior authorization requirements, if any;
  - (e) Are documented in the client's record in accordance with chapter 182-502 WAC;
  - (f) Are within accepted dental or medical practice standards;
  - (g) Are consistent with a diagnosis of dental disease or condition;
  - (h) Are reasonable in amount and duration of care, treatment, or service; and
  - (i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

WAC 182-535-1080 Covered dental-related services-Diagnostic, states in part (effective 5/18/12-4/29/14):

Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

- (1) Clinical oral evaluations. The agency covers:
  - (a) Oral health evaluations and assessments.
  - (b) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
  - (d) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

WAC 182-535-1080 Dental-related services-Covered-Diagnostic, states in part (effective 4/30/14):

Clients described in WAC 182-535-1060 are eligible to receive the dental-related diagnostic services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

- (1) Clinical oral evaluations. The agency covers the following oral health evaluations and assessments, per client, per provider or clinic:
  - (a) Periodic oral evaluations as defined in WAC 182-535-1050, once every six months. Six months must elapse between the comprehensive oral evaluation and the first periodic oral evaluation.
  - (c) Comprehensive oral evaluations as defined in WAC 182-535-1050, once per client, per provider or clinic, as an initial examination. The agency covers an additional comprehensive oral evaluation if the client has not been treated by the same provider or clinic within the past five years.

WAC 182-535-1082 Covered dental-related services-Preventative services, states in part (effective 5/18/12-4/29/14):

Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

- (1) Dental prophylaxis. The agency covers prophylaxis as follows. Prophylaxis:
  - (a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.
  - (b) Is limited to once every:
    - (i) Six months for clients eighteen years of age and younger; and
    - (ii) Twelve months for clients nineteen years of age and older.

- (c) Is reimbursed only when the service is performed:
    - (i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from thirteen to eighteen years of age; and
    - (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older.
  - (d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
  - (e) Is covered for clients of the division of developmental disabilities according to (a), (c), and (d) of this subsection and WAC 182-535-1099.
- (2) Topical fluoride treatment. The agency covers:
- (a) Fluoride rinse, foam or gel, including disposable trays, for clients six years of age and younger, up to three times within a twelve-month period.
  - (b) Fluoride rinse, foam or gel, including disposable trays, for clients from seven to eighteen years of age, up to two times within a twelve-month period.
  - (c) Fluoride rinse, foam or gel, including disposable trays, up to three times within a twelve-month period during orthodontic treatment.
  - (d) Fluoride rinse, foam or gel, including disposable trays, for clients from nineteen to sixty-four years of age, once within a twelve-month period.
  - (e) Fluoride rinse, foam or gel, including disposable trays, for clients sixty-five years of age and older who reside in alternate living facilities, up to three times within a twelve-month period.
  - (f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
  - (g) Topical fluoride treatment for clients of the division of developmental disabilities according to WAC 182-535-1099.
- (3) Oral hygiene instruction. The agency covers:
- (a) Oral hygiene instruction only for clients eight years of age and younger.
  - (b) Oral hygiene instruction, no more than once every six months, up to two times within a twelve-month period.
  - (c) Individualized oral hygiene instruction for home card to include tooth brushing technique, flossing, and use of oral hygiene aides.
  - (d) Oral hygiene instruction only when not performed on the same date of service as prophylaxis.
  - (e) Oral hygiene instruction only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

WAC 182-535-1082 Dental-related services-Covered-Preventative services, states in part (effective 4/30/14):

Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

- (1) Dental prophylaxis. The agency covers prophylaxis as follows. Prophylaxis:
  - (a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on primary or permanent dentition.
  - (b) Is limited to once every:
    - (i) Six months for clients eighteen years of age and younger;
    - (ii) Twelve months for clients nineteen years of age and older; or
    - (iii) Four months for a client residing in a nursing facility.
  - (c) Is reimbursed only when the service is performed:
    - (i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients from thirteen to eighteen years of age;
    - (ii) At least twelve months after periodontal scaling and root planing, periodontal maintenance services, for clients nineteen years of age and older; or
    - (iii) At least six months after periodontal scaling and root planing, or periodontal maintenance services for clients who reside in a nursing facility.
  - (d) Is not reimbursed for separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, or gingivoplasty.
  - (e) Is covered for clients of the developmental disabilities administration of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.
- (2) Topical fluoride treatment. The agency covers the following per client, per provider or clinic:
  - (a) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients six years of age and younger, up to three times within a twelve-month period.
  - (b) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients from seven through eighteen years of age, up to two times within a twelve-month period.
  - (c) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, up to three times within a twelve-month period during orthodontic treatment.
  - (d) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients nineteen years of age and older, once within a twelve-month period.
  - (e) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients who reside in alternate living facilities as defined in WAC 182-513-1301, up to three times within a twelve-month period.
  - (f) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.
  - (g) Topical fluoride treatment for clients of the developmental disabilities administration of DSHS according to WAC 182-535-1099.
- (3) Oral hygiene instruction. Includes individualized instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. The agency covers oral hygiene instruction as follows:
  - (a) For clients eight years of age and younger. For clients nine years of age and older, oral hygiene instruction is included as part of the global fee for oral prophylaxis.

- (b) Once every six months, up to two times within a twelve-month period.
- (c) Only when not performed on the same date of service as prophylaxis.
- (d) Only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

WAC 182-535-1099 Covered dental-related services for clients of the division of developmental disabilities, states in part (effective 5/18/12-4/29/14):

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the agency pays for the dental-related services listed under the categories of services in this section that are provided to clients of the division of developmental disabilities. This chapter also applies to clients of the division of developmental disabilities, regardless of age, unless otherwise stated in this section.

(1) Preventive services.

- (a) Dental prophylaxis. The agency covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).
- (b) Topical fluoride treatment. The agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period.

WAC 182 535-1099 Dental-related services for clients of the developmental disabilities administration of the department of social and health services, states in part (effective 4/30/14):

Subject to coverage limitations, restrictions, and client-age requirements identified for a specific service, the agency pays for the dental-related services listed under the categories of services in this section that are provided to clients of the developmental disabilities administration of the department of social and health services (DSHS). This chapter also applies to clients any age of the developmental disabilities administration of DSHS, unless otherwise stated in this section.

(1) Preventive services.

- (a) Periodic oral evaluations. The agency covers periodic oral evaluations up to three times in a twelve-month period.
- (b) Dental prophylaxis. The agency covers dental prophylaxis or periodontal maintenance up to three times in a twelve-month period (see subsection (3) of this section for limitations on periodontal scaling and root planing).
- (c) Topical fluoride treatment. The agency covers topical fluoride varnish, rinse, foam or gel, up to three times within a twelve-month period, per client, per provider or clinic.

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program, states in part (effective 7/1/11-4/29/14):

The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger...

- (3) The department pays enhanced fees only to ABCD-certified dentists and other department-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:
  - (a) Family oral health education. An oral health education visit:
    - (i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic;

WAC 182-535-1245 Access to baby and child dentistry (ABCD) program, states in part (effective 4/30/14)

The access to baby and child dentistry (ABCD) program is a program established to increase access to dental services for medicaid-eligible clients ages five and younger. . .

- (3) The agency pays enhanced fees only to ABCD-certified dentists and other agency-approved certified providers for furnishing ABCD program services. ABCD program services include, when appropriate:
  - (a) Family oral health education. An oral health education visit:
    - (i) Is limited to one visit per day per family, up to two visits per child in a twelve-month period, per provider or clinic.

**2015-038 The Health Care Authority made improper Medicaid inpatient high outlier payments to hospitals.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Control Units  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) - American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$33,205

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent more than \$11.3 billion in federal and state funds during fiscal year 2015, almost \$7.6 billion of which was spent by the Health Care Authority. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures.

Medicaid in-patient hospital services are predominantly paid based on Diagnosis-Related Group (DRG) - based prospective payments or a set amount of dollars per day of inpatient stay (per-diem). DRG and per-diem payment amounts are calculated based on the inpatient hospital payment rates and the claim specific DRG relative weight for each hospital in effect on the date of admission. The Authority establishes inpatient rates based on hospital cost information.

High outlier payments are supplemental payments approved by the Centers for Medicare and Medicaid Services to compensate hospitals for unusually expensive cases where the cost of care is extraordinarily high in relation to the average cost of treating comparable conditions or illnesses. The actual determination of whether a case qualifies for an outlier payment takes into account both operating and capital costs and DRG payments. High outlier payments are calculated using an adjustment factor effective on the date of admission.

To qualify as a high outlier claim, the estimated costs of the inpatient claim must be above the outlier threshold in effect for the date of admission.



The portion of the estimated claim costs that exceeds the outlier threshold is eligible to receive a high outlier payment. The final payment amount is determined by multiplying the estimated cost above the threshold with the outlier adjustment factor. The high outlier payments are automatically calculated in ProviderOne, the state's Medicaid Management Information System.

In fiscal year 2015, the Authority paid approximately \$53 million for 741 in-patient high-outlier supplemental payments.

In prior audits, we found that the Authority made improper high outlier payments to hospitals. The Authority included denied services when determining high outlier payments because state law did not specify that the denied services should be excluded. The Authority also did not ensure rate changes were applied to all eligible inpatient claims. In response to our prior audit findings, the Authority revised the state law and also changed calculation rules in ProviderOne to specifically exclude denied services in the calculation of high outlier payments to hospitals for claims with admission dates on or after July 1, 2014. Also, the outlier threshold was changed from using a specific outlier criteria percentage effective for the date of admission to a flat amount of \$40,000. The prior finding numbers are 2014-032 and 2013-023.

### **Description of Condition**

Using data mining techniques we identified 60 high outlier claims paid during the audit period, that contained denied charges when client admission dates were before July 1, 2014.

After consulting with Authority staff, we confirmed the denied charges were improperly included in the calculation of the 60 claims, which resulted in overpayments totaling \$42,563.

### **Cause of Condition**

During the audit period, state law was amended and calculation rules in ProviderOne were changed - specifically for the exclusion of denied charges. However, the changes were applicable only to claims with admission dates after July 1, 2014.

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

The Authority made improper inpatient high outlier payments to hospitals totaling \$42,563. We are questioning \$33,205, which is the federal portion of the unallowable costs.

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

## **Recommendation**

We recommend the Authority:

- Ensure denied services are removed prior to calculating high outlier payments.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of questioned costs.

## **Authority's Response**

*As acknowledged by the State Auditor's Office, the Authority corrected both the WAC and the ProviderOne system in July 2014. The State Auditor's Office tested claims with admission dates after July 1, 2014, and confirmed that those claims were paid correctly. The claims in question have admission dates prior to July 1, 2014; WAC and ProviderOne system changes do not apply retroactively.*

*The Authority will consult with the U.S. Department of Health and Human Services to discuss repayment 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**

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

42 CFR 412.80, Outlier cases: General provisions, (a) Basic rule, states in part:

- (3) *Discharges occurring on or after October 1, 2001.* For discharges occurring on or after October 1, 2001, except as provided in paragraph (b) of this section concerning transfers, CMS provides for additional payment, beyond standard DRG payments and beyond additional payments for new medical services or technology specified in §§412.87 and 412.88, to a hospital for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges for covered services, adjusted to operating costs and capital costs by applying cost-to-charge ratios as described in §412.84(h), exceed the DRG payment for the case (plus payments for indirect costs of graduate medical education (§412.105), payments for serving a disproportionate share of low-income patients (§412.106), and additional payments for new medical services or technologies) plus a fixed dollar amount (adjusted for geographic variation in costs) as specified by CMS.

42 CFR 412.84, Payment for extraordinarily high-cost cases (cost outliers), states in part:

- (a) A hospital may request its intermediary to make an additional payment for inpatient hospital services that meet the criteria established in accordance with §412.80(a).
- (b) The hospital must request additional payment—
  - (1) With initial submission of the bill; or
  - (2) Within 60 days of receipt of the intermediary's initial determination.
- (c) Except as specified in paragraph (e) of this section, an additional payment for a cost outlier case is made prior to medical review.
- (d) As described in paragraph (f) of this section, the QIO reviews a sample of cost outlier cases after payment. *The charges for any services identified as noncovered* through this review are denied and any outlier payment made for these services are recovered, as appropriate, after a determination as to the provider's liability has been made.

WAC 182-550-3700 (previous version), DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers, states in part:

- (14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying

criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, *minus the noncovered charges on the claim*, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

WAC 182-550-3700 (Current Version) DRG high outliers, states in part:

- (1) The agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier criteria are met.
  - (a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission...
  - (b) The agency calculates the estimated costs of the claim by multiplying the total submitted charges, *minus the nonallowed charges on the claim*, by the hospital's ratio of costs-to-charges (RCC).
  - (c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria used to determine whether the claim qualifies for high outlier payment is the DRG allowed amount for the claim before the transfer payment reduction.
- (2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.
  - (a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:
    - (i) Pediatric services, including all claims submitted by children-specialty hospitals;
    - (ii) Burn services; and
    - (iii) Nonpediatric services.
  - (b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:
    - (i) Severity of illness (SOI) of one or two; or
    - (ii) SOI of three or four...
- (3) For state-administered programs (SAP), the agency applies the hospital-specific ratable to the outlier adjustment factor...

WAC 182-550-1050 Hospital services definitions contains:

"Nonallowed service or charge" - A service or charge billed by the provider as noncovered or denied by the agency. This service or charge cannot be billed to the client except under the conditions identified in WAC 182-502-0160.

**2015-039 The Health Care Authority did not have adequate internal controls to ensure Children’s Health Insurance Program federal funds were properly claimed as eligible Medicaid expenditures.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Known Questioned Cost Amount:</b>	\$76
<b>Likely Questioned Cost Amount:</b>	\$1,309,902

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures. The state Medicaid program spent approximately \$11.3 billion during fiscal year 2015. The Health Care Authority spent more than \$7.6 billion of the Medicaid funds.

In Washington, Medicaid and the Children’s Health Insurance Program (CHIP) provides medical assistance for children up to 19 years of age who reside in low-income households. Both programs are jointly funded by the state and federal government. The state is reimbursed approximately 65 percent for CHIP expenditures and 50 percent for Medicaid expenditures.

Medicaid expenditures for children whose family income equals or exceeds 133 percent of the federal poverty level but does not exceed the Medicaid applicable income level are eligible for additional CHIP funding. If the Medicaid costs have already been claimed and reimbursed, the state submits a claim for the difference between the CHIP and Medicaid rates.

The Authority identifies the Medicaid expenditures eligible for additional CHIP funding by comparing eligible client data and Medicaid fee-for-service and managed care payment information.

In state fiscal year 2015, the Authority claimed more than \$30.8 million in CHIP funds based on the eligibility of children in the Medicaid program.

In the previous audit, we reported the Authority improperly claimed \$17,397. The prior finding number was 2014-037.

### **Description of Condition**

We found the Authority's internal controls were not effective to ensure additional CHIP funds were claimed only for eligible Medicaid expenditures.

During the audit period, the Authority performed data matches to identify Medicaid expenditures eligible for additional CHIP funding for four quarters of state fiscal year 2014. We selected the first three quarters and obtained all fee-for-service and managed care payments for which the Authority claimed additional CHIP funds.

To determine if payments were eligible for additional CHIP funding we selected a random sample of 135 payments, totaling approximately \$8,002, from a total population of 2,395,451 payments that totaled \$20,777,055.

We found 11 payments, totaling \$511, were not eligible for additional CHIP funds. As a result, the Authority incorrectly claimed \$76 in CHIP funds. This amount was calculated by using 15 percent which was the difference between the CHIP and Medicaid rate.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

The Authority did not have an adequate review process to ensure the CHIP funds were claimed for eligible expenditures.

The Authority could not determine why the errors occurred in the processing of the 11 ineligible CHIP claims. The Authority believes the errors might have occurred during conversion of client files from an old eligibility system to its current eligibility system. During this conversion period there were changes in Medicaid eligibility income standards as well as the methodology for verifying eligibility which may have allowed these 11 claims to process through incorrectly.

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

By not having adequate internal controls in place to ensure additional CHIP funds are only requested for allowable expenses, the Authority is at a higher risk for improper claims of federal funds. We used a statistical sampling method to randomly select the payments we examined in the audit. When we project the results to the entire population of payments, we estimate the likely questioned costs to be \$1,309,902.

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

## **Recommendation**

We recommend the Authority:

- Establish adequate internal controls to ensure CHIP funds are properly claimed for eligible expenditures.
- Consult with the U.S. Department of Health and Human Services to discuss what, if any, of the questioned costs should be repaid.

## **Authority's Response**

*The work performed by the State Auditor's Office highlights a process issue that caused eligibility determination errors to occur during the conversion to the Affordable Care Act. The Authority will review and amend the eligibility determination process to prevent those errors from recurring, and will ensure that prior errors are corrected.*

*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**

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

### Section 300

The auditee shall:

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

Section 510, states in part:

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

- ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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



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

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

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

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

42 U.S.Code §1397ee Payments, states in part:

(g) Authority for qualifying states to use certain funds for Medicaid expenditures. -

(1) State option.—

(A) In general.—Notwithstanding any other provision of law subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 1397dd of this title for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under subchapter XIX of this chapter in accordance with subparagraph (B), instead of for expenditures under this subchapter .

(B) Payments to states.—

(i) In 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.

**2015-040 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls in place to ensure in-home care providers paid by Medicaid had proper background checks.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed, Allowable Costs/Cost Principles, Special Tests and Provisions - Provider Eligibility
<b>Questioned Cost Amount:</b>	\$26,138
<b>Likely Questioned Cost Amount:</b>	\$3,254,863

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.73 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

Almost \$3.8 billion of Medicaid funds was spent by the Department of Social and Health Services. In fiscal year 2015 the Department paid approximately \$184 million to more than 18,000 individual in-home service providers.

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 home and community settings. These services are provided in the client's home by individuals or agencies often chosen by the Medicaid client or the client's legal representative.

All individual providers must meet basic qualifications to provide services to Medicaid clients. They must be at least 18 years old, authorized to work in the United States and meet the Department's minimum training requirements.

In addition, individual providers must successfully complete a state background check every two years, and effective January 8, 2012, all new contracted providers or applicants who have not lived in Washington for three consecutive years must also complete a national fingerprint background check

The Department's Secretary establishes a list of crimes that automatically disqualify individuals from serving vulnerable clients. The list is referred to as "the Secretary's List." Individuals that commit crimes on the Secretary's List 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 on the Secretary's List, they are not automatically disqualified. The Department must perform a character, competence and suitability review to assess and determine if the provider may have unsupervised access to clients.

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 2014-049, 13-40, 12-41, and 11-34.

### **Description of Condition**

During fiscal year 2015, more than 65 percent of all Medicaid payments for in-home care services were made to individual providers contracted by the Department.

We randomly selected 145 Community Options Program Entry System (COPES) individual providers from a total population of 18,621 who provided in-home care services during fiscal year 2015 to ensure that:

- A proper background check had been completed within the last two years.
- Staff with criminal records that were not listed on the Secretary's List of Automatically Disqualifying Convictions and Pending Charges passed a Character, Competence and Suitability (CCS) Review permitting them to work unsupervised with vulnerable adults.
- No individuals with disqualifying crimes listed on the Secretary's List were employed at the time of the audit, or during the month(s) in which they worked.
- The entire period in which the provider had access to Medicaid clients was covered by a Washington State background check.

We found one provider worked for one month with a Medicaid client without a current background check.

We also found the Department did not have adequate internal controls to ensure character, competence and suitability reviews were completed and documented to ensure providers with criminal records were eligible to provide unsupervised in-home care to vulnerable adults. We examined records for 51 providers with criminal records and found six instances (11 percent) when there was no documented evidence an individuals' character review was performed.

We consider this internal control weakness to constitute a significant deficiency.

### Cause of Condition

The Department has adequate procedures in place to materially ensure individual providers meet background check requirements.

However, in one instance, the Department did not confirm that a provider background check was completed every two years as required by state rules. In addition the Department did not adequately monitor its contracted providers to ensure all providers received a character, competence, and suitability review allowing them unsupervised access to vulnerable clients.

### Effect of Condition and Questioned Costs

Providers who do not meet the background check requirement are not eligible to provide services to Medicaid clients. Any payments made by the Department to ineligible providers are unallowable.

A statistical sampling method was used to randomly select the providers we examined in the audit. When we project the results of the audit to the entire population of 18,621 COPES individual providers, we estimate the amount of unallowable payments to be \$6,505,822.

The following table summarizes the unallowable payments we identified in the audit by condition:

Condition	Number of Providers	Total Unallowable Payments	Likely Unallowable Payments
Providers working without a background check	1	\$1,312	\$168,526
Providers with criminal records who worked without documented evidence of a character, competence, and suitability review	6	\$50,943	\$6,337,296
<b>TOTAL</b>	<b>7</b>	<b>\$52,255</b>	<b>\$6,505,822</b>

We are questioning \$3,254,863, which is the federal share of the unallowable payments. The federal share is calculated using the state's 2015 Federal Medical Assistance Percentage (FMAP) rate of 50.03 percent.

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

## **Recommendation**

We recommend the Department:

- Strengthen its monitoring of contracted providers with criminal histories to ensure character, competence, and suitability reviews are completed and adequately documented.
- Follow-up on background check results and ensure ineligible providers do not have access to vulnerable Medicaid clients.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department partially agrees with this finding.*

*While we agree one provider worked for one month with a Medicaid client without a current background check and six providers with criminal records worked with Medicaid clients without documented evidence of a renewed character, competence, and suitability (CCS) review, we disagree the six providers should be tied to questioned costs.*

*These six providers had no disqualifying crimes at any point in their employment. They were subjected to an initial CCS review during the contracting process. There is no RCW or WAC that states that an individual provider becomes unqualified if a new CCS review is not completed at each bi-annual background check when there are no new crimes and they care for the same client, which is the case for these six providers.*

*The Department will continue to strengthen processes to ensure CCS reviews are completed and adequately documented. Clarification to field offices was issued via management bulletin on March 30, 2015, providing clear direction on required forms and frequency of completion for CCS reviews in response to requests from the field.*

*Annually, the Assisted Long-Term Services Administration's Quality Assurance (QA) unit selects a sample of individual provider files for monitoring at each field office and reviews the files for background checks. In 2015, a total of 386 files were reviewed by the QA unit. In addition to these reviews, field office supervisors are required to complete quality assurance reviews on individual provider files. In 2015, a total of 1,293 files were reviewed by supervisors. Overall, internal quality assurance reviews showed a 97% proficiency. This process will continue and will assist us in evaluating our policies and processes for potential changes.*

*The Department will also work to strengthen reports for field staff and future ProviderOne enhancements.*

*Thank you for the opportunity to improve our processes for individual provider background checks. The Department values the safety of clients and has implemented policies to ensure that providers are qualified and clients are protected from harm. Our internal policies are set up to ensure a high level of quality review, exceeding standards put forth in RCW or WAC. This audit provided us with the*

*opportunity to review these standards in the context of our internal policies.*

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

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

We acknowledge the corrective measures taken by the Department during previous audits, as well as the positive results from the Aging and Long-Term Support Administration's most recent quality assurance reviews. Our Office considers the overall health and safety of Medicaid clients a significant factor in evaluating provider eligibility.

The Department's policies and procedures specify reviews of current background check information, as well as references to previous character, competence and suitability determinations must be documented when considering the continuing eligibility of providers. This specific language ultimately led our Office to include these six providers in the finding.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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



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

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

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

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

RCW 74.39A.056, Criminal history checks on long-term care workers, states:

- (1) (a) All long-term care workers shall be screened through state and federal background checks in a uniform and timely manner to verify that they do not have a criminal history that would disqualify them from working with vulnerable persons. The department must perform criminal background checks for individual providers and prospective individual providers and make the information available as provided by law.
  - (a) (i) Except as provided in (b)(ii) of this subsection, for long-term care workers hired after January 7, 2012, the background checks required under this section shall include checking against the federal bureau of investigation fingerprint identification records system and against the national sex offenders registry or their successor programs. The department shall require these long-term care workers to submit fingerprints for the purpose of investigating conviction records through both the Washington state patrol and the federal bureau of investigation. The department shall not pass on the cost of these criminal background checks to the workers or their employers.
  - (ii) This subsection does not apply to long-term care workers employed by community residential service businesses until January 1, 2016.
- (b) The department shall share state and federal background check results with the department of health in accordance with RCW 18.88B.080.
- (2) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority or a court of law or entered into a state registry with a final substantiated finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.
- (3) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have final substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing

requirements. The department shall disclose, upon request, final substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information must also be shared with the department of health to advance the purposes of chapter 18.88B RCW.

(4) The department shall adopt rules to implement this section.

WAC 388-71-0510, "How does a person become an individual provider?" states:

In order to become an individual provider, a person must:

- (1) Be eighteen years of age or older;
- (2) Provide the social worker/case manager/designee with:
  - (a) A valid Washington state driver's license or other valid picture identification; and either
  - (b) A Social Security card; or
  - (c) Proof of authorization to work in the United States.
- (3) Complete the required DSHS form authorizing a background check;
- (4) Disclose any criminal convictions and pending charges, and also disclose civil adjudication proceedings and negative actions as those terms are defined in WAC 388-71-0512;
- (5) Effective January 8, 2012, be screened through Washington state's name and date of birth background check. Preliminary results may require a thumb print for identification purposes.
- (6) Effective January 8, 2012, be screened through the Washington state and national fingerprint-based background check, as required by RCW 74.39A.056.
- (7) Results of background checks are provided to the department and the employer or potential employer unless otherwise prohibited by law or regulation for the purpose of determining whether the person:
  - (a) Is disqualified based on a disqualifying criminal conviction, a pending charge for a disqualifying crime as listed in WAC 388-113-0020, civil adjudication proceeding, or negative action as defined in WAC 388-71-0512 and 388-71-0540; or
  - (b) Should or should not be employed as an individual provider based on his or her character, competence, and/or suitability.
- (8) For those providers listed in RCW 43.43.837 (1), a second Washington state and national fingerprint-based background check is required if they have lived out of the state of Washington since the first national fingerprint-based background check was completed.
- (9) The department may require an individual provider to have a Washington state name and date of birth background check or a Washington state and national fingerprint-based background check, or both, at any time.
- (10) Sign a home and community-based service provider contract/agreement to provide personal care services to a person under a medicaid state plan or federal waiver such as COPES or other waiver program.

WAC 388-71-0513 Is a background check required of a long-term care worker employed by a home care agency licensed by the department of health?

In order to be a long-term care worker employed by a home care agency, a person must:

- (1) Complete the required DSHS form authorizing a background check.
- (2) Disclose any disqualifying criminal convictions and pending charges as listed in WAC [388-113-0020](#), and also disclose civil adjudication proceedings and negative actions as those terms are defined in WAC [388-71-0512](#).
- (3) Effective January 8, 2012, be screened through Washington state's name and date of birth background check. Preliminary results may require a thumb print for identification purposes.
- (4) Effective January 8, 2012, be screened through the Washington state and national fingerprint-based background check, as required by RCW [74.39A.056](#).
- (5) Results of background checks are provided to the department and the employer or potential employer for the purpose of determining whether the person:
  - (a) Is disqualified based on a disqualifying criminal conviction, a pending charge for a disqualifying crime listed in WAC 388-113-0020, civil adjudication proceeding, or negative action as defined in WAC 388-71-0512; or listed in WAC 388-71-0540; or
  - (b) Should or should not be employed based on his or her character, competence, and/or suitability.
- (6) For those providers listed in RCW [43.43.837\(1\)](#), a second national fingerprint-based background check is required if they have lived out of the state of Washington since the first national fingerprint-based background check was completed.
- (7) The department may require a long-term care worker to have a Washington state name and date of birth background check or a Washington state and national fingerprint-based background check, or both, at any time.

The Department's Aging and Long-Term Support Administration – Home and Community Services Division - Long-Term Care Manual, Chapter 7(a): In-Home Provider Requirements, states in part:

You will receive a *RECORD* letter from BCCU when there is a pending charge for a disqualifying crime. However, pending crimes are always disqualifying based on *character, competence, and suitability*, unless there is an outcome in court. The *character, competence, and suitability* determination must be documented on the Assessment Documentation Form or other document that is maintained in the provider's file. Complete a character, competence, and suitability determination in writing if the IP has a conviction for a non-disqualifying crime or the person is not found guilty.

...If you have previously completed a character, competence, and suitability determination, you do not have to complete a new one on the same provider of the same client *if* there are no new convictions or negative actions, *and* the provider meets all other provider qualifications in meeting the client's needs. (If the provider is going to work for another client, you need to complete another determination in relation to the new client.) *If you find that you do not need a new determination*, you still need to document that you have:

- Reviewed the current background check;
- Found that there is no new information;
- Referred to the previous character, competence, and suitability determination made, with the date; and
- Stated your decision.

**2015-041 The Department of Social and Health Services improperly claimed federal reimbursement for payments made on behalf of deceased Medicaid clients.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed or Unallowed
<b>Questioned Cost Amount:</b>	\$22,584

### **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015, more than \$3.8 billion of which was spent by the Department of Social and Health Services.

Medicaid providers may not be reimbursed for services provided after a beneficiary's death. The Department receives quarterly data from the state Department of Health, which is used to identify if Medicaid clients have died. When clients are determined to be deceased they are removed from the Medicaid program. Every month the Department searches for Medicaid payments that were paid after a client's date of death. If such payments are found, the Department initiates a process to recover the overpayments.

In the previous audit, we reported the Department paid providers \$27,687 for services that occurred after a client's death. The prior finding number was 2014-050.

### **Description of Condition**

We examined all Medicaid payments made by the Department in fiscal year 2015 to determine if the Department paid for services after a client died. We found 97 claims were paid for services provided after a client's death.

## **Cause of Condition**

The Department performs monthly reviews to detect unallowable Medicaid payments for services provided after a client's death. However, these reviews are not effective in preventing or detecting all unallowable payments.

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

When the state provides services to ineligible individuals, or the services are unallowable, the services cannot be claimed for federal reimbursement. We found \$45,148 in paid services that occurred after a client's death. We are questioning \$22,584, which is the federal share of the unallowable payments. The federal share is calculated using the state's Federal Medical Percentage or FMAP rate.

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

## **Recommendation**

We recommend the Department:

- Recover the unallowable payments for services provided after the client's death.
- Consult with the U.S. Department of Health and Human Services to determine if repayment of the questioned costs is required.

## **Department's Response**

*The Department partially concurs with this finding.*

*The review found 97 instances of payments made through SSPS and ProviderOne for services provided after the client's date of death. The Department agrees with 77 of these instances. The remaining 20 were determined by the Aging and Long Term Services Administration to be allowable services prior to the client's deaths.*

*The Department acknowledges that the target for payment of services, provided after the date of death is zero and we seek to reach that mark.*

*Current practice includes training staff to ensure termination of authorization of services effective at date of death. The Department continues to work to strengthen our processes including utilizing a revised report that identifies clients who have authorizations that were paid after their date of death. This report is analyzed monthly and post payment review will also occur for payments to ensure that any authorizations or payments not prevented because of both a failure of practice and a system failure*

*are caught and collected. Where necessary, overpayments will be processed timely and federal funds returned to the U.S. Department of Health and Human Services.*

*The Department will continue its partnership with the Health Care Authority to monitor for payments after the date of death.*

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

We thank the Department for its cooperation and assistance throughout the audit, and acknowledge the corrective measures taken by the Department to date.

We received the results of follow-up work performed by the Department for 20 cases pertaining to Aging and Long-Term Support Administration. The Department asserts it performed follow-up work for 20 cases pertaining to the Aging and Long-Term Support Administration. The Department states it has obtained additional supporting documentation from providers of health care services and determined the payments made for these services were justified. Our Office did not confirm if the expenditures were supported and allowable because this activity occurred after the audit had concluded.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

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

... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-133 Compliance Supplement for 2013, *Part 3 – Compliance Requirements*, states in part:

#### Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment include the following:

7. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, such as overpayments or underpayments made to eligible recipients resulting from inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments.
8. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
9. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.
  - f. Be accorded consistent treatment. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost.
  - g. Except as otherwise provided for in 2 CFR part 225, be determined in accordance with generally accepted accounting principles.



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

**2015-042 The Department of Social and Health Services paid Medicaid benefits for clients who did not have valid Social Security numbers.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Eligibility Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$55,719

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington state’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015, more than \$3.8 billion of which was spent by the Department of Social and Health Services.

Federal regulations require the Department to obtain a Social Security number from each individual, including children, applying for Medicaid. The Department is required to verify the number with the Social Security Administration to ensure it was issued to the individual and to verify if the person has been issued any other number. The Department must assist an applicant with applying for a number if they do not have one. Under these circumstances, the agency must obtain evidence to establish the age, citizenship or immigration status, and the true identity of the applicant.

The Washington HealthPlanFinder federally verifies the validity of a Social Security number at the time of application for Medicaid benefits. Department staff verify a client provided a Social Security number using the Federal Health Data Services Hub for unverified Social Security numbers. When an application is submitted without a Social Security number, or the Social Security number is not

federally verified, Department staff contact the applicant and follow-up to obtain a valid Social Security number.

The Social Security Administration provides the state with access to the State On-Line Query, a computer system that enables state agencies to verify the validity of a Social Security number at the time of the Medicaid application.

### **Description of Condition**

We reviewed all claims paid to Medicaid providers through the Department's Social Service Payment System (SSPS) in fiscal year 2015 to determine if the Medicaid clients had valid Social Security numbers.

We identified three clients who did not have a valid Social Security number. The Department paid \$111,384 in Medicaid funds for services provided to these clients in fiscal year 2015.

### **Cause of Condition**

The Department has adequate procedures for obtaining and verifying Social Security numbers, however it is still not preventing or detecting all unallowable payments.

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

When the Department provides services to ineligible individuals, or the services are unallowable and/or unsupported, the services cannot be claimed for federal reimbursement. We are questioning \$55,719, which is the federal share of the unallowable payments. The federal share is calculated using the state's Federal Medical Assistance Percentages (FMAP) rate.

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

### **Recommendation**

We recommend the Department:

- Follow up on the three clients for whom the Department could not provide evidence of a correct Social Security number, and re-determine their Medicaid eligibility.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## Department's Response

*The Department concurs with this finding.*

*Children's Administration will work to strengthen processes to further minimize the allocation of expenditures to Medicaid funding in error.*

*The federal funds for these clients will be returned and Children's Administration will communicate the information to the Health Care Authority so they are able to identify the returned funds as a part of their claiming process.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

Title 42, Code of Federal Regulations, Section 435.910(a) Use of social security number, states in part:

[T]he agency must require, as a condition of eligibility, that each individual (including children) seeking Medicaid furnish each of his or her Social Security numbers (SSN).

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

The agency must verify the SSN furnished by an applicant or beneficiary to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

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

If an applicant cannot recall his SSN or SSNs or has not been issued a SSN the agency must:

- (1) Assist the applicant in completing an application for an SSN;
- (2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true identity of the applicant; and
- (3) Either send the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to furnish the number.

Title 42, Code of Federal Regulations, Section 435.916 Periodic renewal of Medicaid eligibility, (a) states in part,

[T]he eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months[.]

Title 42, Code of Federal Regulations, Section 435.920 Verification of SSNs states:

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

**2015-043 The Department of Social and Health Services did not accurately claim the federal share of Medicaid payments for Presumptive Supplemental Security Income clients.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Control Units  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Matching  
**Questioned Cost Amount:** \$130,234

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. Medicaid is the state’s largest program and accounts for approximately one third of the state’s federal expenditures.

The Federal Medical Assistance Percentage (FMAP) is used in determining the amount of federal matching funds for states’ Medicaid expenditures. This rate is calculated annually by the federal Department of Health and Human Services. Washington’s FMAP for federal fiscal year 2015 was 50.03 percent.

The Affordable Care Act expanded Medicaid coverage to low-income adults without children beginning on January 1, 2014. The Act provides 100 percent federal funding for medical assistance payments for newly eligible adults until January 2017. This rate will decrease to 90 percent by 2020.

When the Affordable Care Act was enacted in March 2010, Washington also expanded Medicaid coverage to Presumptive Supplemental Security Income (PSSI) clients who have long-term medical conditions that are likely to meet federal disability criteria, but whose disability determination is

pending. Until January 1, 2014, Medicaid services for PSSSI clients were financed at the regular FMAP rate. Beginning on January 1, 2014, a new Expansion State FMAP (ESFMAP) went into effect which is higher than the current FMAP. By 2019 this rate will gradually increase and equal the enhanced matching rate available for newly-eligible adults.

The Medicaid matching rates are automatically applied to Medicaid expenditures through the Department's cost allocation process. When the Affordable Care Act went into effect, the Department did not have a unique code identifying PSSSI clients in its payment system. The Department manually prepared PSSSI expenditure reports and processed adjustments to claim the correct federal amount based on ESFMAP.

In fiscal year 2015, the state Medicaid program spent approximately \$251 million for the PSSSI program. Approximately \$15.5 million was spent by the Department.

### **Description of Condition**

We found the Department did not process adjustments for all social and nursing home services in a timely manner between January 2014 and June 2015. As a result, the Department claimed an incorrect federal share for Medicaid PSSSI expenditures of \$1.5 million.

The Department completed its adjustments after our audit period.

### **Cause of Condition**

The Department stated that it was not able to produce a Medicaid PSSSI expenditure report in a timely manner due to a significant transition of its social service payment system to a new payment system, ProviderOne.

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

The Department over-claimed \$151,170 in Medicaid expenditures between January 2014 and June 2015. We are questioning \$130,234, which is the over-claimed portion for fiscal year 2015.

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

### **Recommendation**

We recommend the Department:

- Ensure questioned costs were repaid to federal grantor.
- Ensure it claims the correct federal share of PSSSI expenditures in the future.

## **Department's Response**

*The Department concurs with the finding.*

*All questioned costs were returned to the Centers for Medicare and Medicaid Services by December 2015. To correctly account for Presumptive Supplemental Security Income (PSSI), the Department developed new financial and functional Recipient Aide Categories (RACs) separating out this group of clients, which allowed the PSSI expenditures to be directly coded to the appropriate match rate. The new RACs began in ProviderOne on February 1, 2015 and the Department worked with Health Care Authority (HCA) to develop new reports to correct Provider One PSSI expenditures. Due to the timing of the new RACs, changes in the Social Service Payment System (SSPS) for 1099 services was not possible for these clients and corrections for SSPS were made via journal voucher once new reports were developed for this population as well.*

*In addition, since SSPS only had one year remaining to pay W2 services, new SSPS codes were not created for W2 services. Instead, reports were developed to identify PSSI expenditures but reports were not available to correct these costs timely. After Individual ProviderOne implementation, the new RACs will be used to directly code expenditures.*

*Additionally, we continue to work with HCA to obtain reports to determine if additional corrections are needed for payments processed through ProviderOne.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

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



- ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

42 U.S. Code 1396d Definitions, states in part:

(z) Equitable Support for Certain States.—

- (2)(A) For calendar quarters in 2014 and each year thereafter, the Federal medical assistance percentage otherwise determined under subsection (b) for an expansion State described in paragraph (3) with respect to medical assistance for individuals described in section 1902(a)(10)(A)(i)(VIII) who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 shall be equal to the percent specified in subparagraph (B)(i) for such year.
- (3) A State is an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

**2015-044 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have internal controls in place to ensure follow up on nursing home survey deficiencies were conducted in a timely manner.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Control Units  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act  
**Federal Award Number:** 5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT  
**Applicable Compliance Component:** Special Tests and Provisions – Provider Health and Safety Standards  
**Questioned Cost Amount:** None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

In fiscal year 2015, the state Medicaid program spent approximately \$10.4 million for the state survey and certification of health care providers. The Department of Social and Health Services (Department) spent more than \$3.8 million during fiscal year 2015.

Residential Care Services, under the Department of Social and Health Services, Aging and Long-Term Support Administration, is the state survey agency for Washington.

In fiscal year 2015, the state had 220 nursing homes that were Medicare and/or Medicaid certified. The survey for certification of a nursing home is a resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation. The survey focuses on the nursing home’s administration and patient

services. The survey also assesses compliance with federal health, safety and quality standards designed to ensure patients receive safe and quality care services.

States are required to complete a standard survey within 15.9 months following the previous survey and the state-wide average must not exceed 12.9 months for nursing homes as stated in the Mission and Priority Statement issued by Centers for Medicare and Medicaid Services (CMS). If deficiencies are found in the facility the Department is responsible for mailing a statement of deficiency to the facility within 10 working days of the survey date. The facility is then required to submit a plan of correction to the Department within 10 calendar days of receipt. The Centers for Medicare and Medicaid services measures state agencies using the federal fiscal year and our audit period looked at surveys during the state fiscal year.

We reported the Department did not have adequate internal controls to ensure surveys were conducted timely in our prior audit. The prior finding number was 2014-046.

### **Description of Condition**

The Department has procedures in place to ensure the standard surveys get completed timely, but those procedures do not include a process to ensure applicable statement of deficiencies are sent timely or that corrective action is received timely.

A statistical sampling method was used to randomly select 41 nursing homes to determine if the Department mailed statements of deficiency within 10 working days as required. We found eight (20 percent) exceeded the required timeframe.

We also examined the same nursing homes to determine if the plan of correction was received within 10 calendar days and found that 15 (37 percent) were submitted late.

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

### **Cause of Condition**

The Department noted the cause of delays was due to administrative enforcement decision making, technical issues, and/or staffing issues.

### **Effect of Condition**

When the Department does not follow up on deficiencies timely, the state is paying the facilities for services provided to Medicaid clients without assurance they are in compliance with federal and state health standards and regulations.

## **Recommendation**

We recommend the Department establish procedures to ensure statements of deficiency and correction plans are submitted timely.

## **Department's Response**

*The Department agrees with this finding.*

*While the Centers for Medicare and Medicaid Service's State Operational Manual guidelines do not require formal tracking of the statement of deficiencies or plans of correction, the Department did implement a statewide formal tracking system in January 2016, to improve compliance.*

*The Department will continue to enhance its formal tracking of statement of deficiency mailings and receipting of plans of corrections. Standard operating procedures will be enhanced to ensure implementation of the tracking.*

## **Auditor's Concluding Remarks**

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

## **Applicable Laws and Regulations**

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

### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

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

Title 42, Code of Federal Regulations, Section 488.402 General provisions. States in part:

(d) Plan of correction requirement.

- (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency.
- (2) Isolated deficiencies. A facility is not required to submit a plan of correction when it has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

Centers for Medicare and Medicaid Services State Operations Manual Chapter 7 - 7319.1 - Non-State Operated Skilled Nursing Facilities and Nursing Facilities or Dually Participating Facilities (Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10) states in part:

1. The State conducts the survey and certifies compliance.
2. The State sends the facility Form CMS-2567 and if applicable, the “Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm” (Form A), within 10 working days of the last day of survey.
3. If the facility is in substantial compliance, but deficiencies constitute a pattern or widespread findings causing no actual harm and potential for only minimal harm, the State instructs the facility to submit a plan of correction to the State’s office. (This must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.) There is no requirement for the State to conduct a revisit to verify correction, but the facility is expected to comply with its plan of correction.

Centers for Medicare & Medicaid Services State Operations Manual Chapter 7 - 7304.4 - Acceptable Plan of Correction - states in part:

- (f) Provides that an acceptable plan of correction is required in response to deficiencies listed on the Form CMS-2567 and must be received within 10 calendar days of the facility's receipt of the CMS-2567. The plan of correction will serve as the facility's allegation of compliance;
- (g) Informs the facility of the opportunity for informal dispute resolution;
- (h) Specifies that if an acceptable plan of correction is not received within 10 calendar days of the facility's receipt of the CMS-2567, the State will notify the facility that it is recommending to the regional office and/or the State Medicaid Agency that remedies other than category 1, and/or denial of payment for new admissions, be imposed effective as soon as notice requirements are met. As authorized by CMS and/or the State Medicaid Agency, formal notice of imposition of category 1 remedies may be officially provided in this initial notice, and notice of imposition of denial of payment for new admissions may be officially provided in this notice or in the first revisit letter;

**2015-045 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls in place to ensure surveys for Medicaid nursing home and intermediate care facilities were completed in a timely manner.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Special Tests and Provisions – Provider Health and Safety Standards
<b>Questioned Cost Amount:</b>	None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

In fiscal year 2015, the state Medicaid program spent approximately \$10.4 million for the survey and certification of health care providers. The Department of Social and Health Services (Department) spent more than \$3.8 million of that amount.

Residential Care Services, part of the Department of Social and Health Services, Aging and Long-Term Support Administration, is the state survey agency for the state of Washington.

The state has 13 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). An ICF/IID is an institution whose primary purpose is for the provision of health or rehabilitation services to individuals with intellectual disabilities or related conditions that receive care and services under the Medicaid program.

The Department is required to perform an annual certification survey of each ICF/IID. The primary focus of the annual certification survey is on the "outcome" of the facility's implementation of ICF/IID active treatment services.

States are required to complete a standard survey within 15.9 months following the previous survey and the state-wide average must not exceed 12.9 months. If deficiencies are found in a facility the Department must mail a statement of deficiency to the facility within 10 working days of the survey date. The facility is then required to submit a plan of correction to the Department within 10 calendar days of receipt. The Centers for Medicare and Medicaid services measures state agencies using the federal fiscal year and our audit period looked at surveys during the state fiscal year.

We reported the Department did not have adequate internal controls to ensure surveys were conducted timely in our prior audit. The prior finding number was 2014-046.

### **Description of Condition**

We examined all 13 ICF/IID facilities and found the Department did not ensure surveys were performed in accordance with the frequency required by state and federal laws.

- Two (15 percent) surveys exceeded the 15.9 month requirement.
- The statewide average of 13.7 months exceeded the 12.9 month requirement.

We found four (30 percent) instances when the Department failed to mail statements of deficiency within 10 working days of the survey date. The number of actual days ranged from 11 to 36 days. Three of the four facilities submitted their plan of correction after 10 calendar days, ranging from 12 to 17 days.

We also reviewed the Department's tracking process and found one facility did not have the correct survey on the tracking spreadsheet and the Department did not have one facility on the tracking spreadsheet.

We consider this control deficiency to be a material weakness.

### **Cause of Condition**

In September 2014, the Department was asked to postpone an annual survey for one facility so that a joint nursing home and ICF/IID survey could be conducted along with federal surveyors. As a result, the survey was postponed more than once, which led to the delay in conducting this and one other ICF/IID facility annual survey.



The Department noted staffing challenges as part of the cause to ensure the statement of deficiencies and plan of corrections are done timely.

### **Effect of Condition**

When surveys are not conducted and follow up on deficiencies are not performed timely, the state is paying the facilities for services provided to Medicaid clients without assurance they are in compliance with federal and state health standards and regulations.

### **Recommendation**

We recommend the Department conduct ICF/IID surveys in accordance with the frequency required by federal and state laws. We also recommend the Department establish internal controls to ensure statement of deficiencies and plan of corrections are completed timely.

### **Department's Response**

*The Department partially concurs with this finding.*

#### *Survey Interval for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID):*

*The Department agrees it did not meet two annual ICF/IID recertification surveys in accordance with the frequency and interval required by federal and state laws. The Department will schedule and monitor surveys to meet standards. The department was provided with two additional full time equivalent surveyor positions and has filled these positions to conduct recertification surveys and complaint investigations. The Department has requested additional basic surveyor training classes be made available from the Centers for Medicare and Medicaid Services (CMS) to enable new hires to function independently to conduct surveys and investigations.*

#### *Statement of Deficiency (SOD) Mailing and Plans of Correction Receipts*

*The Department does not agree, that not formally tracking the receipt of plans of correction is a material weakness. The CMS State Operational Manual guidelines do not require formal tracking. The Department has been informally tracking SOD mailings and plans of correction receipts:*

- *SOD Mailing - The Department has been informally tracking mailing of SODs and recording these in the ICF/IID electronic system (SharePoint site) and also recording them on the hard copy ICF/IID tracking form. In addition to mailing the SODS, they are also faxed to the facilities.*
- *Plan of Correction Receipts - The Department has enhanced the tracking log within the SharePoint site and added this item. In addition, this item was also added into the hard copy of the ICF/IID tracking form to monitor receipt of plan of corrections. A written standard*

*operating procedure will be developed to ensure implementation of the tracking form and to document follow-up action done by the program to ensure timely receipt of the plans of correction.*

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

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

We acknowledge that the Department has made improvements to the tracking process to ensure follow-up action is completed.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

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

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

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

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

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, states in part:

7205 - Survey Frequency: 15-Month Survey Interval and 12-Month State-wide Average

7205.2 - Scheduling and Conducting Surveys (Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

The State must complete a standard survey of each skilled nursing facility and nursing facility not later than 15 months after the previous standard survey.

Facilities with excellent histories of compliance may be surveyed less frequently to determine compliance, but no less frequently than every 15 months and the State-wide standard survey average must not exceed 12 months.

7319.1 - Non-State Operated Skilled Nursing Facilities and Nursing Facilities or Dually Participating Facilities (Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10)

1. The State conducts the survey and certifies compliance.
2. The State sends the facility Form CMS-2567 and if applicable, the “Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm” (Form A), within 10 working days of the last day of survey.

3. If the facility is in substantial compliance, but deficiencies constitute a pattern or widespread findings causing no actual harm and potential for only minimal harm, the State instructs the facility to submit a plan of correction to the State's office. (This must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.) There is no requirement for the State to conduct a revisit to verify correction, but the facility is expected to comply with its plan of correction.

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 2- The Certification Process, states in part:

2138G - Schedule for Recertification

(Rev. 91, Issued: 09-27-13, Effective: 09-27-13, Implementation: 09-27-13)

The SA completes a recertification survey an average of every 12 months and at least once every 15 months (see §2141).

2141 - Recertification - ICFs/IID

(Rev. 91, Issued: 09-27-13, Effective: 09-27-13, Implementation: 09-27-13)

- The regulation at §442.15 provides that provider agreements for ICF/IID's would remain in effect as long as the facility remains in compliance with the Conditions Of Participation (COP's). Regulations at §442.109 through §442.111.
- Beginning on May 16, 2012, ICF/IID's are no longer subject to time-limited agreements. However, they are to be surveyed for re-certification an average of every 12 months and at least once every 15 months.
- If during a survey the survey agency finds a facility does not meet the standards for participation the facility may remain certified if the survey agency makes two determinations – The facility may maintain its certification if the survey agency finds Immediate Jeopardy doesn't exist, and if the facility provides an acceptable plan of correction.

Title 42, Code of Federal Regulations, Section 488.402 General provisions. States in part:

(d) Plan of correction requirement.

- (1) Except as specified in paragraph (d)(2) of this section, regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements must submit a plan of correction for approval by CMS or the survey agency.
- (2) Isolated deficiencies. A facility is not required to submit a plan of correction when it has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

Centers for Medicare & Medicaid Services State Operations Manual Chapter 7 - 7319.1 - Non-State Operated Skilled Nursing Facilities and Nursing Facilities or Dually Participating Facilities (Rev. 63, Issued: 09-10-10, Effective: 09-10-10, Implementation: 09-10-10) states in part:

1. The State conducts the survey and certifies compliance.
2. The State sends the facility Form CMS-2567 and if applicable, the “Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm” (Form A), within 10 working days of the last day of survey.
3. If the facility is in substantial compliance, but deficiencies constitute a pattern or widespread findings causing no actual harm and potential for only minimal harm, the State instructs the facility to submit a plan of correction to the State’s office. (This must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.) There is no requirement for the State to conduct a revisit to verify correction, but the facility is expected to comply with its plan of correction.

Centers for Medicare & Medicaid Services State Operations Manual Chapter 7 - 7304.4 - Acceptable Plan of Correction - states in part:

- (f) Provides that an acceptable plan of correction is required in response to deficiencies listed on the Form CMS-2567 and must be received within 10 calendar days of the facility's receipt of the CMS-2567. The plan of correction will serve as the facility's allegation of compliance:
- (g) Informs the facility of the opportunity for informal dispute resolution;
- (h) Specifies that if an acceptable plan of correction is not received within 10 calendar days of the facility's receipt of the CMS-2567, the State will notify the facility that it is recommending to the regional office and/or the State Medicaid Agency that remedies other than category 1, and/or denial of payment for new admissions, be imposed effective as soon as notice requirements are met. As authorized by CMS and/or the State Medicaid Agency, formal notice of imposition of category 1 remedies may be officially provided in this initial notice, and notice of imposition of denial of payment for new admissions may be officially provided in this notice or in the first revisit letter;

**2015-046 The Department of Social and Health Services made improper payments for unallowable services provided to newly eligible Medicaid clients under the Affordable Care Act.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Controls  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$58,572

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures.

The Affordable Care Act (ACA) expanded Medicaid coverage to low-income adults without children beginning on January 1, 2014. The Alternative Benefits Plan (ABP) is Medicaid benefit coverage for newly eligible adults under the ACA's expansion. ABP for newly eligible adults must include the ten categories of essential health benefits (EHB) required by the ACA, provide parity in coverage between physical and mental health services, and offer certain preventive services. In Washington State, ABP services are equivalent to traditional Medicaid clients with the addition of a benefit for habilitative services. All available benefit/services under ABP are specified in the Medicaid State Plan.

ABP benefits package includes coverage for nursing home care and Medicaid Personal Care (MPC) but does not include coverage for home and community-based waiver services authorized by either Department of Social and Health Services (Department) Home and Community Services or Developmental Disability Administration. Medicaid Personal Care (MPC) services provide individual

provider or agency support in order to meet a person's needs for assistance with activities such as bathing, dressing, eating, meal preparation, housework, and travel to medical services. This service is provided in the person's own home or adult family home. To be eligible for nursing home or MPC service, clients must be functionally eligible for the services. The functional eligibility is determined based on an assessment of an individual's functional unmet needs. For clients who need additional services that MPC cannot offer, home and community based waiver services are considered, but clients need to financially qualify for such services using waiver criteria. In addition to personal care services, clients can receive other services such as assisted living services, supported living services, environmental modifications and home delivered meal services in home and community based waiver program. Those services are not included as an ABP benefit.

In fiscal year 2015, the state Medicaid program spent approximately \$3.2 billion for newly Medicaid eligible clients under ACA, more than \$318 million of which was spent by the Department.

**2015**

**Description of Condition**

We reviewed all claims paid through the Department's social service payment system in fiscal year 2015 to determine if the Department made improper Medicaid payments for claims not included in the ABP service package for newly Medicaid eligible clients.

We found the Department paid \$117,087 in Medicaid funds for unallowable services.

The following table summarizes the unallowable services we determined were provided for newly Medicaid eligible clients:

<b>Service Description</b>	<b>Unallowable Payments</b>	<b>Federal Share*</b>
Supported living services	\$ 42,926	\$21,476
Environmental modifications	\$ 24,605	\$12,309
Assisted living care	\$ 15,927	\$ 7,966
Special medical equipment	\$ 8,454	\$ 4,228
Adult day care	\$ 6,443	\$ 3,223
Enhanced adult residential care	\$ 5,323	\$ 2,662
Behavioral support and management services	\$ 5,715	\$ 2,859
Other unallowable services	\$ 8,213	\$ 4,108
<b>Total</b>	<b>\$117,087</b>	<b>\$58,572</b>

\*The federal share is calculated using the state's 2015 Federal Medical Assistance Percentage (FMAP) rate assigned per expenditure type.

The amount of unallowable payments noted in the table above includes a \$55,064 adjustment the Department processed after the audit period to move fiscal year 2015 expenditures to state only funding, the federal share of this adjustment was \$27,543. We found the Department did not identify an additional \$62,023 in unallowable payments, the federal share was \$31,029. Total questioned costs are \$58,572.

The Department also identified unallowable ABP payments of \$43,418 in state fiscal year 2014 and moved its federal share of \$21,709 to state only funding.

### **Cause of Condition**

Some case managers mistakenly authorized unallowable home and community based waiver services because they misunderstood these services to be an allowable service for newly eligible clients.

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

The Department improperly claimed federal reimbursement for unallowable payments of \$117,661. We are questioning \$58,572, which is the federal portion of the unallowable costs.

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

### **Recommendation**

We recommend the Department consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

### **Department's Response**

*The Department concurs with this finding.*

*To correctly account for the Alternative Benefits Plan (ABP), the Department developed functional Receipt Aid Categories (RACs). A specific category is now paired with one specific financial RAC separating out this group of clients, which allows the ABP expenditures to be directly coded to the appropriate match rate. The new RACs began in ProviderOne on January, 1, 2015 for 1099 services in ProviderOne.*

*In addition, since the Social Service Payment System only had one year remaining to pay W2 services, reports were developed to identify expenditures that were coded incorrectly. After Individual Provider One implementation, the new functional RACs will be paired with the one financial RAC to directly code expenditures.*



*The Department will return all questioned costs.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

WAC 182-501-0060 Health care coverage—Program benefit packages—Scope of service categories, states in part:

- (1) This rule provides a table that lists:
  - (a) The following Washington apple health (WAH) programs:
    - (i) The alternative benefits plan (ABP) medicaid
  - (6) Scope of service categories. The following table lists the agency's categories of health care services...
    - (b) The letter "Y" means a service category is included for that program. Services within each service category are subject to limitations and restrictions listed in the specific medical assistance program rules and agency issuances.
    - (c) The letter "N" means a service category is not included for that program.
    - (d) Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services.

Service Categories		ABP 20-	ABP 21+
Ambulance (ground and air)		Y	
Applied behavior analysis (ABA)		Y	N
Behavioral health services			
•	Mental health (MH) inpatient care	Y	Y
•	MH outpatient community care	Y	Y
•	MH psychiatric visits	Y	Y
•	MH medication management	Y	Y
•	Substance use disorder (SUD) detoxification	Y	Y
•	SUD diagnostic assessment	Y	Y
•	SUD residential treatment	Y	Y
•	SUD outpatient treatment	Y	Y
Blood/blood products/related services		Y	Y
Dental services		Y	Y
Diagnostic services (lab and X ray)		Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services		Y	N
Habilitative services		Y	Y
Health care professional services		Y	Y
Hearing evaluations		Y	Y
Hearing aids		Y	N
Home health services		Y	Y
Hospice services		Y	Y
Hospital services Inpatient/outpatient		Y	Y
Intermediate care facility/services for persons with intellectual disabilities		Y	Y
Maternity care and delivery services		Y	Y
Medical equipment, durable (DME)		Y	Y
Medical equipment, nondurable (MSE)		Y	Y
Medical nutrition services		Y	Y
Nursing facility services		Y	Y
Organ transplants		Y	Y
Orthodontic services		Y	N
Out-of-state services		Y	Y
Outpatient rehabilitation services (OT, PT, ST)		Y	Y
Personal care services		Y	Y
Prescription drugs		Y	Y
Private duty nursing		Y	Y
Prosthetic/orthotic devices		Y	Y
Reproductive health services		Y	Y

Respiratory care (oxygen)	Y	Y
School-based medical services	Y	N
Vision care Exams, refractions, and fittings	Y	Y
Vision hardware Frames and lenses	Y	N

**2015-047    The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure complaints of abuse and neglect of clients at Medicaid residential facilities were responded to properly.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775    State Medicaid Fraud Controls 93.777    State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778    Medical Assistance Program (Medicaid; Title XIX) 93.778A    Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1405WA5MAP; 5-1405WA5ADM; 5-1405WAIMPL; 5-1405WAINCT
<b>Applicable Compliance Component:</b>	Special Tests and Provisions – Provider Health and Safety Standards
<b>Questioned Cost Amount:</b>	None

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington’s largest public assistance program and accounts for approximately one third of the state’s federal expenditures. The program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

The Centers for Medicare and Medicaid Services (CMS), which administers the program at the federal level, allows states to provide long-term care services to Medicaid clients that require daily nursing services. Medicaid coverage for nursing homes and intermediate care facilities for intellectually disabled clients is only authorized when services are provided in a residential facility licensed and certified by the state survey agency. The state survey agency is also responsible for investigating complaints and allegations of abuse, neglect or misappropriation.

Residential Care Services, under the Department of Social and Health Services’ Aging and Long-Term Support Administration, is the Medicaid survey agency for Washington. Residential Care Services manages the Complaint Resolution Unit, which is the front-line response system for addressing complaints from staff, residents, family members and the public.

Reports can be submitted to the Complaint Resolution Unit by mail, email, fax and telephone, Voicemail messages can be left on the Unit’s hotline 24 hours a day, seven days a week. Messages received after hours, on holidays, and on weekends are responded to the next business day. The Unit uses the Tracking Incidents of Vulnerable Adults (TIVA) case management system to input, prioritize and track complaints.

Review of all report types regardless of delivery method is conducted prior to being input into the TIVA case management system. Initial review of a report is performed by a program specialist. Clinical triage nurses determine the final priority assignment of all nursing home and intermediate care facility reports.

The following table lists the five different levels of prioritization for new complaints and the respective required response times.

<b>Prioritization</b>	<b>Required Response</b>
Immediate Jeopardy	Initiate investigation within 2 working days of receipt
Non Immediate Jeopardy-High	Initiate investigation within 10 working days of prioritization
Non Immediate Jeopardy-Medium	Initiate investigation within 20 working days of prioritization
Non Immediate Jeopardy-Low	Initiate investigation within 45 working days of prioritization
Quality Review	None required

Complaints are prioritized as a quality review for two reasons. First, the matter has already been or is in the process of being investigated. Secondly, the initial intake assessment indicates there is no threat to the resident or appropriate steps have already been taken to safeguard the resident. By classifying complaints as a quality review it makes the information accessible to field staff, but an investigation is not performed.

Complaints are prioritized to ensure the level of response corresponds to the severity of the allegation. All complaints not prioritized as quality reviews are prioritized and assigned to the Department’s field unit offices within two working days of receipt of the complaint.

The CMS State Operations Manual requires an assessment of each nursing home complaint to be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his or her knowledge and experience of current clinical standards of practice and federal requirements. The complaints are then assigned to field staff. In fiscal year 2015, the Department received 28,438 complaints. Of these, 21,149 were assigned a priority and sent to the Residential Care Services field units to be investigated. The other 7,289 complaints were categorized as quality reviews.

The following table shows the number of complaints received for each provider type served by the Complaint Resolution Unit:

<b>Provider Type</b>	<b>Number of Complaints Received</b>
Adult Family Home	3,527
Assisted Living Facility	6,487
DEL Licensed	1
Intermediate Care Facility/ID	1,410
Nursing Home	11,527
RCS Intake Only	321
Supported Living	5,165
<b>Total Complaints</b>	<b>28,438</b>

Of the 28,438 complaints received during fiscal year 2015, there were 15,923 complaints that required an initiation of a response within 24 hours of receipt. The following table shows the number of complaints received for each allegation category that must meet this requirement:

<b>Allegation Code</b>	<b>Number of Complaints Received</b>
01 - Resident/Patient/Client Abuse	7,986
02 - Resident/Patient/Client Neglect	5,918
03 - Misappropriation of property	1,907
05 - Restraints/Seclusion - Death	3
06 - Restraints/Seclusion - General	109
<b>Grand Total</b>	<b>15,923</b>

Field staff investigate the complaint and perform follow-up within the assigned time frame determined by the severity of the issue.

In prior audits, we reported the Department did not respond timely to complaints of abuse or neglect. The prior finding numbers were: 2014-045 and 13-033. A performance audit was also performed in 2015. The audit report number was 1015480.

### **Description of Condition**

As described below, we found the Department did not have adequate internal controls in place to ensure complaints were responded to timely, which we consider a material weakness in controls over compliance with these requirement.

*Timeliness of responses to complaints*

We found 4,336 (27 percent) of all complaints received in fiscal year 2015 that the Department determined were to be responded to within 24 hours were not entered into the Department’s TIVA system timely. The following table shows the number of complaints that were not assessed timely and the range of days in which they were responded to.

<b>Working days to initiate a response</b>	<b>Number of complaints</b>
2 - 10 days	4,175
11 - 20 days	129
21 - 44 days	32
<b>Total responses initiated after 24 hours</b>	<b>4,336</b>

*Assessment of nursing home complaints by qualified individuals*

We found the following complaints for nursing homes and intermediate care facilities were not reviewed by a clinical triage nurse:

- 203 nursing home complaints (2 percent)
- 584 intermediate care facility complaints (41 percent)

*Timeliness of onsite survey – Immediate Jeopardy*

Three nursing home complaints involving immediate jeopardy cases were not investigated within two working days of receipt.

*Timeliness of prioritization and referrals to the Residential Care Services field unit*

The following intakes prioritized as non-immediate jeopardy, were not assigned to field staff within two days of receipt:

- 392 of 9,021 (4 percent) for nursing homes
- 69 of 1,050 (7 percent) for intermediate facilities

Additionally, investigations into the following non-immediate jeopardy complaints did not begin timely:

- 946 out of 9,021 (11 percent) for nursing homes
- 636 out of 1,050 (61 percent) for intermediate facilities

We could not determine if the Department assigned complaints timely for 868 (10 percent) nursing home complaints and 266 (25 percent) intermediate facility complaints. Critical dates for these complaints were not recorded in the Department's TIVA system.

### **Cause of Condition**

Although the Department has continued to improve its policies and procedures, training and systems, the transcription of the complaints from the voicemail system continues to be a time consuming process. Further, the Department does not ensure that all nursing home and intermediate care facility complaints are reviewed by a nurse.

### **Effect of Condition**

The Department did not comply with the requirements related to assessment of and response to complaints. When complaints are not received, prioritized and investigated timely, vulnerable residents are at a higher risk of abuse, neglect and financial exploitation.

### **Recommendation**

We recommend the Department strengthen its internal controls to ensure complaints are responded to as required by federal regulations and state law.

### **Agency's Response**

*The Department concurs with this finding.*

*The Department will continue to implement plans to strengthen internal controls and ensure complaints/reports are responded to and investigated, as required by federal regulation and state law.*

*The Tracking Incidents of Vulnerable Adults (TIVA) database is being redesigned to add information fields to improve the existing complaint process. These information fields are scheduled to be added to TIVA by June 1, 2016 and will expedite priority assignments by clearly identifying dates of "Knowledge" and "Initiate a Response."*

*Effective April 1, 2016 the Department will be authorizing overtime, as an interim solution, to ensure that complaints/reports are responded to within 24 hours of "knowledge." During this time we will also be considering other viable long term solutions, such as a per diem on-call staffing pool, which could be utilized on high volume days. Increased staffing will help with responding to complaints/reports generated over weekends and holidays.*

*During January 2015, the Complaint Resolution Unit's (CRU) "intake prior to assignment" procedure, for Nursing Home and Intermediate Care Facilities/ Individuals with Intellectual Disabilities (ICF/ IID), was implemented. This process improvement eliminates a review by a*



*Program Specialist 3 and directly assigns all complaints/reports from both provider types directly to Nurse Consultants.*

*In October 2015, the Department hired additional in field investigators, to improve the timeliness of investigations of non-immediate jeopardy Nursing Home and ICF/IID complaints.*

*During November 2015, to ensure investigations begin within two working days of receipt, the CRU Unit implemented the online reporting system for providers. This reporting option will assist the Department to meet required timelines and streamline the complaints/reports processing by reducing manual transcription time. The outcomes of the online reporting system, impacts on work flow, and timeliness are scheduled to be reviewed during April 2016.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.

- e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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

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

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

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

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

42 U.S. Code § 1396r(g)(4) Survey and Certification Process, states:

- (4) Investigation of complaints and monitoring nursing facility compliance --

Each state shall maintain procedures and adequate staff to-

- (A) Investigate complaints of violations of requirements by nursing facilities, and
- (B) Monitor, on site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d) of this section, if -
  - (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
  - (ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
  - (iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering, and preserving evidence, and carrying out appropriate enforcement actions against substandard nursing facilities.

Center for Medicare and Medicaid Services, State Operations Manual, Chapter 5-Complaint Procedures, 5070 - Priority Assignment for Nursing Homes, Deemed and Non-Deemed Providers/Suppliers, and EMTALA states in part:

An assessment of each intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge and/or experience of current clinical standards of practice and Federal requirements. In situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to investigate within two working days of receipt of the information. For all non-immediate jeopardy situations, the complaint/incident is prioritized within two working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information.

Title 42, Code of Federal Regulations, Section 488.335 Action on complaints of resident neglect and abuse, and misappropriation of resident property, states in part:

- (a) Investigation.
  - (1) The State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in § 488.332.
  - (2) If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the State must investigate the allegation.
  - (3) The State must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property.

RCW 74.34.063 Response to report – Timing – Reports to law enforcement agencies -- Notification to licensing authority, states in part:

- (1) The department shall initiate a response to a report, no later than twenty-four hours after knowledge of the report, of suspected abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult.

Residential Care Services Operational Principles and Procedures Complaint Resolution Unit  
Prioritization of Intakes – IV. Operational Procedures (A) July 2014:

For complaints prioritized as a 10WD (working day) complaint "Complaint and incident investigations shall be initiated within 10 working days of linking the intake to the RCS Field Unit." For complaints prioritized as 20WD (working day) "Complaint and incident investigations shall be initiated within 20 working days of linking the intake to the RCS Field Unit.". For 45WD (working day) - "Complaint and incident investigations shall be initiated within 45 working days of linking the intake to the RCS Field Unit".

**2015-048 The Department of Social and Health Services improperly claimed federal Medicaid reimbursement for non-emergency services provided to nonqualified aliens.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.775 State Medicaid Fraud Control Units  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles Eligibility  
**Questioned Cost Amount:** \$37,426

**Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is Washington state's largest public assistance program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015, more than \$3.8 billion of which was spent by the Department of Social and Health Services.

Under federal law all United States citizens and certain legal immigrants who meet Medicaid's financial and non-financial eligibility criteria are eligible to receive Medicaid benefits. Nonqualified aliens are not eligible to receive standard Medicaid benefits, but may be eligible for care and services necessary in an emergency medical situation.

Federal law requires the state to have an Alien Emergency Medical program for medical emergencies for nonqualified aliens who meet all Medicaid program requirements with the exception of immigration status. This program covers low-income families, children and adults who are aged, blind or disabled.

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

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

Under the Alien Emergency Medical program, any visit or service not meeting the criteria of an emergency situation is considered unallowable. This includes, but is not limited to:

- Physical, occupational, speech therapy or audiology services
- Hospital clinic services
- Office or clinic-based services rendered by a physician, an Advanced Registered Nurse Practitioner, or any other licensed practitioner
- Laboratory, radiology, and any other diagnostic testing
- Personal care services
- Waiver services
- Nursing facility services
- Home health services

The state can choose to pay for non-emergency services for nonqualified aliens. However, the federal government will not share the cost of these services.

In the previous audit, we reported the Department paid providers \$688,081 for non-emergency services provided to nonqualified aliens. The prior finding number was 2014-050.

### **Description of Condition**

We found the Department improperly charged the Medicaid program \$74,813 for services that were provided to five nonqualified aliens. Providers were paid for 495 claims for non-emergency related services.

### **Cause of Condition**

The Department performs periodic reviews to detect unallowable Medicaid payments for services provided to nonqualified aliens. However, these reviews are not effective to prevent or detect all unallowable payments.

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

When the state provides services to ineligible individuals, or the services are not allowable, the services cannot be claimed for federal reimbursement. We are questioning the federal share of \$37,426 of the unallowable payments identified in the audit.

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

## **Recommendation**

We recommend the Department:

- Recover the unallowable payments for non-emergency services provided to nonqualified aliens.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department concurs with this finding.*

*The Children's Administration will work to strengthen the review of these cases to help minimize the possibility of funds being allocated to Medicaid in error.*

*For the Aging and Long Term Support and the Developmental Disabilities Administrations Clients were assigned the wrong Medicaid Recipient Aid Category (RAC) in error. Due to the implementation of ProviderOne, staff needed additional training on how to select the correct RAC for these clients.*

*The federal portions of these questioned costs will be returned to CMS.*

## **Auditor's Concluding Remarks**

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-133 Compliance Supplement for 2013, *Part 3 – Compliance Requirements*, states in part:

### Improper Payments

Under OMB guidance, Public Law (Pub. L.) No. 107-300, the Improper Payments Information Act of 2002, as amended by Pub. L. No. 111-204, the Improper Payments Elimination and Recovery Act, Executive Order 13520 on reducing improper payments, and the June 18, 2010 Presidential memorandum to enhance payment accuracy, Federal agencies are required to take actions to prevent improper payments, review Federal awards for such payments, and, as applicable, reclaim improper payments. Improper payment include the following:

10. Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements, such as overpayments or underpayments made to eligible recipients resulting from inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for the incorrect amount, and duplicate payments.
11. Any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments where authorized by law).
12. Any payment that an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation.



OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

Title 42 Code of Federal Regulations, Section 435.139 Coverage for certain aliens states:

The agency must provide services necessary for the treatment of an emergency medical condition, as defined in §440.255(c) of this chapter, to those aliens described in §435.406(c) of this subpart.

Title 42, Code of Federal Regulations, Section 440.255, Limited services available to certain aliens, states:

- (a) FFP for services. FFP is available for services provided to aliens described in this section which are necessary to treat an emergency medical condition as defined in paragraphs (b)(1) and (c) or services for pregnant women described in paragraph (b)(2).
- (b) Legalized aliens eligible only for emergency services and services for pregnant women. Aliens granted lawful temporary resident status, or lawful permanent resident status under sections 245A, 210 or 210A of the Immigration and Nationality Act, who are not in one of the exempt groups described in §§435.406(a)(3) and 436.406(a)(3) and who meet all other requirements for Medicaid will be eligible for the following services—
  - (1) Emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    - (i) Placing the patient's health in serious jeopardy;
    - (ii) Serious impairment to bodily functions; or
    - (iii) Serious dysfunction of any bodily organ or part.
  - (2) Services for pregnant women which are included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine post-partum care. States, at their option, may provide additional plan services for the treatment of conditions which may complicate the pregnancy or delivery.
- (c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must

receive the services necessary to treat the condition defined in paragraph (1) of this section if—

- (1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
  - (i) Placing the patient's health in serious jeopardy;
  - (ii) Serious impairment to bodily functions; or
  - (iii) Serious dysfunction of any bodily organ or part, and
- (2) The alien otherwise meets the requirements in §§435.406(c) and 436.406(c) of this subpart.

WAC 182-500-0030, Medical assistance definitions—E., states in part:

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (1) Placing the patient's health in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

WAC 182-507-0115, Alien emergency medical program (AEM), states:

- (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) or (c) of this subsection:
  - (a) The Medicaid agency determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 182-500-0030, and the condition is confirmed through review of clinical records; and
  - (b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:
    - (i) Inpatient;
    - (ii) Outpatient surgery;
    - (iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or
  - (c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section).
- (2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:
  - (a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

- (b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:
  - (i) Medications;
  - (ii) Laboratory, X-ray, and other diagnostics and the professional interpretations;
  - (iii) Medical equipment and supplies;
  - (iv) Anesthesia, surgical, and recovery services;
  - (v) Physician consultation, treatment, surgery, or evaluation services;
  - (vi) Therapy services;
  - (vii) Emergency medical transportation; and
  - (viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the agency or its designee as described in subsection (3) of this section.
- (3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:
  - (a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;
  - (b) The person is transferred directly to this facility from the hospital; and
  - (c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).
- (4) The agency does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the agency or its designee under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.
- (5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.
- (6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.
- (7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.
  - (a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - The admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.
  - (b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.
- (8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 182-501-0060. This includes, but is not limited to:

- (a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the agency to be a qualifying emergency medical condition, including but not limited to:
  - (i) Laboratory X ray, or other diagnostic procedures;
  - (ii) Physical, occupational, speech therapy, or audiology services;
  - (iii) Hospital clinic services; or
  - (iv) Emergency room visits, surgery, or hospital admissions.
- (b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;
- (c) Organ transplants, including pre-evaluations, post-operative care, and anti-rejection medication;
- (d) Services provided outside the hospital settings described in subsection (1) of this section including, but not limited to:
  - (i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;
  - (ii) Prenatal care, except labor and delivery;
  - (v) Laboratory, radiology, and any other diagnostic testing;
  - (iv) School-based services;
  - (v) Personal care services;
  - (vi) Physical, respiratory, occupational, and speech therapy services;
  - (x) Waiver services;
  - (xi) Nursing facility services;
  - (ix) Home health services;
  - (xii) Hospice services;
  - (xiii) Vision services;
  - (xiv) Hearing services;
  - (xv) Dental services;
  - (xvi) Durable and nondurable medical supplies;
  - (xvii) Nonemergency medical transportation;
  - (xviii) Interpreter services; and
  - (xvii) Pharmacy services, except as described in subsection (4) of this section.
- (9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.
- (10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

**2015-049 The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls to ensure Medicaid payments to supported living service 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 Controls  
93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare  
93.778 Medical Assistance Program (Medicaid; Title XIX)  
93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)  
**Federal Award Number:** 5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT  
**Applicable Compliance Component:** Activities Allowed/Unallowed Allowable Costs/Cost Principles  
**Known Questioned Cost Amount:** \$43,697  
**Likely Questioned Cost Amount:** \$13,173,381

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

The Department's Developmental Disabilities Administration administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service of this program and is delivered by staff of contracted supported living providers. Contractor employees assist clients in activities of daily living and with the social and adaptive skills necessary to live in the community.

The Department pays supported living providers a daily rate for each day of service provided to clients. The number of hours and type of support services clients are authorized to receive is based on the client's assessed needs, which varies from a few hours a week up to 24 hours per day. The majority of clients receiving supported living services require daily support to maintain their health and safety.

Department case managers use the Comprehensive Assessment Reporting Evaluation system to conduct assessments of client needs and determine levels of support. 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. As part of that process, the Department captures economies of scale which allows clients to share hours within households or clusters. 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. Providers are required to maintain adequate payroll records, including staff timesheets, work schedules, and payroll vouchers, to support payment claims.

In fiscal year 2015, the Department paid approximately \$360 million to 116 supported living providers for services provided to more than 3,900 clients.

The Department assigned one employee to conduct periodic reviews of supported living providers. The reviews consist of comparing employee hours provided to clients' contracted hours, and providing training to providers about necessary payroll documentation. In fiscal year 2015, the employee conducted 25 reviews of provider payroll records to ensure reported service hours were supported. Since 2013, the Department has reviewed records for 46 of the providers.

Supported living providers are required to submit a cost report at the end of each calendar year. The Department uses the reports to determine if the total support hours claimed by providers for the year agree to authorized service hours. Cost reports are reconciled and analyzed based on total hours provided to all clients in the agency, while payments are based on individual client need.

In prior audits, we found the Department did not have adequate internal controls to ensure supported living providers maintained adequate documentation to ensure payments for supported living services were allowable. The prior finding numbers were 2014-042, 2013-036 and 12-39. Additionally, we reported the Department made \$75,818 in overpayments to supported living providers. The prior finding number was 2014-043.

### **Description of Condition**

Although the Department has improved its monitoring of provider payroll documentation, internal controls were still not effective to ensure Medicaid payments claimed by supported living providers were allowable.

The Department's review process was not effective to ensure payments claimed by providers for the assessed needs of each individual client were for actual support hours provided. For the 25 reviews the Department employee performed during the audit period, employee timesheets were not reconciled to provider payments.

In addition, Department analysts relied on payroll hours reported in summary level cost reports from providers, but did not compare the information with supporting payroll documentation (such as time sheets) to ensure the hours reported were accurate.

In some cases, Department policy allows providers to settle their cost reports over a two year period in order to minimize settlements. This practice allows providers to claim payment for hours they did not provide in the current year and intend to make up the following year. This practice resulted in unallowable payments made to providers for services they did not provide.

We consider these internal control deficiencies to constitute a material weakness in internal controls over compliance.

### **Cause of Condition**

The Department does not have sufficient policies and procedures for service providers to follow to ensure payroll documentation was adequate. As a result, providers were unclear about what documentation was required to support payment claims.

The Department believes the cost report reconciliation process provides adequate support for provider payments. We concluded this process is inadequate to ensure Medicaid payments were paid only for allowable services.

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

A statistical sampling method was used to randomly select 86 monthly payments, totaling \$767,616, from the population of 46,037 monthly payments totaling nearly \$360 million. We reconciled payments with individual provider timesheets and work schedules and found 52 payments, totaling \$49,194, were not supported by adequate payroll records, such as timesheets.

We are questioning \$24,609, which is the federal portion of the unallowable payments. When we project the results to the entire population of supported living payments, we estimate the Department made \$26,334,417 in unallowable payments to providers. The federal portion of the estimated total questioned cost is \$13,173,381.

In addition, we found four duplicate payments out of 46,037 total supported living payments to providers related to ProviderOne system defects. We expanded testing to identify all overpayments having similar system defects and found 12 additional payments. In total, we identified 16 payments, totaling \$38,152, were improperly issued to supported living providers due to system defects in the ProviderOne payment system. We are questioning \$19,088, which is the federal portion of the unallowable costs.

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

## **Recommendation**

We recommend the Department:

- Compare provider payroll documentation with authorized hours and payment system billings to ensure services provided to individual clients reconcile with amounts claimed.
- Develop sufficient policies and procedures for providers to follow when documenting service hours provided to clients and compiling payroll records.
- Increase the rate and frequency of provider payroll reviews.
- Require providers to submit cost reports annually.
- Work with the federal grantor to determine if the cost report settlement process adequately supports provider payments.
- Seek recovery of funds paid to providers that did not maintain adequate payroll documentation or who were overpaid due to defects in the payment system.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department does not concur with this finding.*

*RCW 71A.12.060 clearly provides the Secretary of the Department of Social and Health Services (Department) the authority to authorize payments for individuals in community residential programs. To date, the Secretary has authorized a system that requires payment for the total annual contracted Instruction and Support Services (ISS) hours to be reconciled to the actual hours provided. The approved system allows for more efficient use of taxpayer resources, by allowing additional staffing for peak demand, and allows for better service and flexibility by allowing providers to move resources to meet the daily changing needs of clients.*

*Using the annual cost report process (Developmental Disabilities Administration Policy 6.04), the Department verifies the ISS hours provided are equal to or exceed the total hours of service the Department has authorized. Through this verification system, if the actual ISS hours reported in the annual cost report are less than the total authorized hours for all clients served by the Supported Living (SL) provider or are not supported by documentation that shows that the reported hours were actually worked, the Department seeks recovery of any overpayment through the cost report settlement process (DDA Policy 6.04 (III)).*

*The system is designed to allow for resource flexibility by the SL provider throughout the year to enable the provider to meet the changing needs of the individual client. The Department requires, over a year's time, that clients within the agency receive all authorized ISS hours. Providers are given a calendar year to maintain the flexibility needed to address client instruction and support needs. Any*



*audit finding that considers a limited time frame does not accurately capture the entire delivery of service, or any corresponding annual underpayment or overpayment.*

*SL providers are required to complete an annual cost report. The cost report reconciles hours and ISS dollars authorized to hours and ISS dollars provided. 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 (delivery of hours or expenditure of dollars).*

*We believe the audit has erred in treating cost settlements in the same way as overpayments. Overpayments are the result of human or systemic errors or omissions in specific instances whereas cost settlements are based on reimbursement methodologies defined in policy, rule and contract. Cost settlements are typically done in the aggregate on an annual basis and not on a client by client or case by case basis. See 42 CFR, Section 413 –Principles of Reasonable Cost Reimbursement.*

*The Department has additional measures in place to further review or audit the provider cost reporting:*

- *The Department's Enterprise Risk Management Office (ERMO) will periodically audit selected providers.*
- *The Department's Aging and Long-Term Support Administration, Residential Care Services (RCS) performs a cursory review of hours provided as part of the certification evaluation process.*
- *If concerns are identified in the RCS certification evaluation, the Department will conduct an additional review of the SL provider.*

*The audit recommends the Department continues to improve internal controls to ensure SL providers maintain adequate documentation to support payments claimed against payroll records. Current Department policy requires additional schedules to report ISS hours in a format reconcilable to payroll records.*

*Currently, reviews are being conducted on roughly 20% of residential provider's ISS hours. The scope of this compliance review includes reconciliation of hours in the contract by households compared to employee payroll records delivered within the household. Consultation and training to service providers related to the tracking and documentation of ISS hours is provided at the time of the review.*

*Through policy revision, the Department has clarified the expectations that the service provider's payroll system must adequately document ISS hours delivered. Additionally, Department policy outlines acceptable margins of flexibility of ISS hours delivered. Training on these new policies occurred over the summer and fall of 2015.*

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

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

We acknowledge the complexity of providing services to supported living clients and the changing needs of each client. However, neither the Department's reviews of annual cost reports or its additional measures reconciled provider payments to source documentation. Without this level of review, the Department was unable to demonstrate it met the federal requirement under OMB Circular A-87 that states in order for costs to be allowable, they must be adequately documented.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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

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

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

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

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

Revised Code of Washington (RCW) 71A.12.060, Payment authorized for residents in community residential programs states:

The secretary is authorized to pay for all or a portion of the costs of care, support and training of residents of a residential habilitation center who are placed in community residential programs under this section and RCW 71A.12.070 and 71A.12.080.

The Department's *Division of Developmental Disabilities' Community Residential Service Contract, Section 11* states in part:

Maintenance of Records. The Contractor shall maintain records relating to this Contract and the performance of the services described herein. The records include, but are not limited to, accounting procedures and practices, which sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Contract. All records and other materials relevant to this Contract shall be retained for six (6) years after expiration or termination of this contract.

**2015-050** The Department of Social and Health Services, Developmental Disabilities Administration, made overpayments to Medicaid supported living providers who did not ensure staff, with access to developmentally disabled clients, received a proper background check.

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid, Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Allowable Costs/Cost Principles, Special Tests and Provisions - Provider Eligibility
<b>Questioned Cost Amount:</b>	\$52,592

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

Almost \$3.8 billion of total Medicaid funds were spent by the Department of Social and Health Services. The Department paid more than \$360 million to supported living services providers for the care of more than 3,900 clients in fiscal year 2015.

The Department's Developmental Disabilities Administration (DDA) administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service of this program and is offered through staff of contracted supported living providers. Staff assist clients in activities of daily living and assist with the social and adaptive skills necessary to live in the community. DDA clients receiving supported living services reside in private residences. Client support varies from a few hours of staff assistance each month to as much as 24 hours a day.

The Department contracts with private agencies to provide supported living services to supported living clients. On June 30 2015, there were 116 supported living providers contracted with the Department.

All supported living service providers and their employees who are employed directly or by contract and have unsupervised access to supported living clients must successfully complete a background check through the Department's Background Check Central Unit (BCCU). A state background check is required, at minimum, every three years. If the individual resided outside of Washington within the past three consecutive years, they must also be screened through a national fingerprint-based background check.

State rule specifies a list of crimes that automatically disqualify individuals from having unsupervised access to adults receiving services from the Developmental Disabilities Administration.

The rule state, if an individual is found to have committed a non-disqualifying crime, they are not automatically disqualified. The provider must perform a Character, Competence and Suitability review to assess and determine if the individual may have unsupervised access to clients.

In prior audits we reported the Department did not ensure all staff at provider agencies with unsupervised access to clients with developmental disabilities had completed a proper background check before providing care to clients. The prior finding numbers were 2014-044, and 13-34.

### **Description of Condition**

In fiscal year 2015, 3,944 supported living clients received Medicaid services. We randomly selected 86 clients and identified 1,066 supported living staff assisted these clients.

We performed tests to determine if all staff who had unsupervised access to supported living clients completed background checks and to ensure the following eligibility requirements were met:

- A proper BCCU background check had been completed within the last three years.
- No individuals with disqualifying crimes provided support to clients at the time of the audit, or during the month(s) they worked.
- Staff with criminal records that were not automatically disqualified received a Character, Competency and Suitability (CCS) review permitting them to work unsupervised with supported living clients.
- The entire period when an individual had access to Medicaid clients was covered by a completed background check.
- Individuals who have not lived in Washington State for at least three consecutive years also completed a fingerprint-based background check as required by state law.

We found:

- One individual worked without having a background check.
- One individual worked with disqualifying background check results.
- Two individuals provided care to clients without a background check during part of the audit period.

Disqualified individuals are permitted to work with clients if they pass a Character, Competence, and Suitability (CCS) review conducted by the provider. We found one individual with a disqualifying background check had worked with supported living clients. The employee was hired by a supported living contractor prior to being charged with the disqualifying crime. The provider had no knowledge that a disqualifying crime occurred until the employee resigned voluntarily. The individual is no longer working for any supported living provider.

### **Cause of Condition**

During the audit period, we found the Department had internal controls in place and performed extensive provider training to ensure all supported living providers are aware of all program eligibility requirements. Since April 2014, the Department's contracted evaluators have begun performing on-site review of background check results for 100 percent of current employees for the providers they are evaluating. In addition, the Department increased random background check testing of supported living providers, which are carried out by the Department's Internal Audit Division.

However, the Department's monitoring of providers remains limited and infrequent due to lack of available resources.

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

Any caregiver, or person who has direct, unsupervised contact with a client who does not meet the background check requirements is not eligible to provide services to Medicaid clients. When individuals who do not meet background check requirements have unsupervised access to vulnerable Medicaid clients, there is an increased risk of neglect, harm, exploitation and abuse.

The Department pays supported living contractors, who in turn pay their employees for services provided to Medicaid clients. We followed up with the Department and reviewed payroll documentation for the four individuals.

The following table summarizes \$105,120 in unallowable payments we identified in the audit by condition:

<b>Condition</b>	<b>Number of Individuals</b>	<b>Unallowable Payments</b>
Individuals working with disqualified background check results.	1	\$25,897
Individuals serving the client without a background check during part of the audit period.	2	\$69,853
Individuals with no background check completed	1	\$9,370
<b>Total individuals ineligible to provide services.</b>	<b>4</b>	<b>\$105,120</b>

We are questioning \$52,592, which is the federal portion of the unallowable payments. The federal share is calculated using the state’s Federal Medical Assistance Percentages (FMAP) rate.

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

**Recommendation**

We recommend the Department:

- Follow-up on background check results of supported living staff to ensure ineligible individuals do not have unsupervised access to vulnerable Medicaid clients.
- Ensure that all individuals’ background checks are renewed in a timely manner.
- Consult with the U.S. Department of Health and Human Services to discuss if repayment of the questioned costs is required.

**Department’s Response**

*The Department partially concurs with this finding.*

*The one staff with a disqualifying result worked for two supported living agencies. Both agencies ran an initial background check, both checks allowed the individual to work. During a renewal background check, one of the two agencies received a disqualifying result. That agency terminated the employee appropriately. The second agency was not required to run a renewal background check on the employee for several months. As the employee did not self-report, the second agency was not aware that he had a new disqualifying crime since his initial background check with their agency. The employee resigned prior to the required renewal background check. Both agencies were in compliance with the law, rules, policies, and contractual requirements.*



*The Department has demonstrated substantial improvement in background check compliance. This has been achieved through:*

- *Updating the Background Authorization policy and providing training to residential contracted providers and Department employees.*
- *Training for providers occurs regularly within each region and will continue into the next year.*
- *Continual monthly reviews conducted by the Enterprise Risk Management Office (ERMO) to ensure agencies are in compliance with background check laws, rules, and policies.*

*The Department will continue to take the following measures to ensure this positive trend:*

- *Provide ongoing training to Department employees and to the provider group.*
- *Dedicate a Department headquarters position available to provide direct support and consultation to providers on interpretation of result letters.*
- *Monitor for background check compliance through reviews conducted by ERMO and Residential Care Services (RCS) certification reviews.*
- *Continue to partner with the Background Check Central Unit.*

*The Department will continue its efforts to inform, educate, and train providers related to background check policy, rules, and WAC.*

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

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

We agree that the Department ensured the employers of the individual in question followed the required background check procedure. However, the cost of services provided by disqualified individuals are not allowable, regardless of their employer's knowledge. This ultimately led our Office to question the costs.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

Section 510, states in part:

- (g) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

RCW 74.15.030, Powers and duties of secretary, states in part:

The secretary shall have the power and it shall be the secretary's duty:

- (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:

- (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](#);
- (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;

- (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.
- (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;
- (7) To inspect agencies periodically to determine whether or not there is compliance with chapter 74.15 RCW and RCW 74.13.031 and the requirements adopted hereunder;
- (8) To review requirements adopted hereunder at least every two years and to adopt appropriate changes after consultation with affected groups for child day-care requirements and with the children's services advisory committee for requirements for other agencies; and,
- (9) To consult with public and private agencies in order to help them improve their methods and facilities for the care of children, expectant mothers and developmentally disabled persons.

RCW 43.43.830, Background checks – Access to children or vulnerable persons – definitions, states in part:

- (13) “Unsupervised” means not in the presence of:
  - (a) Another employee or volunteer from the same business or organization as the applicant; or
  - (b) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the applicant has access during the course of his or her employment or involvement with the business or organization.
- (14) “Vulnerable adult” means "vulnerable adult" as defined in chapter 74.34 RCW, except that for the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.

WAC 388-101-3000 Definitions, states in part:

**"Client"** means a person who has a developmental disability as defined in RCW [71A.10.020](#)(4) and who also has been determined eligible to receive services by the division of developmental disabilities under chapter [71A.16](#) RCW. For purposes of informed consent and decision making requirements, the term "client" includes the client's legal representative to the extent of the representative's legal authority.

WAC 388-101-3245 Background check – General, states:

- (1) The department is authorized to conduct background checks under the background check requirements of this chapter and of chapter [388-113](#) WAC. Background checks include but are not limited to an inquiry into any of the following:

- (a) Department and department of health findings;
  - (b) Administrative actions taken by the department or by other agencies;
  - (c) Washington state criminal background check information from the Washington state patrol;
  - (d) National fingerprint-based background check information from the Federal Bureau of Investigation, when required; and
  - (e) Information from Washington state courts.
- (2) Nothing in this chapter should be interpreted as requiring the employment of a person against the better judgment of the service provider. In addition to chapter [71A.12 RCW](#), these rules are authorized by RCW [43.20A.710](#), RCW [43.43.830](#) through [43.43.842](#) and RCW [74.39A.056](#).

WAC 388-101-3250, Background checks – Requirements for service providers, states:

- (1) Service providers must follow the background check requirements described in chapter 388-133 WAC and in this chapter. In the event of an inconsistency, this chapter applies.
- (2) The service provider must obtain background checks from the department for all administrators, employees, volunteers, students, and subcontractors who may have unsupervised access to clients.
- (3) The service provider must not allow the following persons to have unsupervised access to clients until the service provider receives the department's background check results:
  - (a) Administrators;
  - (b) Employees;
  - (c) Volunteers or students; and
  - (d) Subcontractors.
- (4) If the department's background check results show an administrator, employee, volunteer, student, or subcontractor has any of the following, then the service provider must prevent that person from having unsupervised access to clients:
  - (a) A disqualifying conviction or pending criminal charge under chapter 388-113 WAC; or
  - (b) A disqualifying negative action under WAC 388-101-3090.
- (5) If the background check results show any of the following, then the service provider must conduct a character, suitability, and competence review before allowing the person unsupervised access to clients:
  - (a) The person has a conviction or pending criminal charge, but the conviction or criminal charge is not disqualifying under WAC [388-113-0020](#);
  - (b) The person has a conviction or pending criminal charge that meets one of the exceptions listed in WAC [388-113-0040](#); or
  - (c) Any of the circumstances described in WAC [388-101-3080](#) apply to the individual.
- (6) When a service provider receives the results of a person's background check, the service provider must:
  - (a) Inform the person of the results of the background check;
  - (b) Inform the person that they may request a copy in writing of the results of the background check. If requested, a copy of the background check results must be provided within ten working days of the request; and
  - (c) Notify the department and other appropriate licensing or certification agency of any person resigning or terminated as a result of having a conviction record.

- (7) The service provider must renew the Washington state background check for each administrator, employee, volunteer, student, or subcontractor of a service provider. The service provider must at least every thirty-six months keep current background check results for each administrator, employee, volunteer, student, or subcontractor of a service provider.
- (8) Licensed assisted living facilities or adult family homes must adhere to the current regulations in this chapter and in the applicable licensing laws.
- (9) All applicants for certification must have a background check.

WAC 388-101-3255 Background checks—Provisional hire—Pending results.

Persons identified in WAC 388-101-3250 and who have lived in Washington state less than three years, or who are otherwise required to complete a fingerprint-based background check, may be hired for a one hundred twenty-day provisional period when:

- (1) The person is not disqualified based on the initial results of the background check from the department; and
- (2) A national fingerprint-based background check is pending.

WAC 388-113-0020 Which criminal convictions and pending charges automatically disqualify an individual from having unsupervised access to adults or minors who are receiving services in a program under chapters 388-71, 388-101, 388-76, 388-78A, 388-97, 388-825, and 388-107 WAC?

- (1) Individuals who must satisfy background checks requirements under chapters 388-71, 388-101, 388-76, 388-78A, 388-97, 388-825, and 388-107 WAC may not work in a position that may involve unsupervised access to minors or vulnerable adults if he or she has been convicted of or has a pending charge for one of the following crimes:
  - (a) Abandonment of a child;
  - (b) Abandonment of a dependent person;
  - (c) Abuse or neglect of a child;
  - (d) Arson 1;
  - (e) Assault 1;
  - (f) Assault 2;
  - (g) Assault 3;
  - (h) Assault 4/simple assault (less than three years);
  - (i) Assault of a child;
  - (j) Burglary 1;
  - (k) Child buying or selling;
  - (l) Child molestation;
  - (m) Coercion (less than five years);
  - (n) Commercial sexual abuse of a minor/patronizing a juvenile prostitute;
  - (o) Communication with a minor for immoral purposes;
  - (p) Controlled substance homicide;
  - (q) Criminal mistreatment;
  - (r) Custodial assault;
  - (s) Custodial interference;
  - (t) Custodial sexual misconduct;
  - (u) Dealing in depictions of minor engaged in sexual explicit conduct;

- (v) Domestic violence (felonies only);
- (w) Drive-by shooting;
- (x) Drug crimes, if they involve one or more of the following:
  - (i) Manufacture of a drug;
  - (ii) Delivery of a drug; and
  - (iii) Possession of a drug with the intent to manufacture or deliver.
- (y) Endangerment with a controlled substance;
- (z) Extortion;
- (aa) Forgery (less than five years);
- (bb) Homicide by abuse, watercraft, vehicular homicide (negligent homicide);
- (cc) Identity theft (less than five years);
- (dd) Incendiary devices (possess, manufacture, dispose);
- (ee) Incest;
- (ff) Indecent exposure/public indecency (felony);
- (gg) Indecent liberties;
- (hh) Kidnapping;
- (vi) Luring;
- (jj) Malicious explosion 1;
- (kk) Malicious explosion 2;
- (ll) Malicious harassment;
- (mm) Malicious placement of an explosive 1;
- (nn) Malicious placement of an explosive 2 (less than five years);
- (oo) Malicious placement of imitation device 1 (less than five years);
- (pp) Manslaughter;
- (qq) Murder/aggravated murder;
- (rr) Possess depictions minor engaged in sexual conduct;
- (ss) Promoting pornography;
- (tt) Promoting prostitution 1;
- (uu) Promoting suicide attempt (less than five years);
- (vv) Prostitution (less than three years);
- (ww) Rape;
- (xx) Rape of child;
- (yy) Residential burglary;
- (zz) Robbery;
- (aaa) Selling or distributing erotic material to a minor;
- (bbb) Sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;
- (ccc) Sexual exploitation of minors;
- (ddd) Sexual misconduct with a minor;
- (eee) Sexually violating human remains;
- (fff) Stalking (less than five years);
- (ggg) Theft 1;
- (hhh) Theft 2 (less than five years);
- (vii) Theft 3 (less than three years);
- (jjj) Unlawful imprisonment
- (kkk) Unlawful use of building for drug purposes (less than 5 years);

- (lll) Use of machine gun in a felony;
  - (mmm) Vehicular assault;
  - (nnn) Violation of temporary restraining order or preliminary injunction involving sexual or physical abuse to a child;
  - (ooo) Violation of a temporary or permanent vulnerable adult protection order (VAPO) that was based upon abandonment, abuse, financial exploitation, or neglect; and
  - (ppp) Voyeurism.
- (2) If "(less than five years)" or "(less than three years)" appears after a crime listed in subsection (1) above, the individual is not automatically disqualified if the required number of years has passed since the date of the conviction. For example, if three or more years have passed since an individual was convicted of Theft in the 3rd degree that conviction would not be automatically disqualifying. If the required number of years has passed, the employer must conduct an overall assessment of the person's character, competence, and suitability before allowing unsupervised access to vulnerable adults and minors.
- (3) When the department determines that a conviction or pending charge in federal court or in any other court, including state court is equivalent to a Washington state crime that is disqualifying under this section, the equivalent conviction or pending charge is also disqualifying.

**2015-051 The Department of Social and Health Services, Aging and Long-Term Support Administration, did not adequately monitor Adult Family Home providers to ensure Medicaid providers and their employees had proper background checks.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed, Allowable Costs/Cost Principles, Special Tests and Provisions – Provider Eligibility
<b>Known Questioned Cost Amount:</b>	\$153,536
<b>Likely Questioned Cost Amount:</b>	\$2,632,334

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

Almost \$3.8 billion of total Medicaid funds were spent by the Department of Social and Health Services. The Department paid approximately \$138 million to 2,400 Adult Family Home providers.

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 basic qualifications to provide services to Medicaid clients, which include background checks, certifications and training. Adult Family Home providers and their employees



must complete a state background check every two years and, effective January 8, 2012, a national fingerprint background check through the Department's Background Check Central Unit.

The Department's Aging and Long-Term Support Administration, Residential Care Services division is responsible for ensuring all adult family homes and their providers meet and maintain minimum licensing requirements to serve Medicaid clients. The Department performs an inspection of all adult family homes at least every 18 months to ensure the adult family home provider is in compliance with all requirements to remain eligible to provide Medicaid services to clients. During the inspection, Department staff review background check result letters for the provider, resident manager and all adult family home employees to ensure they are eligible to work and have completed the required background check every two years.

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 in regulation, WAC 388-113. Individuals that 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. The provider must perform a Character, Competence and Suitability review to assess and determine if the individual may have unsupervised access to clients.

In prior audits we reported the Department did not ensure providers completed background checks before providing services to Medicaid clients. We also found providers did not ensure staff met all background check requirements before providing care to vulnerable adult clients. The prior finding numbers were 2014-048, and 13-37.

### **Description of Condition**

#### *Adult Family Home providers:*

During fiscal year 2015, approximately 16 percent of all Medicaid payments made by the Department under the Home and Community Based Services Program were made to adult family home providers. We randomly selected 140 Adult Family Homes authorized to accept Medicaid clients from a total population of 2,400 to ensure that:

- A proper background check had been completed by the provider within the last 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) in which the provider received payment from the Department.

- Staff with criminal records that were not listed in state rule of Automatically Disqualifying Convictions and Pending Charges passed a Character, Competence and Suitability (CCS) review permitting them to work unsupervised with vulnerable adults.
- The entire period in which the provider had access to Medicaid clients was covered by a Washington State background check.

The Department did not have adequate internal controls in place to ensure providers renew background checks in a timely manner. We found 20 (14 percent) of the 140 providers we randomly selected did not renew their background checks timely and therefore received unallowable Medicaid payments. The following table shows the range of months the providers were paid for services without a background check:

<b>Number of months clients received services paid by Medicaid by a provider without a background check</b>	<b>Number of Providers</b>
1-2 Months	12
3-6 Months	4
7-8 Months	4
<b>Total</b>	<b>20</b>

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

*Adult Family Home employees:*

Using wage information reported by employers, we identified 564 employees working for the 140 adult family home providers in fiscal year 2015. In addition, a social security number and date-of-birth match was performed with the Department’s background check database to determine if background checks were completed for each employee.

We found:

- Fourteen individuals with overdue background checks continued to work during the audit period without completing a renewal.
- Fifteen instances when there was no evidence a Character, Competence and Suitability (CCS) review was completed for provider employees.  
One employee with an automatically disqualifying criminal history worked for a facility during the audit period. That facility has since closed. Therefore, the individual is no longer providing care to AFH clients; however, the provider did not present evidence of termination for this individual or if they worked supervised with residents.

We were not able to determine if records for 16 adult family home employees selected for testing included proper background checks because their employers did not respond to our request for information.

### **Cause of Condition**

The Department has procedures in place to ensure adult family homes meet minimum licensing requirements. However, there is a high rate of employee turnover in adult family homes, which increases the risk of provider noncompliance with state and federal background check requirements.

Residential Care Services licensors examine the records of 100 percent of adult family home staff for background checks during their on-site visits. Due to the Department's regulatory scope and allotted resources, unless there is a complaint, up to 18 months may pass before an adult family home receives another inspection from the Department, which could allow a significant period of time for an individual to work without a background check before being terminated by their provider. This measure is only effective in detecting individuals who are *currently* working without a background check at the time of inspection.

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

When providers who do not meet background check requirements have unsupervised access to vulnerable Medicaid clients, there is 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.

The Department paid a total of \$306,921 to the 20 providers we found did not complete a required background check timely. We are questioning the federal portion of these payments of \$153,536, calculated using the state's Federal Medical Assistance Percentage (FMAP) rate.

A statistical sampling method was used to randomly select the providers examined in the audit. When the results are projected to the entire population of 2,400 Adult Family Home providers, we estimate the amount of unallowable payments to be \$5,261,511.

We are questioning \$2,632,334 as likely questioned costs, which would be the federal share of the estimated unallowable payments calculated using the same FMAP rate.

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

## **Recommendation**

We recommend the Department:

- Improve internal controls to ensure adult family home providers complete background checks in a timely manner.
- Strengthen its monitoring of adult family home providers to ensure they perform adequate background checks for all caregivers, representatives and resident managers who are employed directly or by contract.
- Follow-up on background check results for those who did not have a Character, Competence and Suitability review and ensure disqualified caregivers do not have unsupervised access to vulnerable Medicaid adults.
- Consult with the U.S. Department of Health and Human Services to determine if repayment of the questioned costs is required.

## **Department's Response**

*The Department partially agrees with this finding.*

*It is the Adult Family Home (AFH) provider's responsibility to ensure background checks are being submitted timely. In addition, AFH home licensing regulations only require the provider to keep the background check for two years after the date an employee either quits or is terminated. This further complicates the Department's ability to verify if the background checks are valid.*

*Due to the Department's allotted resources and lack of access to employment/payroll records of AFH staff, we feel our current Management Bulletin #R14-009 from April 2014, which requires licensors to examine all employee background checks while conducting their on-site visits, is meeting our regulatory obligation. Since November 2015, the Department has required licensors conducting their on-site visits to check the background checks of anyone who worked in the AFH home since the previous inspection, even if they no longer work in the home. We believe this further strengthens our monitoring of AFH providers and staff.*

*Not all action steps from corrective action plan for audit 2014-048 were completed before the auditor's sample was pulled for this review. Therefore, we believe the results from this audit period may not reflect the effectiveness of all actions from the previous corrective action plan.*

*Thank you for the opportunity to improve our processes for AFH provider background checks. Residential Care Services takes their regulatory role seriously and we are committed to the safety of our residents.*

## **Auditor's Concluding Remarks**

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

We acknowledge the corrective measures taken by the Department to date, and agree that the results of these measures will take time to become effective.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines, state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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

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

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

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

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

RCW 74.39A.056, Criminal history checks on long-term care workers, states:

(1) (a) All long-term care workers shall be screened through state and federal background checks in a uniform and timely manner to verify that they do not have a criminal history that would disqualify them from working with vulnerable persons. The department must perform criminal background checks for individual providers and prospective individual providers and make the information available as provided by law.

- (b) (i) Except as provided in (b)(ii) of this subsection, for long-term care workers hired after January 7, 2012, the background checks required under this section shall include checking against the federal bureau of investigation fingerprint identification records system and against the national sex offenders registry or their successor programs. The department shall require these long-term care workers to submit fingerprints for the purpose of investigating conviction records through both the Washington state patrol and the federal bureau of investigation. The department shall not pass on the cost of these criminal background checks to the workers or their employers.
- (ii) This subsection does not apply to long-term care workers employed by community residential service businesses until January 1, 2016.
- (c) The department shall share state and federal background check results with the department of health in accordance with RCW 18.88B.080.
- (2) No provider, or its staff, or long-term care worker, or prospective provider or long-term care worker, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority or a court of law or entered into a state registry with a final substantiated finding of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.
- (3) The department shall establish, by rule, a state registry which contains identifying information about long-term care workers identified under this chapter who have final substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing requirements. The department shall disclose, upon request, final substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information. This information must also be shared with the department of health to advance the purposes of chapter 18.88B RCW.
- (4) The department shall adopt rules to implement this section.

WAC 388-76-10015, License-Adult family home-compliance required, states:

- (1) The licensed adult family home must comply with all the requirements established in chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and
- (2) The provider is ultimately responsible for the day-to-day operation of each licensed home.
- (3) The provider must promote the health, safety, and well-being of each resident residing in each licensed adult family home.

WAC 388-76-10161, Background checks -- Who is required to have.

- (1) An adult family home applicant and anyone affiliated with an applicant must have the following background checks before licensure:
  - (a) A Washington state name and date of birth background check; and
  - (b) If applying after January 7, 2012, a national fingerprint background check.
- (2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:
  - (a) A Washington state name and date of birth background check; and
  - (b) A national fingerprint background check.
- (3) All household members over the age of eleven, volunteers, students, and noncaregiving staff who may have unsupervised access to residents must have a Washington state name and date of birth background check. They are not required to have a national fingerprint background check

WAC 388-76-10165 Background checks – Washington State name and date of birth background check – Valid for two years – National fingerprint background check – Valid indefinitely, states:

- (1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:
  - (a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161;
  - (b) There is a valid Washington state background check for all individuals listed in WAC 388-76-10161.
- (2) A national fingerprint background check is valid for an indefinite period of time. The adult family home must ensure there is a valid national fingerprint background check for individuals hired after January 7, 2012 as caregivers, entity representatives or resident managers. To be considered valid, the individual must have completed the national fingerprint background check through the background check central unit after January 7, 2012.

WAC 388-76-10166 Background checks – Household members, noncaregiving and unpaid staff – Unsupervised access.

- (1) The adult family home must not allow individuals specified in WAC [388-76-10161\(3\)](#) to have unsupervised access to residents until the home receives results of the Washington state name and date of birth background check from the department.
- (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.

WAC 388-76-10175 Background checks – Employment – Conditional hire – Pending results of Washington state name and date of birth background check, states:

An adult family home may conditionally employ a person directly or by contract, pending the result of a 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.

WAC 388-76-10176 Background checks – Employment – Provisional hire – Pending results of national fingerprint check.

The adult family home may provisionally employ individuals hired after January 7, 2012 and listed in WAC 388-76-10161(2) for one hundred twenty-days and allow those individuals to have unsupervised access to residents when:

- (1) The individual is not disqualified based on the results of the Washington state name and date of birth background check; and
- (2) The results of the national fingerprint background check are pending.

WAC 388-76-10180 Background checks – Employment – Disqualifying information. [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.

WAC 388-76-10181 Background checks – Employment – Nondisqualifying information.

- (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.

WAC 388-113-0020 Which criminal convictions and pending charges automatically disqualify an individual from having unsupervised access to adults or minors who are receiving services in a program under chapters 388-71, 388-101, 388-76, 388-78A, 388-97, 388-825, and 388-107 WAC?

- (1) Individuals who must satisfy background checks requirements under chapters 388-71, 388-101, 388-76, 388-78A, 388-97, 388-825, and 388-107 WAC may not work in a position that may involve unsupervised access to minors or vulnerable adults if he or she has been convicted of or has a pending charge for one of the following crimes:
  - (a) Abandonment of a child;

- (b) Abandonment of a dependent person;
- (c) Abuse or neglect of a child;
- (d) Arson 1;
- (e) Assault 1;
- (f) Assault 2;
- (g) Assault 3;
- (h) Assault 4/simple assault (less than three years);
- (i) Assault of a child;
- (j) Burglary 1;
- (k) Child buying or selling;
- (l) Child molestation;
- (m) Coercion (less than five years);
- (n) Commercial sexual abuse of a minor/patronizing a juvenile prostitute;
- (o) Communication with a minor for immoral purposes;
- (p) Controlled substance homicide;
- (q) Criminal mistreatment;
- (r) Custodial assault;
- (s) Custodial interference;
- (t) Custodial sexual misconduct;
- (u) Dealing in depictions of minor engaged in sexual explicit conduct;
- (v) Domestic violence (felonies only);
- (w) Drive-by shooting;
- (x) Drug crimes, if they involve one or more of the following:
  - (i) Manufacture of a drug;
  - (ii) Delivery of a drug; and
  - (iii) Possession of a drug with the intent to manufacture or deliver.
- (y) Endangerment with a controlled substance;
- (z) Extortion;
- (aa) Forgery (less than five years);
- (bb) Homicide by abuse, watercraft, vehicular homicide (negligent homicide);
- (cc) Identity theft (less than five years);
- (dd) Incendiary devices (possess, manufacture, dispose);
- (ee) Incest;
- (ff) Indecent exposure/public indecency (felony);
- (gg) Indecent liberties;
- (hh) Kidnapping;
- (ii) Luring;
- (jj) Malicious explosion 1;
- (kk) Malicious explosion 2;
- (ll) Malicious harassment;
- (mm) Malicious placement of an explosive 1;
- (nn) Malicious placement of an explosive 2 (less than five years);
- (oo) Malicious placement of imitation device 1 (less than five years);
- (pp) Manslaughter;
- (qq) Murder/aggravated murder;
- (rr) Possess depictions minor engaged in sexual conduct;

- (ss) Promoting pornography;
  - (tt) Promoting prostitution 1;
  - (uu) Promoting suicide attempt (less than five years);
  - (vv) Prostitution (less than three years);
  - (ww) Rape;
  - (xx) Rape of child;
  - (yy) Residential burglary;
  - (zz) Robbery;
  - (aaa) Selling or distributing erotic material to a minor;
  - (bbb) Sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;
  - (ccc) Sexual exploitation of minors;
  - (ddd) Sexual misconduct with a minor;
  - (eee) Sexually violating human remains;
  - (fff) Stalking (less than five years);
  - (ggg) Theft 1;
  - (hhh) Theft 2 (less than five years);
  - (iii) Theft 3 (less than three years);
  - (jjj) Unlawful imprisonment
  - (kkk) Unlawful use of building for drug purposes (less than 5 years);
  - (lll) Use of machine gun in a felony;
  - (mmm) Vehicular assault;
  - (nnn) Violation of temporary restraining order or preliminary injunction involving sexual or physical abuse to a child;
  - (ooo) Violation of a temporary or permanent vulnerable adult protection order (VAPO) that was based upon abandonment, abuse, financial exploitation, or neglect; and
  - (ppp) Voyeurism.
- (2) If "(less than five years)" or "(less than three years)" appears after a crime listed in subsection (1) above, the individual is not automatically disqualified if the required number of years has passed since the date of the conviction. For example, if three or more years have passed since an individual was convicted of Theft in the 3rd degree that conviction would not be automatically disqualifying. If the required number of years has passed, the employer must conduct an overall assessment of the person's character, competence, and suitability before allowing unsupervised access to vulnerable adults and minors.
- (3) When the department determines that a conviction or pending charge in federal court or in any other court, including state court is equivalent to a Washington state crime that is disqualifying under this section, the equivalent conviction or pending charge is also disqualifying.

**2015-052 The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls to ensure Medicaid payments to supported living service providers for cost of care adjustments were allowable.**

<b>Federal Awarding Agency:</b>	U.S. Department of Health and Human Services
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	93.775 State Medicaid Fraud Controls 93.777 State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare 93.778 Medical Assistance Program (Medicaid; Title XIX) 93.778A Medical Assistance Program (Medicaid; Title XIX) – American Recovery and Reinvestment Act (ARRA)
<b>Federal Award Number:</b>	5-1505WA5MAP; 5-1505WA5ADM; 5-1505WAIMPL; 5-1505WAINCT
<b>Applicable Compliance Component:</b>	Activities Allowed/Unallowed Allowable Costs/Cost Principles
<b>Questioned Cost Amount:</b>	\$20,629
<b>Likely Questioned Cost Amount:</b>	\$285,442

## **Background**

Medicaid is a jointly funded state and federal partnership providing coverage for approximately 1.8 million eligible low-income individuals who otherwise might go without medical care. Medicaid is the state's largest program and accounts for approximately one third of the state's federal expenditures. The state Medicaid program spent approximately \$11.3 billion in federal and state funds during fiscal year 2015.

The Department's Developmental Disabilities Administration administers the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service of this program and is delivered by staff of contracted supported living providers. Contractor employees assist clients in activities of daily living and with the social and adaptive skills necessary to live in the community.

The Department uses an assessment to evaluate a client's support needs. The results of the assessment are used to calculate the number of support hours a client needs to live in the community. The assessment predicts a level of care as if the client lives alone but most live with other clients. Since many support hours can be shared with roommates, the Department looks for shared hour opportunities to help providers care for clients in a cost effective manner.

When a client is temporarily out of the home, a provider can request a cost of care adjustment to cover the administrative and staff support costs necessary to maintain the residence and the client's affairs. If a client permanently leaves the household, providers can request a cost of care adjustment to maintain the household's shared supports until a new housemate can be found.

In fiscal year 2015, the Department paid supported living providers nearly \$1.5 million for approximately 1,000 care adjustments.

Providers complete a cost of care adjustment request form (DSHS 06-124) and are required to include a justification that substantiates the need for the payment. Depending on the type of rate claimed, providers submit varying levels of justification to document and support the need for additional funds. Providers submit the form to a Department resource manager who reviews the form for accuracy and completeness and forwards the form to their supervisor for final approval and payment authorization. To be allowable, claims for payment must be submitted within one year of the service.

In prior audits, we found the Department did not have adequate internal controls to ensure cost of care adjustments were allowable. The prior finding numbers were 2014-041 and 2013-038.

### **Description of Condition**

The Department's review process was not effective to ensure cost of care adjustment requests contained the required elements to be allowable.

We randomly selected and examined 64 payments for cost of care adjustment, totaling \$183,596, and found:

- Documentation for eleven payments, totaling \$27,598, did not contain sufficient justification to support the payment.
- Two claims, totaling \$6,885, were processed more than one year after the date of service.
- One payment, totaling \$8, was made for more than the authorized amount.
- One payment, totaling \$2,695, was inaccurately calculated, which led to an overpayment.

Additionally, the Department's record keeping practices were not adequate to ensure cost of care adjustment forms were retained. We found three payments, totaling \$4,059, were made without an authorized cost of care adjustment form on file.

We consider these internal control weaknesses to constitute a material weakness in internal controls over compliance.

## **Cause of Condition**

Some providers were not knowledgeable about the required justification necessary to support their request for a cost of care adjustment. Some Department staff were not aware of policies and guidelines when reviewing and approving allowable cost of care adjustment requests and approving payments. Calculations and entries into the payment system were not reviewed for accuracy.

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

A statistical sampling method was used to randomly select the 64 cost of care adjustment payments, totaling \$183,596, we examined from a population of 984 monthly payments totaling nearly \$1.5 million. We found 18 payments totaling \$41,245 were not supported by adequate documentation.

We are questioning \$20,629, which is the federal portion of the unallowable payments. When we project the results to the entire population of cost of care payments, we estimate the Department paid \$570,668 for unallowable payments to providers. The federal portion of the estimated total questioned cost is \$285,442.

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

## **Recommendation**

We recommend the Department:

- Provide training to providers and Department staff regarding policies, procedures, and required documentation to support allowable payments for cost of care adjustments.
- Ensure Department supervisors follow policies and procedures to ensure cost of care adjustments are adequately supported and completed in compliance with Department policies.
- Consult with the U.S. Department of Health and Human Services to discuss repayment of the questioned costs.

## **Department's Response**

*The Department does not concur with this finding.*

*The Department disagrees with the comment in the first bullet of the Description of Condition, "...did not contain sufficient justification to support the payment."*

*Most of the sampled forms for Cost of Care Adjustments (COCA) contained justification per Department policy requirements. The Resource Managers who reviewed the services made recommendations and the Resource Administrators who approved the services, based their decisions on the justifications that were provided on the forms.*

*The Department strongly takes issue with the following statements in the audit:*

- *“Some providers were not knowledgeable about the required justification necessary to support their request for a cost of care adjustment.”*
- *“Some Department staff were not aware of policies and guidelines when reviewing and approving allowable cost of care adjustment requests and approving payments.”*
- *“Calculations and entries into the payment system were not reviewed for accuracy.”*

*The Department has provided in-depth training for both staff and providers after policy and the required forms were updated.*

*The Department agrees with the remaining four payments that two were paid more than a year after the date of service, one was overpaid by \$8 and that one was inaccurately calculated.*

*The Department will continue to monitor for accuracy and compliance with the requirements.*

### **Auditor’s Concluding Remarks**

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

The Department’s guidelines for Cost of Care Adjustments states in part, “The service provider will include detailed justification for the requested hours...” In our judgment, the exceptions contested by the Department did not contain detailed justification from providers. OMB Circular A-87 states that to be allowable under federal awards, costs must be adequately documented.

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

#### Section 510, states in part:

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



- ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

OMB Circular A-87, 2 CFR § 225: Cost Principles for State, Local and Indian Tribal Governments; Attachment A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - b. Be allocable to Federal awards under the provisions of 2 CFR part 225, Appendix A.
  - c. Be authorized or not prohibited under State or local laws or regulations.
  - d. Conform to any limitations or exclusions set forth in these principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.
  - e. Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit.

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

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

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

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

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

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

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

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

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

Revised Code of Washington (RCW) 71A.12.060, Payment authorized for residents in community residential programs states:

The secretary is authorized to pay for all or a portion of the costs of care, support and training of residents of a residential habilitation center who are placed in community residential programs under this section and RCW 71A.12.070 and 71A.12.080.

Developmental Disabilities Administration Policy 6.02, states in part:

#### Definitions

Cost-of-Care Adjustment means a reimbursement adjustment intended to cover the necessary costs of non-variable staff support and administration to provide services to clients when there is a temporary loss of a client served by the agency.

#### E. Cost of Care Adjustments (COCA)

1. When there is a potential COCA, the division shall consider with the contractor whether a COCA adjustment or rate reassessment for clients sharing the household is most appropriate.
2. Each COCA authorization may be approved for a maximum of three (3) months. COCAs beyond three (3) months may be approved by exception to policy by the Regional Administrator.
3. The COCA must not exceed the total daily rate of the client who temporarily left the program.
4. For adults receiving SL/GH/GTH services:
  - a. The COCA applies to existing or new programs.
  - b. The COCA may not exceed the cost of care per client when the program is operating at full capacity.
  - c. A COCA may be authorized under the following circumstances:
    - i. As part of a resident “phase-in” process when a new program is being developed or an existing program is being expanded; and
    - ii. In an existing program when a client shares support hours with other clients and moves out, either permanently or temporarily, and there is no other

client available to move in immediately or the client's home must be maintained until the client's return.

**2015-053 The Department of Social and Health Services did not have adequate internal controls in place and did not comply with the level of effort requirements for the Block Grants for Prevention and Treatment of Substance Abuse.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.959 Block Grants for Prevention and Treatment of Substance Abuse  
**Federal Award Number:** 2B08TI010056-13; 2B08TI010056-14; 2B08TI010056-15  
**Applicable Compliance Component:** Level of Effort  
**Questioned Cost Amount:** None

### **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent over \$38 million in grant funds during fiscal year 2015.

Federal regulations require the Department to maintain state spending at certain levels in order to meet federal grant requirements. Specifically for the Block Grants for Prevention and Treatment of Substance Abuse, the Department must maintain state spending for:

- Treatment services for pregnant women and women with dependent children at a level that is not less than the amount spent for the same services in 1994.
- Tuberculosis services at a level that is not less than the average calculated in fiscal year 1991 and 1992.
- Authorized activities at a level that is not less than the average of the previous two years spending for the program.

We reported a finding in the fiscal year 2014 audit for the Department not meeting level of effort requirements. This was reported as finding number 2014-051.

### **Description of Condition**

The Department did not have internal controls in place to ensure it complied with the first two requirements listed above. In both cases the Department had no ongoing monitoring and waited until the end of each fiscal year to determine whether they were in compliance.

During the audit period the Department began to track the third requirement listed above, but it was not adequate to prevent material noncompliance. We determined the Department did not meet the state spending requirement for fiscal year 2015.

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

### **Cause of Condition**

The Department did not monitor the first two requirements because it assumed compliance would be met. For the third requirement, which was not met, the appropriation received from the state Legislature was not sufficient to meet the compliance requirement.

### **Effect of Condition**

Without adequate internal controls in place, the Department could not ensure it would meet all level of effort requirements during the audit period. By not adequately monitoring to ensure level of effort requirements are being met, the Department is not in compliance with federal requirements for the Block Grant.

For the requirement to maintain state spending at a level that is not less than the average spending during the previous two years, we determined the Department spent approximately \$16.6 million less than what was required for fiscal year 2015.

### **Recommendation**

We recommend the Department establish policies, procedures and other internal controls sufficient to ensure the monitoring and documentation of level of effort requirements is performed.

The Department should also monitor state-funded spending to ensure it spends at least the minimum required amount each year for the grant. If the Department determines it will not meet one of the requirements, it should contact its federal grantor to determine an appropriate course of action.

### **Agency's Response**

*The Department concurs with this finding.*

*Through technical assistance provided by the Substance Abuse Mental Health Services Administration (SAMHSA), the Department will formalize a procedure to monitor and manage maintenance of efforts for both pregnant women and women with dependent children as well as for tuberculosis services. The procedure will include frequency for monitoring expenditure levels appropriate to meet maintenance of effort requirements; to include, collaboration with state partners, what documentation is necessary, and actions to be implemented if below the maintenance of effort levels.*

*Further, the Department will formalize a procedure to document the maintenance of effort challenges and communications to our federal partners when we feel we will not be in compliance. The Department has been monitoring this on a quarterly basis and will continue to do so and more frequently if levels look insufficient. Further the Department is seeking technical assistance from SAMHSA as to what maintenance of effort reporting should be with the integration of mental health and substance abuse services.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

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

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

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

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

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

performing the control does not possess the necessary authority or competence to perform the control effectively.

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

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

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

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

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

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

#### Title 45, Code of Federal Regulations

Section 96.134 Maintenance of effort regarding State expenditures, states in part:

- (a) With respect to the principal agency of a State for carrying out authorized activities, the agency shall for each fiscal year maintain aggregate State expenditures by the principal agency for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the two year period preceding the fiscal year for which the State is applying for the grant. The Block Grant shall not be used to supplant State funding of alcohol and other drug prevention and treatment programs.

Section 96.124 – Certain allocations, states in part:

- (c) Subject to paragraph (d) of this section, a State is required to expend the Block Grant on women services as follows:
- (3) For grants beyond fiscal year 1994, the States shall expend no less than an amount equal to the amount expended by the State for fiscal year 1994.

Section 96.127 – Requirements regarding tuberculosis, states in part:

- (c) With respect to services provided for by a State for purposes of compliance with this section, the State shall maintain Statewide expenditures of non-Federal amounts for such services at a level that is not less than an average level of such expenditures maintained by the State for the 2-year period preceding the first fiscal year for which the State receives such a grant. In making this determination, States shall establish a reasonable funding base for fiscal year 1993. The base shall be calculated using Generally Accepted Accounting Principles and the composition of the base shall be applied consistently from year to year.



**2015-054 The Department of Social and Health Services did not have adequate internal controls in place and did not comply with requirements to ensure treatment service providers spending Block Grants for Prevention and Treatment of Substance Abuse funds were peer reviewed.**

**Federal Awarding Agency:** U.S. Department of Health and Human Services  
**Pass-Through Entity:** None  
**CFDA Number and Title:** 93.959 Block Grants for Prevention and Treatment of Substance Abuse  
**Federal Award Number:** 2B08TI010056-13; 2B08TI010056-14; 2B08TI010056-15  
**Applicable Compliance Component:** Special Tests and Provisions – Independent Peer Reviews  
**Questioned Cost Amount:** None

## **Background**

The Department of Social and Health Services, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Department subawards some of the funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. The Department spent over \$38 million in grant funds during fiscal year 2015.

Federal regulations require the Department to conduct independent peer reviews of treatment service providers. The peer reviews must assess the quality, appropriateness and effectiveness of treatment services provided to individuals. The Department must ensure:

- At least five-percent of the treatment service providers in the state are reviewed.
- The providers reviewed are representative of those providing treatment services.
- The peer reviewers are independent.

Department staff determine how many treatment service providers must be peer reviewed for the calendar year. Each peer review was performed by one to four reviewers. Prior to conducting a peer review, the Department has reviewers sign a disclaimer form in order to certify their independence. This certification includes stating that they do not have administrative oversight, are not an employee, have no financial interest and are not involved in any funding decisions at the treatment service provider they are scheduled to review.

The Department oversaw peer reviews for calendar years 2014 and 2015 during the audit period.

## **Description of Condition**

During the audit period the Department did not have adequate internal controls in place to ensure it complied with peer review requirements. We examined the documentation for both years to determine whether the Department was in compliance with federal requirements. We found:

- The Department did not ensure at least five-percent of treatment service providers were peer reviewed for calendar year 2014. A minimum of 16 reviews were needed, but only 13 occurred.
- Nine out of 25 disclaimer forms for the calendar year 2014 review were not adequate to ensure the peer reviewers were independent. Four forms did not contain the name of the treatment service provider and five were not supported by any documentation.
- Five out of 34 disclaimer forms for the calendar year 2015 review were not adequate to ensure the peer reviewers were independent. All five did not contain the name of the treatment service provider that was reviewed.

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

## **Cause of Condition**

The Department did not have written policies or procedures in place to ensure it complied with the peer review requirements. Additionally, management did not adequately monitor to ensure the Department complied with the federal requirements.

Until we requested documents, Department staff were not aware that the incorrect number of treatment service providers were peer reviewed during calendar year 2014. They were also unaware that they did not have all of the required disclaimer forms.

## **Effect of Condition**

Without establishing adequate internal controls, the Department was not able to ensure the correct number of treatment service providers were peer reviewed or that peer reviewers were independent. By not properly monitoring that the federal requirements were met, the Department was not compliant with federal requirements for the grant.

## **Recommendation**

We recommend the Department establish internal controls sufficient to ensure the independent peer review process is adequate. Additionally, we recommend at least five percent of the treatment service providers are peer reviewed and reviewers are verifying their independence.

## **Department's Response**

*The Department concurs with this finding.*

*The Department had adequate peer reviews scheduled however, the reviews were not rescheduled when they were cancelled. As a result the Department did not review five percent of the treatment*

*providers as required. Further, disclaimers were not updated when there was a change in reviewer. For the current review period the correct amount of reviews were done and all disclaimers have been submitted and updated when necessary. The Department will formalize the policy for this by January 31, 2016.*

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

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

### **Applicable Laws and Regulations**

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

#### Section 300

The auditee shall:

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

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

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

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

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

Deficiency in internal control over compliance. A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned

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

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

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

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

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

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

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

Title 45, Code of Federal Regulations, Section 96.136 – Independent peer review, states in part:

- (a) The State shall for the fiscal year for which the grant is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved, and ensure that at least 5 percent of the entities providing services in the State under such program are reviewed. The programs reviewed shall be representative of the total population of such entities.
- (e) The State shall ensure that the independent peer review will not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there be a separation of peer review personnel from funding decisionmakers. In addition, the State shall ensure that independent peer review is not conducted as part of the licensing/certification process.

- (f) The States shall develop procedures for the implementation of this section and such procedures shall be developed in consultation with the State Medical Director for Substance Abuse Services.

**2015-055 The Department of Social and Health Services made improper payments to providers for medical evidence records.**

**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:** 13-0404WADI00, 14-0404WADI00, 15-0404WADI00  
**Applicable Compliance Component:** Activities Allowed or Unallowed  
Allowable Costs/Cost Principles  
**Questioned Cost Amount:** \$29  
**Likely Questioned Cost Amount** \$79,476

**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.

As part of the program the Department reimburses providers for medical evidence records. The amount that is allowed to be reimbursed is established in a fee schedule provided to participating providers. The Department reviews all reimbursement requests for accuracy prior to authorizing payment.

The Department spent \$48.7 million in federal program funds in fiscal year 2015. Of that, \$5.8 million was reimbursed for approximately 170,000 medical evidence record payments.

**Description of Condition**

We examined reimbursements for 59 medical evidence record payments, which totaled \$1,995, to determine if the Department paid providers in accordance with the fee schedule. We found two reimbursements were made to providers that exceeded the Department’s fee schedule by \$29.

**Cause of Condition**

Department staff did not adequately review the support for the payments prior to approving them.

**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 questioned costs to be \$79,476.

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 payments.

### **Recommendation**

We recommend the Department ensure payments are supported and adequately reviewed prior to reimbursing providers.

The Department should consult with the Social Security Administration to determine what, if any, of the questioned costs should be repaid.

### **Department's Response**

*The Department concurs with this finding and agrees that payments must be supported and adequately reviewed prior to reimbursing providers.*

*To immediately address the issue, DDS leadership will meet with the Medical Claims Unit staff responsible for authorizing these reimbursements, and will carefully walk through the appropriate review process. DDDS leadership will also remind staff that DDS cannot pay the WAC approved fee schedule, and must follow the DSHS approved fee schedule.*

*Leadership will follow this in-person meeting with an email outlining the correct business process and expectations.*

*The aged technology DDS currently uses to view medical documentation impacts their ability to achieve 100% accuracy in counting pages of the medical evidence provided by medical sources.*

*The federal Social Security Administration is developing and DDS will implement (likely December 2016) a new Disability Case Processing System, which the Department believes will offer increased capacity for accurately counting the number of pages contained in the medical evidence records.*

*D DDS will share these audit results with the Social Security Administration.*

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

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

### **Applicable Laws and Regulations**

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

The auditee shall:

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

Section 510, states in part:

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

... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor. In evaluating the effect of questioned costs on the opinion on compliance, the auditor considers the best estimate of total costs questioned (likely questioned costs), not just the questioned costs specifically identified (known questioned costs). The auditor shall also report known questioned costs when likely questioned costs are greater than \$10,000 for a type of compliance requirement for a major program.

OMB Circular A-87: Cost Principles for State, Local and Indian Tribal Governments (2 CFR Part 225); Appendix A - General Principles for Determining Allowable Costs; Section C - Basic Guidelines state in part:

1. Factors affecting allowability of costs. To be allowable under Federal awards, costs must meet the following general criteria:
  - a. Be necessary and reasonable for proper and efficient performance and administration of Federal awards.
  - ...
  - j. Be adequately documented.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2015, Part 4- Social Security Administration, states in part:

A. Activities Allowed or Unallowed

DDSs make disability determinations based on the law and regulations and on written guidelines issued by SSA. Each State making disability determinations is entitled to receive from the Trust funds reimbursement for the cost of making those disability determinations for SSA. Activities shall be in accordance with the budget request approved by SSA. Purchased medical services, such as Medical Evidence of Record (MER) and Consultative Examinations (CE), must be in accordance with the DDS's fee schedule for purchased medical services. Activities allowed under the disability programs include personnel services, purchased medical services, indirect costs and other non-personnel costs (42 USC 421 (e) and (f); 20 CFR sections 404.1626 and 416.1026).



**2015-056 The Military Department improperly charged grant expenditures after the end of the Emergency Management Performance Grants' period of availability.**

<b>Federal Awarding Agency:</b>	U.S. Department of Homeland Security
<b>Pass-Through Entity:</b>	None
<b>CFDA Number and Title:</b>	97.042 Emergency Management Performance Grants
<b>Federal Award Number:</b>	EMW-2013-EP-00050
<b>Applicable Compliance Component:</b>	Period of Availability
<b>Questioned Cost Amount:</b>	\$12,592

The Military Department administers the Emergency Management Performance Grants. The funds are provided to local jurisdictions and tribes to sustain and enhance their emergency management programs. The Department spent approximately \$7.5 million in grant funds during fiscal year 2015.

The Department is responsible for ensuring grant funds are used for costs that are allowable and related to each grant's purpose. Each federal grant specifies a period during which program costs may be obligated. Payments for costs obligated after the end date of a grant are not allowed without prior approval by the grantor.

**Description of Condition**

The Department's fiscal year 2013 grant required all costs to be obligated prior to September 30, 2014. We found the Department obligated two payments, totaling \$12,592, to the grant in October 2014. The Department did not have prior authorization from the grantor to charge costs to the grants after the end of the performance period.

**Cause of Condition**

The Department did not ensure that all obligations were made before the period of availability ended.

**Effect of Condition and Questioned Costs**

We are questioning improperly charged grant expenditures of \$12,592 made after the end of the grant's period of availability.

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

**Recommendation**

We recommend the Department only charge expenditures to federal grants if they are obligated during the period of availability. The Department should consult with the U.S. Department of Homeland Security to determine what, if any, of the questioned costs should be repaid.

## Agency's Response

*The Department concurs with the finding. The Department will be more diligent to ensure expenditures do not occur outside the performance period. The questioned costs will be transferred to the fiscal year 2014 grant and the federal government will be reimbursed for the questioned costs for the fiscal year 2013 grant.*

## Auditor's Concluding Remarks

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

## Applicable Laws and Regulations

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

### Section 300

The auditee shall:

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

### Section 510, states in part:

- (a) Audit findings reported. The auditor shall report the following as audit findings in a schedule of findings and questioned costs:
  - ... (3) Known questioned costs which are greater than \$10,000 for a type of compliance requirement for a major program. Known questioned costs are those specifically identified by the auditor.

U.S. Office of Management and Budget Circular A-133, Compliance Supplement 2015, Part 3 – Compliance Requirements, states in part:

## H. PERIOD OF AVAILABILITY OF FEDERAL FUNDS

### Compliance Requirements

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