Washington State Auditor's Office

Audit Report

Medicaid

Audit Period
July 1, 2004 through June 30, 2005

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April 27, 2006

Washington State Auditor
Brian Sonntag

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Robin Arnold-Williams, Secretary
Department of Social and Health Services

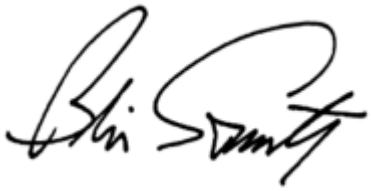
Report on the Medicaid Program

Please find attached our report on Medicaid and the program's compliance with federal and state laws and regulations.

We also perform an audit of the material line items in the basic financial statements related to Medicaid prepared by the Department of Social and Health Services, which are included in the Agency's separate Comprehensive Annual Financial Report.

The results of that audit are also published in reports issued by the Office of Financial Management.

Sincerely,



BRIAN SONNTAG,CGFM
STATE AUDITOR

Insurance Building, P.O. Box 40021 • Olympia, Washington 98504-0021 • (360) 902-0370 • (866) 902-3900 • TDD Relay (800) 833-6388
FAX (360) 753-0646 • http://www.sao.wa.gov

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ABOUT THE AUDIT

This report contains the results of our independent audit of the Medicaid program for the period from July 1, 2004 through June 30, 2005. In some instances, we included the period from January 1, 2004 through June 30, 2004 in our audit work as we noted some areas of particular high risk. Also, we were unable to audit this period in our previous audit due to a scope limitation imposed by the Agency.

We evaluated internal controls and performed audit procedures on the Medicaid program's compliance with federal and state laws and regulations. Our work focused on specific areas that have potential for noncompliance, misappropriation or misuse of public resources.

DESCRIPTION OF THE MEDICAID PROGRAM

Medicaid is a jointly funded state and federal partnership providing health coverage for selected categories of people with low incomes who might otherwise go without medical care. It is the largest source of funding for medical- and health-related services for people with limited income. The state of Washington Medicaid program spent more than $6.2 billion during fiscal year 2005.

Title XIX of the Social Security Act requires that, in order to receive federal matching funds, states must offer certain basic services to the needy population. States may receive additional federal Medicaid matching funds if they elect to provide other optional services.

Medicaid does not provide medical assistance for all low-income persons. Even under the broadest provisions of the federal law, the program does not provide health care services, even for very poor persons, unless they are in one of the designated groups. Low income is only one test for Medicaid eligibility; assets and other resources also are considered. Some who have too much income or too many assets to be eligible may become eligible due to extensive medical expenses. Federal regulations require anyone receiving Medicaid benefits to have a valid Social Security number. If an applicant does not have one, the state agency administering the program is to help the client obtain one.

Medicaid is different in every state. Within broad federal guidelines, states determine the type, amount and duration of services offered. States may place limits on Medicaid services based on certain criteria. For example, they may limit the number of physician visits or may require authorization be obtained prior to service.

The state Medicaid Plan, prepared by the administering agency, is the comprehensive document that defines how each state will operate its program. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage and provider reimbursement. Each state submits its plan to the federal Centers for Medicare and Medicaid Services for approval. The state is then expected to operate the program according to the approved plan, providing to the federal government assurance that the program will be administered according to law.

In the state of Washington, Department of Social and Health Services administers the Medicaid program and submits the state plan to the federal grantor for approval. Amendments can be incorporated and approved when necessary.

The federal grantor also may grant waivers from certain Medicaid requirements. For instance, Medicaid began as a fee-for-service program; however, Washington has obtained a waiver allowing it to offer to its clients the option of a health maintenance organization called Healthy Options.

Most payments to providers for benefits received by Medicaid clients are made through the Department of Social and Health Services' Medical Management Information System. A smaller portion is made through the Department's Social Services Payment System. A record of all costs is entered into the state's Agency Financial Reporting System, which is used to compile the state's financial statements.

The plan and any waivers are the basis for the state's claims for federal financial participation. When paying for services, the state first uses state funds and then submits a report to the federal grantor requesting the program's federal share. While the federal share percentage changes slightly each year, it generally is about 50 percent in this state. In other words, the federal government matches almost every dollar the state spends.

GENERAL AUDIT REQUIREMENTS FOR FEDERAL PROGRAMS

As a condition of receiving federal matching funds, the federal government requires that the state obtain an annual audit to determine if the state has established adequate internal controls to ensure it can comply with federal requirements and to determine if it is in compliance with those requirements. The State Auditor's Office performs this audit for the state of Washington and reports its findings in the annual State of Washington Single Audit Report prepared by the Office of Financial Management.

The federal Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and the *Circular A-133 Compliance Supplement* describe audit requirements that must be followed in any audit of federal programs. These include a requirement that the audit be conducted in accordance with generally accepted government auditing standards, which are described in the 2003 revision of *Government Auditing Standards*, issued by the Comptroller General of the United States.

Government Auditing Standards prescribes general standards which are applicable to all types of governmental audits. These include requirements that the auditor be independent and competent and use professional judgment. The standards define audits of financial statements to include audits of compliance with regulations relating to federal award expenditures. Field work standards for financial audits include adequate planning, a sufficient understanding of internal controls, the collection and documentation of sufficient evidence to reach a conclusion and communication of information to the audited entity

Auditing standards require the auditor to test both controls and compliance related to the administration of federal programs. The federal government also requires that issues from audits of previous years be assessed annually, for at least three years, until the condition is resolved or the federal government takes no action. In addition, auditors are required to expand the audit scope if other issues come to their attention.

State agency managers generally understand what controls an agency has established to ensure compliance with program requirements; however, they may not be aware of whether those controls are used by the line staff responsible for following them. Therefore, in order to fully assess risk and review internal controls, auditors must be able to interview line staff separately,

without managerial presence, to determine whether the planned controls are being used as management intends.

During audits of controls and compliance, auditors must also be free to examine original source documents. If such documents are not available, auditors may not be able to reach a conclusion in either area. Agency-prepared spreadsheets or narratives, which may or may not be based on accurate source information, generally do not provide the level of evidence auditors require to reach conclusions in which they can have confidence. Documentation requested by the auditor should be provided in a timely manner so the audit can be completed efficiently and effectively. If lengthy delays occur in providing the documents, their reliability may be impaired.

Government Auditing Standards also state that auditors must be free from external impairments. Chapter 3 of that publication deals with auditor independence issues and states at Section 319:

> Factors external to the audit organization may restrict the work or interfere with auditors' ability to form independent and objective opinions and conclusions. External impairments to independence occur when auditors are deterred from acting objectively and exercising professional skepticism by pressures, actual or perceived, from management and employees of the audit entity . . . .

Government Auditing Standards contains a list of examples of external impairments, including:

- External interference or influence that could improperly or imprudently limit or modify the scope of an audit or threaten to do so.
- External interference with the selection or application of audit procedures or in the selection of transactions to be examined.
- Unreasonable restrictions on the time allowed to complete an audit or issue the report.
- Threat of replacement over a disagreement with the contents of an audit report, the auditor's conclusion, or the application of an accounting principle or other criteria.

Such external impairments may interfere with the auditor's ability to form independent and objective opinions and conclusions. When auditors cannot perform the tests needed to reach a conclusion, they are required by auditing standards to disclaim on the audit objective. A disclaimer means the auditor cannot determine whether program requirements have been met.

MEDICAID AUDIT REQUIREMENTS

Because of the large amount of funding involved and its complex requirements, the Medicaid program is included in the State of Washington Single Audit every year. The federal *Compliance Supplement* pertaining to the program describes areas of requirements that must be considered in every audit of a federal program. These areas can be excluded from coverage only if they are not applicable and/or significant to the particular program being audited. The following is a list of all areas, with highlighting used for those areas the State Auditor's Office usually determines to be applicable and/or significant to Medicaid in this state:

A. Activities Allowed or Unallowed
B. Allowable Costs/Cost Principles
C. Cash Management
D. Davis-Bacon Act
E. Eligibility
F. Equipment and Real Property Management
G. Matching, Level of Effort, Earmarking

H. Period of Availability of Federal Funds
I. Procurement and Suspension and Debarment
J. Program Income
K. Real Property Acquisition and Relocation Assistance
L. Reporting
M. Subrecipient Monitoring
N. Special Tests and Provisions
- **1. Utilization Review and Program Integrity**
- **2. Hospital and Long-Term Care Audits**
- **3. Automated Data Processing Risk Analysis**
- **4. Provider Eligibility**
- **5. Provider Health and Safety**
- **6. Managed Care**

Because of the size and complexity of the Medicaid audit, auditors cannot review every aspect of each compliance area each year; instead, they must focus on the riskiest areas for each.

MEDICAID AUDIT FOR FISCAL YEAR 2005

This audit was directly supervised by an assistant audit manager, who is both a certified public accountant and a registered nurse. The supervisor joined our office five years ago, following many years of work in the medical field, bringing a considerable understanding of the Medicaid program to her work as an auditor. Because of the many issues identifed in previous years we increased the number of hours devoted to this audit from 5,000 in 2004 to 6,000 in 2005.

In our previous audit, we were not able to reach a final conclusion about Medicaid's compliance with allowability and eligibility requirements. This was because external, agency-imposed limitations prevented us from completing our review of the types of procedures we had determined we would use as the basis for our conclusions on allowability and eligibility.

During our current audit, we were given access to all areas of the Department. Most of the information we requested was given to us in a timely manner. We did, however, encounter difficulties obtaining complete records from the Aging and Disability Services Administration for our review of complaints filed on facilities for developmentally disabled clients. While we still do not have access to the State On-line Query for our testing of Social Security numbers, we have been given independent access to all computer systems that we have requested of the Department.

We noted significant improvement in the liaison system that the Department set up this year. The Department assigned new liaisons for almost all of its Administrations. This has made communications more expeditious and effective. Monthly update meetings, that the Department has initiated, are a very useful mode of communication. We hope next year these meetings will be broadened to include other managers who could benefit from this communication.

While executive management appears to be generally receptive to our recommendations, we found some managers are not always receptive to recommendations that could correct issues. Additionally, we have found some managers do not communicate the results of our audit work to their supervisors. This causes issues to go unresolved. We believe if corrective actions were initiated sooner, repeat findings could be reduced. More than $200 million of questioned costs reported in our audit can be attributed to this lack of communication.

During this audit, we also found some issues that were caused, in part, by information given to the Department by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). We found some of the directives given by CMS to the state were contrary to current federal regulations and law. We found this to be the case in the areas of

health care facility surveys and surety bonds for home health care agencies. This is part of the reason for more than $728 million of the almost $1 billion in questioned costs that we are reporting for this audit. Our determination to report these costs was under the direction of the Office of the Inspector General from whom we sought guidance when we noted discrepancies between directives that CMS had given to the state and the federal law.

The decision to question these costs, however, was also based on the fact that the state's noncompliance with federal survey standards may have affected, sometimes adversely, the quality of care that was received by some of Washington State's most vulnerable citizens while residing at the intermediate facilities for the developmentally disabled. The situations that we found were known to the Department in the form of complaints by staff and family members of the residents.

RESULTS

We found the Department made some efforts toward improving certain issues found in our previous audit. We appreciate the Department's commitment in resolving these matters. In particular:

- Economic Services Administration and Health and Recovery Services Administration have established controls to provide reasonable assurance that significant noncompliance with applicable laws and regulations for third-party liability for children receiving child support would be prevented or detected on a timely basis.

- The Department corrected an issue pertaining to skilled medical professionals working at the Area Agencies on Aging reported in our previous audit. We found that the Aging and Disability Services Administration is complying with the subrecipient monitoring requirement and that claims for reimbursement were calculated correctly and are adequately supported.

- The Aging and Disability Services Administration has established controls to ensure supplemental Medicaid funds are not used in rate calculations when setting nursing home bed rates.

- As we found in other years, controls related to the use of Medicaid funds in the appropriate period were present.

- While other states were reporting Medicaid reimbursements for erectile dysfunction drugs on behalf of sexual offenders, we found the Health and Recovery Services Administration authorized no such reimbursements.

We also identified conditions that were previously reported in which corrective action was not taken or the issues remaining were significant enough to report as findings:

- We again analyzed the validity of Medicaid clients' Social Security numbers as well as claims that could have been paid after a person had died. We found little change in issues identified during previous audits. Our testing revealed potential provider fraud as well as identity theft.

- A valid Social Security number is a requirement for Medicaid eligibility. During our audit for fiscal year 2004, and again in 2005, we found numerous instances in which no Social Security numbers were listed in the Department's records for Medicaid clients. We also found instances in which two or more people shared the same number and other cases in

which payments were made for medical services for clients who did not appear to ever have been enrolled in Medicaid.

- We have reported control weaknesses in the area of emergency services for undocumented aliens since fiscal year 2003. During the current audit, we found no improvements in the Department's controls from previous years. Undocumented aliens continue to receive non-emergent and routine care. This includes nursing home services and treatments for chronic conditions. Additional testing in this area also showed the Department's policy and procedure manuals with respect to this issue are in conflict with federal law.

- We found that the state continues to misrepresent expenditures reported on the federal claim form when it reports no expenditures for undocumented aliens. We also found that the state may have to repay the federal portion of those expenditures that the federal government instructed the Department not to claim while the issue is under review. The estimated liability could be up to $32 million.

- We have reported for five consecutive years control weaknesses in Basic Health Plus, a health insurance program for children funded by Medicaid. In our follow-up work we saw some improvement. The Department is no longer accepting a declaration of income for its wage-earner clients. However, it is not determining if adults other than the head-of-household are employed. Additionally, no improvements in controls have been made for self-employed clients. The Department continues to rely on a client's declaration of income for this population and makes no efforts to determine if the spouse in the household is employed. We found clients with incomes well above the income standard for this program.

- Inadequate controls related to cosmetic procedures and those requiring pre-authorization continue. From the information that we could obtain from the Department in this area, we found reimbursements for procedures that the federal government would generally not consider acceptable for the Medicaid program.

- We found no evidence that supplemental Medicaid payments made to public hospital districts were made using a payment methodology approved by the federal government and included in the Medicaid State Plan. No changes were made to correct the internal control weakness identified in our previous audit. The Department reported that current supplemental program is to be phased out and will be replaced by another program as of June 30, 2005. Because of the phase-out, the Department indicated it saw no need to improve the conditions under which the two payments issued under the old program were made. The total payments made under the old program were $41,154,000.

- We found improvement in some of the Department's refunding procedures pertaining to warrants that were cancelled or beyond the 180-day statute of limitations. However, we still found weaknesses. Although we found all the warrants we reviewed were refunded to the federal government, only 14 percent were refunded in a timely manner. We also found no controls to ensure that refunds were made using the correct percentage.

- In our previous audit we reported control weaknesses related to the required reporting of instances of abuse and neglect to the Medicaid Fraud Control Unit. In our current audit we found that Eastern and Western State Hospitals, the Mental Health Division Headquarters and the Department of Alcohol and Substance Abuse have a procedure to report allegations of abuse and neglect to the Fraud Unit. In most cases, however, the procedures were not in effect during the audit period.

- Health and Recovery Services Administration has not established any additional internal controls or addressed the weaknesses in provider documentation for claims of motorized

wheelchairs. The Department reported in its corrective action plan that it did not agree with our previous year's finding in this area.

- For controls related to licenses for providers of durable medical equipment, we found no new procedures in place to address internal control weaknesses we identified during audit year 2004. During that audit, we visited 25 out-of-state providers and for 23 found no evidence of an actual business, or the information we found concerning the business was inconsistent with the Department's records. While the Department has increased staff in provider enrollment, new documentation and review procedures were not put in place until after our audit ended. We reviewed the new policies and found some weaknesses have not been addressed.

- In previous audits we reported serious control weaknesses in compliance requirements related to hospitals. In our current audit we found these to be largely unaddressed by either the Health Department or the Department of Social and Health Services. Specifically:

    1. Surveys are not being performed with the frequency stipulated in state law. The time between surveys was lengthened from 12 months to 18 months by the 2005 Legislature. Even with the new frequency standard, we found 77 percent of the hospitals were not surveyed according to state law.

    2. The Department of Social and Health Services has not specified, as federal regulations require, the forms, methods and procedures the Health Department must use to determine provider eligibility and certification under Medicaid for its surveys of hospitals.

    3. The Health Department has no documentation in its files to give us reasonable assurance that its employees had conducted the surveys according to federal regulations.

- Health and Recovery Services Administration continues to be unable to obtain information from either Aging and Disabilities Services Administration or the federal government of nursing homes that are not in substantial compliance with health and safety requirements. We have found payments to providers who accepted new Medicaid clients when they were in Denial of Payment status.

- The Department has disagreed with the audit finding issued in our previous audit related to managed care. We found no changes in this area. Health and Recovery Services Administration is not monitoring to ensure that the data received from its managed care providers is accurate. No checks are being performed to ensure that up-coding by providers is not occurring. The Department spent more than $900 million in payments to these providers without reasonable assurance that the rates paid to them are based on accurate data.

We also identified new conditions that were significant enough to report as findings:

- We found no controls to ensure the state is refunding the federal portion of Medicaid overpayments as federal regulations require.

- Federal regulations require states to perform a retrospective drug use review in order to identify patterns of fraud, abuse, gross overuse and inappropriate or medically unnecessary care among physicians, pharmacists and Medicaid recipients. We found some of the controls that the Department represented it was using to ensure the validity of its pharmaceutical claims were actually not being used.

- We found no controls related to ensuring that reimbursements for Somatropin, a steroid used for growth disorders, are only being made when it is prescribed for U.S. Food and Drug Administration approved uses. We also found wide variations in drug pricing for this drug, at the same dose and even the same provider, ranging from $47.79 per dose to $5,061.31 per dose.

- We found several issues related to home health agencies. Specifically:

    1. Health and Recovery Services Administration does not ensure all home health agencies caring for Medicaid clients are Medicare certified, as the law requires.

    2. Health and Recovery Services Administration does not ensure all home health agencies caring for Medicaid clients have a surety bond as federal statutes require.

    3. Aging and Disability Services Administration does not have controls to ensure all home health providers meet the criteria for participating in the Medicaid program.

    4. The Health Department does not retain documentation that would provide evidence to ensure all home-health agency providers performed criminal background checks and obtained disclosures on employees having unsupervised access to children and vulnerable adults, as the law requires.

- We also found significant control weaknesses and evidence of unreported abuse and neglect of developmentally disabled clients residing in the state's intermediate care facilities for the developmentally disabled. Specifically:

    1. We found no controls to ensure facilities that were not in substantial compliance with conditions of participation did not receive payment for new Medicaid clients.

    2. Surveys are not being conducted according to federal standards. The Department reports that its limited review has been approved by the Centers for Medicare and Medicaid Services (CMS). CMS concedes that this is true.

    3. The Aging and Disability Services Administration reported it received more than 25,000 complaints in 2004 for residential care services. We found complaints of abuse and neglect including sexual abuse, financial exploitation, fractures, alcohol poisoning and death. Our tests showed investigations that should have been investigated according to federal guidelines were not conducted in compliance with those standards. When incidents arose that would suggest substandard care, we found no evidence of independent investigations or its outcomes. In most instances, the Administration relied on the investigative efforts of the facility where the incident occurred.

AUDIT HISTORY

We audit the Medicaid program annually. The U.S. Department of Health and Human Services has identified Medicaid as a program of higher risk because it spends more federal dollars than any other program. While auditors are not precluded from determining that Medicaid qualifies as a low risk program, prior audits would have to have shown strong internal controls and compliance with Medicaid requirements in order to justify not auditing the program. Washington State has not been able to meet this standard and, as such, the State Auditor's Office is required to consider this program high risk.

For each year since state fiscal year 2001, as we have identified more risk, we have devoted more resources to this audit. Consequently, we have reported more issues. Since 2001 repeat findings have been issued for every consecutive year. A summary is provided below:

State Fiscal Year	Issues Reported	Issues Resolved
2000	1	1
2001	4	2
2002	5	0
2003	10	1
2004	22	4
2005	28	

State fiscal year 2006 will mark the sixth consecutive year that we will be auditing the Basic Health Plus program. Although we have seen improvements in this area, significant control weaknesses that jeopardize program integrity remain unaddressed. The weaknesses identified in the Department's lack of compliance with federally mandated requirements for Social Security numbers, provider licensing and provider health and safety standards for hospitals and nursing homes will be audited for the fifth consecutive year. Although we have seen movement toward improving controls in some of these areas, the Department has not made progress in one area we see as critical: obtaining valid Social Security numbers for persons applying for Medicaid. The use of invalid Social Security numbers, those belonging to deceased persons or by multiple persons, is common in the Department's records.

Schedule of Audit Findings

State of Washington
Medicaid

M05-08 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), received federal Medicaid funds for unallowable services provided to undocumented aliens.

Background

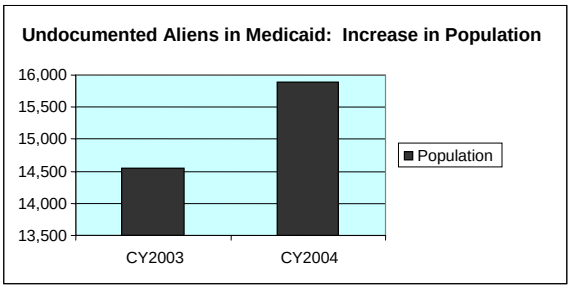
As a requirement for receiving federal Medicaid funds (CFDA 93.778), the Department of Social and Health Services must provide medical benefits to three groups: eligible residents of the United States who are citizens, aliens lawfully admitted for permanent residence, and certain aliens granted lawful temporary resident status. Undocumented aliens are not included in these three groups.

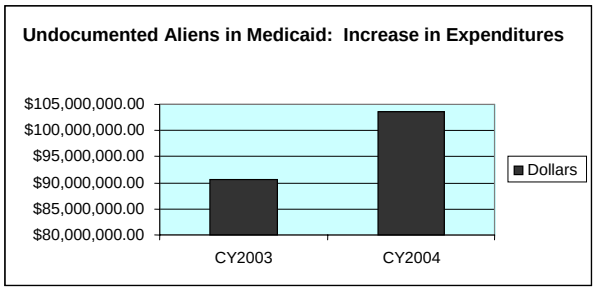
In most cases, if a state chooses to provide medical services to undocumented aliens, it must use its own funds. Federal Medicaid matching funds are available only if the medical services provided are the result of an emergency situation, including obstetrical services at the time of delivery. Emergency medical services are defined in the U.S. Code of Federal Regulations and the Medicaid State Plan. Non-emergency medical services provided to undocumented aliens cannot be charged to the federal government. The Department and the federal government define "emergency medical condition" as the sudden onset of a medical condition so severe that, without immediate medical attention, serious jeopardy to a person's health, serious impairment of bodily functions, or a serious dysfunction of a bodily organ or part would be expected.

In our audit of fiscal year 2003, Department records showed that 9,717 undocumented aliens received medical services from July 2002 through December 2003. Based on our risk analysis, we selected 169 of these patients in six service categories and found that non-emergency procedures, routine medical services and durable medical equipment were provided to undocumented aliens and paid for with Medicaid funds. We found payments for adult day care, massages, dental fillings, routine eye exams, regular office visits and in-home care, as well as supervision of normal pregnancies and routine postpartum follow-up. Medicaid payments were made for eyeglasses and contact lenses, breast pumps, dentures, contraceptive devices, disposable incontinence garments and replacement wheels for wheelchairs. We found payments for conditions such as menopause, cough, breast engorgement and nearsightedness. As a result, we questioned $1,342,420 in state and federal costs.

In our audit of fiscal year 2004, we were unable to determine if the Department made any improvements to its systems because the Department did not allow us access to all the records that we needed to perform our testing. For the testing we were able to accomplish, we found that the Department provided non-emergency services to 274 undocumented aliens totaling $5,141,726. These services included adult day care, dental, nursing home, in-home services and personal care services.

Department records showed that, from January 2003 through December 2003, 14,553 undocumented aliens received services through the Medicaid program for a total of $90,590,401. For the same period in 2004, the Department's records indicated that it provided services to 15,890 undocumented aliens. The Medicaid program paid $103,698,442 for this care. This is an increase of 9 percent in population and 14 percent in expenditures from the previous year.





Description of Condition

In our current audit, we followed up to determine if improvements had been made to the controls, which would ensure that only emergency services were paid for with federal funds. Using the Department's records, we found that 4,692 diagnostic codes, totaling $103,698,442, were reported by providers in the claims they submitted for services provided to undocumented aliens.

The diagnostic code tells what condition the client had that required treatment. The procedure code, on the other hand, shows the actual treatment that the client was given. Generally, these are related in that the services rendered are deemed customary for the client's condition. Our preliminary analysis revealed the procedures for which the claim was paid often were unrelated to the diagnoses. For instance, we found diagnostic codes for sprained ankles or limb contusions associated with durable medical equipment such as breast pumps. This revealed that the diagnostic code alone, as reported in the Department's system, could not be relied upon to determine whether the expenditure was for an emergent or non-emergent service and, thus, allowable for federal Medicaid funds. This required us to perform more detailed testing that would incorporate an analysis of the procedure code as well as the diagnostic code for each transaction that we wished to test.

We reviewed 333 (7 percent) of the 4,692 diagnostic codes and $88,039,565 (85 percent) of the $103,698,442 in expenditures reported in the Department's records for undocumented alien clients. This review included related procedures and associated transactions. In all, we tested 647,131 transactions. Our testing attempted to determine whether or not the diagnostic code and procedure code associated with it adhered to the federal definition of emergent and whether or not the Department had enough information within the accounting system to determine the propriety of the transaction.

Our testing revealed that:

- $28,013,625 (32 percent) was paid for diagnoses and procedures that did not conform to the federal definition of emergent.

- The following expenditures were paid on claims for which information in the Department's system was inadequate to determine the propriety of the transaction.

    - $47,043,702 (53.4 percent) was paid on claims with no procedure codes.

    - $1,648,452 (1.9 percent) was paid on claims with no diagnostic codes.

    - $3,326,866 (3.8 percent) was paid on claims with no diagnostic codes and no procedure codes.

    - $3,167,289 (3.6 percent) was paid on prescription medications when no indication was given for what condition the drug was being used.

- $3,961,673 (4.5 percent) was paid for diagnoses and procedures that conformed to the federal definition of emergent. $290,645 (0.3 percent) was paid for with state funds.

We did not test diagnostic categories that were related strictly to newborns, as it is reasonable to assume that the newborn may be a citizen even if the mother is an undocumented alien. We did not determine whether these clients were actually born in the United States, but relied on the Department's designation of "newborn" in the accounting records. This total was $877,959.

In general, claims were paid on the following diagnostic categories:

$57,803,194	Pregnancy-related which included prenatal, labor and delivery, postnatal and sterilizations. Of this amount $2,911,194 was for labor and delivery.
$ 2,327,481	Treatments for cancer including chemotherapy and radiation therapy.
$ 2,697,283	Treatments for kidney diseases including transplants.
$ 1,691,934	Dental care including oral evaluations and check ups, cleanings, fillings, bridges, crowns and cosmetic treatments.
$ 245,770	Eye exams, spectacles and contact lenses.
$ 1,055,949	Gynecological procedures including male and female contraceptive devices, contraceptive supervision and annual checkups.
$12,591,709	Miscellaneous diagnostic codes which included hearing exams, physical therapy, carpal tunnel syndrome, in growing nails, acne, irregular menstruation and others.

We found no improvements in the Department's controls from previous years. Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program as federal law requires. Although undocumented aliens do not have Social Security numbers, we have found evidence in which staff has accepted a Social Security card given to them by an undocumented alien. Instances in which the Department has accepted verbal representations of a number by a client are common in its records.

The Department's accounting system continues to be unable to differentiate undocumented aliens who have received emergency services from those who have not. Staff has informed us that the programming needed to perform this function will not be addressed until June 2007 when a new computer system is expected to arrive.

We found no improvements to the procedure manuals that staff is required to use. We found instances in which the guidance provided in the manual conflicts with federal law for the program.

Cause of Condition

- Social Security numbers are not consistently verified prior to admitting clients into the Medicaid program. Further, the Department does not heed federal alerts notifying staff of invalid Social Security numbers.

- The Department's accounting system does not differentiate undocumented aliens who have received emergency services from those who have received non-emergency services.

- When the Department enters an undocumented alien into its system in order to pay for emergency medical costs, it enters that client for a three-month period. During that time, it pays for all medical services provided to that client, emergency or not. At the end of three-months, the

client can be approved for an additional amount of time. This appears to occur continually, as we have seen clients in the system over a period of several years.

- Department staff stated the procedure manuals contain insufficient and unclear guidance and are often too technical for non-medical personnel to understand.

- In its eligibility manual, the Department lists certain medical diagnoses that are pre-authorized as emergencies. If a client who is an undocumented alien has a medical diagnosis that is not on the list, staff members are instructed to refer the case to the Department's medical staff. We found these referrals were not being made in a consistent manner.

Effect of Condition

The Census Bureau reported that 45 million Americans did not have health insurance in 2003, an increase of 1.4 million from 2002 and 5.2 million from 2000. People often do not have access to Medicaid because states do not have sufficient funding to provide quality care for all. Economic factors as well as natural disasters force states and individuals to rely on the federal government for assistance and to compete for limited health-care dollars.

Washington State is providing services to thousands of ineligible clients using federal Medicaid money. The majority of these clients were admitted into the program due to unaddressed significant weaknesses in the Department's controls. This is causing the nation's taxpayers to subsidize Washington State's noncompliance. Our testing showed that the state made $83,199,933 in questionable expenditures of which half were paid with federal Medicaid funds. Lack of compliance with federal regulations could jeopardize future federal funding.

Recommendation

With respect to compliance with federal regulations, we recommend the Department:

- Revise its policies regarding emergent conditions to conform to federal regulations.

With respect to strengthening internal controls, we recommend the Department:

- Develop internal controls that require employees to verify applicants' Social Security numbers and heed alerts sent by the Social Security Administration pertaining to invalid numbers.

- Develop clear and complete policy and procedure manuals.

- Develop an accounting system that will differentiate emergency from non-emergency procedures so that the appropriate funds can be used to pay for the designated services.

With respect to caring for the state's growing undocumented alien population, we recommend the Department:

- Fund a state program that would pay for the additional care that the state wishes to provide.

Department's Response

The Department disagrees with this finding. The Department has made improvements in the policy, tracking and reporting of Alien Emergency Medical (AEM) expenditures.

- *The Department initiated a review of its AEM policies as a result of the FY2003 audit. Since then, it has clarified these policies regarding the allowability of AEM expenditures effective July 2005. We believe the current policies are consistent with federal and state regulations. There have*

been updates to manuals, forms and procedures within the Department to reflect these changes. The accounting system has been setup to identify these services and implemented a quarterly review of these expenditures.

- *The Department has also been notified of an Office of Inspector General audit for this program to commence on March 1, 2006. The result of this audit will clarify the Department's interpretation of the AEM policy regarding emergent vs. non-emergent services.*

- *The State Auditor's Office (SAO) recommends the Department fund a state program that would pay for the additional care that the state wishes to provide. The Department suggests the SAO either remove this recommendation from their report or direct the recommendation to the Office of Financial Management or the Legislature. It is not within the Department's authority to create and fund a program using General Fund-State dollars.*

Auditor's Concluding Remarks

- The Department has not brought to our attention any policy changes it has made or intends to make with respect to allowability of expenditures it is making on behalf of undocumented aliens. Any changes that were implemented after July 1, 2005, were after our audit period and will be reviewed during our fiscal year 2006 audit.

- We are aware that the Office of the Inspector General will conduct an audit regarding the allowability of the Department's expenditures in the Alien Emergency Medical program. The Inspector General's Office has been in contact with the State Auditor's Office.

- If the Department desires to expend federal funds for a purpose that is unallowable, as it has done with its undocumented alien clientele, then it is the Department's responsibility to inform the Office of Financial Management and the Legislature of its needs.

Applicable Laws and Regulations

Allowability and Eligibility

Section 1903 of the Act (41 U.S.C., Section 1396(b)) provides in part:

> (1) No payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or other wise permanently residing in the United States under color of law.
>
> (2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if -
>
> > (A) such care and services are necessary for the treatment of an emergency medical condition of the alien,
> >
> > (B) such alien otherwise meets the eligibility requirement for medical assistance . . . and
> >
> > (C) such care and services are not related to an organ transplant procedure.

Washington Administrative Code 388-500-0005 describes emergency services as follows:

> Emergency medical condition means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including

severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

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

Washington Administrative Code 388-500-0005 also defines emergency medical expense requirements as follows:

> A specified amount of expenses for ambulance, emergency room or hospital services, including physician services in hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

The Department's *A-Z Eligibility Manual* describes what constitutes an emergency medical condition. It states, in part:

> 1 . . . In order to be eligible for the Alien Emergency Medical (AEM) program, a person must: . . .
>
> a. Have an emergency medical condition. (Refer to the list of emergency medical conditions in the Medically Indigent section) . . . .

Washington Administrative Code 388-438-0110 describes alien emergency medical as follows:

> An alien, who is not eligible for other medical programs, is eligible for emergency medical care and services:
>
> (1) Regardless of their date of arrival in the United States;
>
> (2) Except for citizenship, meets Medicaid eligibility requirements as described in Washington Administrative Code 388-505-0210, 388-505-0220 or Washington Administrative Code 388-505-0110; and
>
> (3) Limited to the necessary treatment of an alien's emergency medical condition as defined in Washington Administrative Code 388-500-0005, except that organ transplants and related medical care services are not covered.

Washington Administrative Code 388-424-0010 describes alien status and eligibility requirements for medical benefits. Paragraph (3) states the extent of those services:

> An alien who would qualify for Medicaid benefits but is ineligible solely because of his or her alien status, can receive medical coverage as follows:
>
> (a) State-funded categorically needy (CN) scope of care for . . .
> (i) Pregnant women, as specified in Washington Administrative Code 388-462-0015

Administrative Code 388-462-0015 states that care to pregnant women who do not meet eligibility requirements due to citizenship status will be provided under state funded programs only:

> A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

Revised Code of Washington 43.20A.550 states that rules and regulations in conflict with federal law are deemed inoperative:

> . . . Any section or provision of law dealing with the department, which may be susceptible to more than one construction, shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

Schedule of Audit Findings

State of Washington
Medicaid

M05-09 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), is not complying with federal requirements to defer Medicaid expenditures related to undocumented aliens.

Background

The federal government requires states to report expenditures for medical assistance and administrative costs on a quarterly basis. This report is referred to as the CMS-64. The federal government reimburses states for a defined percentage of expenditures based on the information submitted in these reports. Line 6, Item 27 of the CMS-64 claim form, Emergency Services Undocumented Aliens, is to be used to report allowable emergency expenditures for undocumented aliens.

In our audits of state fiscal year 2003 and 2004, we found that Department of Social and Health Services was not reporting payments for alien emergency medical (AEM) services on the claim form as required. Instead, it combined payments for both allowable emergency services and unallowable non-emergency services and reported that amount in other categories of the form as allowable expenditures. In our audit of state fiscal year 2004, we reported that the Department was receiving federal Medicaid funds to which it was not entitled.

On May 6, 2005, Centers for Medicare and Medicaid Services (CMS) informed the Department that a deferral of $3,636,690 in federal funds for the quarter ending December 31, 2004, was being made to the Medicaid grant for federal fiscal year 2005. This means the funds drawn for that quarter could not be claimed, pending a determination of allowability. In addition, the following quarter expenditures would have to be reduced by the same amount. CMS also directed the Department not to draw any funds for emergency services for undocumented aliens from the annual grant until the federal government reviewed the expenditures being claimed by the Department. We were informed by the Office of Inspector General that a federal audit of expenditures related to the Alien Emergency Medical program would be conducted sometime in the near future.

Description of Condition

In our audit of state fiscal year 2005 we found:

- We could not confirm the Department's representations that all expenditures for undocumented aliens were deferred in the second quarter of federal fiscal year 2005 as required by the federal government. Since we could not confirm the deferral and since no changes had been made in the Department's procedures in this area we have no reasonable assurance that the deferral occurred in subsequent quarters as well.

- The Department conceded it was not deferring expenditures related to labor and delivery, as they believed that these expenditures were for emergent care. However, in our review of Alien Emergency Medical in another part of our audit, we found, even though a client may have a diagnosis of labor and delivery, the procedures for which the claims were paid included

treatments for dental care, eye exams and other non-emergent procedures. We also found what the Department termed "labor and delivery" was actually pregnancy-related expenditures, which often include prenatal and postpartum procedures, which do not conform to the federal definition of emergent.

- The state continues to misrepresent expenditures reported on the claim form when it reports no expenditures for undocumented aliens when, in fact, it is drawing funds for pregnancy-related expenditures paid on behalf of undocumented aliens. These unallowable expenditures that should be deferred are being commingled with other expenditures and reported on lines reserved for clients that have been deemed eligible for the Medicaid program.

Cause of Condition

The Department has no coding in its accounting records to differentiate emergency services from non-emergency services for undocumented aliens. All of these services are included in one accounting category.

The Department believes that all pregnancy-related expenditures qualify as emergent conditions and thus are exempt from deferral. The Department's decision to isolate these expenditures and not defer them as instructed by CMS was solely the Department's. We are not aware of any exemption granted by the federal government.

Effect of Condition

The state may have to repay the federal portion of those expenditures that should have been deferred but were not. The estimated liability to the state ranges from $9,088,295 to $10,704,756 for the second federal fiscal quarter and for each subsequent quarter that deferred expenditures were drawn. Estimated liability for state fiscal year 2005 is $18,176,590 to $21,409,511. As the state continues to draw these funds the liability increases on a quarterly basis. Estimated liability to the state as of September 30, 2005, was approximately $27,264,885 to $32,114,267.

Recommendation

We recommend the Department:

- Develop account coding that would differentiate emergency from non-emergency services for undocumented aliens and report the proper allowable amount on the correct line of the CMS-64 claim form.

- Not draw funds for emergency services for undocumented aliens from the Medicaid award until instructed to do so by the federal government.

- Work with the U.S. Department of Health and Human services to determine if any un-deferred costs charged to Medicaid must be returned.

Department's Response

The Department does not concur with this finding for the reasons outline below:

- *The Department's Office of Accounting Services (OAS) has deferred all AEM expenditures effective October 1, 2004 as required by the Centers for Medicare and Medicaid Services (CMS) in a letter dated May 6, 2004. This deferral requires that the state does not draw down federal matching funds for AEM expenditures, except for labor and delivery. The deferral is shown strictly in the state's accounting system, Agency Financial Reporting System (AFRS), since all payments from the Medicaid Management Information System (MMIS) will continue to show*

federal match. At the end of each quarter, which coincides with the CMS64 reporting cycle, the OAS prepares an accounting entry in AFRS so that all AEM expenditures are funded with state funds only. This process recognizes that AFRS is the state's official accounting and reporting system and the MMIS is only a payment system.

- *The Department received written clarification from a CMS official, John Lynch's e-mail dated November 17, 2005, which affirms that labor and delivery charges are excluded from the deferral and have shared this with the State Auditor's Office (SAO). Additionally, this information was shared with the SAO in an e-mail from Susan Lucas on December 15, 2005. Therefore, the Department does not believe that the federal match of approximately $35.0 million per fiscal year is inappropriate. (These email documents are available from DSHS.)*

- *As a result of prior audits, the Department has improved its reporting and monitoring of this program. These changes include establishing necessary account coding so that these expenditures can be properly report on the CMS64; update and clarify the Department's policy on AEM that focus on emergent conditions; and obtain a thorough understanding of the MMIS data as it relates to this program so as to ensure that others would not misinterpret the data. Currently, the Department differentiates emergent vs. non-emergent services through its policy as well as the use of both diagnosis and procedures codes and quarterly review of the AEM expenditures.*

Finally, the Department has received notification of the Office of Inspector's General audit for this program, which will begin on March 1, 2006. We look forward to this audit as it will provide needed clarifications and guidance on the allowability of AEM expenditures.

Auditor's Concluding Remarks

- The Department interprets the instructions issued by the Center for Medicare and Medicaid as a requirement "that the state does not draw down federal matching funds for AEM expenditures, except for labor and delivery". We believe that the letter dated May 6, 2004, is plainly worded:

  > You are advised not to draw funds for emergency services for undocumented aliens from this award because CMS will not provide funding for these expenditures nor approve reimbursement for these claims via the CMS-64 Quarterly Statement of Expenditures Report process until final resolution of this issue.

  Resolution of this issue did not occur in our audit period and to this date remains pending.

- The Department states that an email from the Center for Medicare and Medicaid dated November 17, 2005, provides further clarification and affirms its position "that labor and delivery charges are excluded from the deferral" and that they have shared this with the State Auditor's Office. While the Department's interpretation of the content was shared with us the actual email was first seen with this response.

  Reading beyond the first sentence the email reiterates our position. Specifically,

  - Diagnostic and procedures codes must be present to determine the allowability of the transaction for the Alien Emergency Medical program.

  - In the Department's records there are expenditures under the diagnosis of labor and delivery, which are not allowable.

In that email, CMS stated:

> The problem in looking at the accounting codes for the $30 million . . . as Emergency Services for undocumented aliens is that it obviously does not identify the diagnosis/procedure codes for them. In fact in reviewing the acct codes . . . some costs for example EPSDT Screening **(Early and Periodic Screening, Diagnostic, and Treatment, added for clarification)** are listed . . . Obviously these costs are not 'ER for undoc aliens' or Labor & Delivery and should not be reported on the CMS 64 or CMS 21. Also there is Dental-Adult in the amount of $286,089 TC and Dental-Children amount of $40,686 under Subprogram 1277 which are also not Labor & Delivery.

CMS concluded as follows:

> Therefore the State should not claim the $30 million Total Computable this quarter (7/1-9/30/05) and send us a CD in Microsoft Access for the detail of these claims/costs for the $30 million TC with the name/client identifier, service date, paid date, diagnosis code, CPT 4 code, ICD 9, etc. (description of service rendered), and if at all possible the subobject code for example M412 Prescription Drugs FP, M510 Dental Adults for each claim. Then we will review the claims and determine which amounts are Labor & Delivery, which can be reclaimed next quarter.

We do not know if the instructions given by CMS in this email were followed.

- The Department states it "differentiates emergent vs. non-emergent services through its policy as well as the use of both diagnosis and procedures codes and quarterly review of the AEM expenditures". We do not know how the Department would be able to do this. Our testing showed that diagnosis and or procedures codes were not always present. We found expenditures with:

Diagnosis codes without procedure codes	$44,571,491.47
No diagnosis or procedure codes	$ 3,326,866.47
Procedure codes without diagnosis codes	$ 1,648,451.61
Prescriptions with no diagnosis codes	$ 3,167,288.51
Total	$52,714,088.06

Thus, 60 percent of the expenditures tested either had no diagnosis codes or no procedure codes or in some cases neither was present.

We also found that the Department has no way of determining which transactions are emergent vs. non-emergent for Alien Emergency Medical. Our testing showed that at the end of each quarter the Department downloaded all transactions related to undocumented aliens and transferred these expenditures to an account code designated as Alien Emergency Medical without regard to whether or not the transaction met the definition of emergent. The Department stated that they did not have the time or the expertise to review diagnosis or procedure codes and felt that diagnosis and procedure codes were not necessary in order to pay the claim or to call the transactions emergent.

We reaffirm our finding and our recommendation that the Department needs to develop account coding that would differentiate emergency from non-emergency services for undocumented aliens, report the proper allowable amount on the correct line of the CMS-64 claim form and not draw funds for emergency services for undocumented aliens from the Medicaid award until instructed to do so by the federal government.

Applicable Laws and Regulations

The state of Washington's Office of Financial Management's *State Administrative and Accounting Manual,* Section 50.30.45.2, describes the reporting responsibilities of state agencies that administer or expend federal awards:

> Identify, account for, and report all expenditures of federal awards in accordance with laws, regulations, contract and grant agreements, and requirements included in this and other sections of the OFM *State Administrative and Accounting Manual***.**

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A State must expend and account for grant funds in accordance with State laws and procedures for expending and accounting for its own funds.

Title 42, Code of Federal Regulations, Section 430.30(c), states:

> Expenditure reports (1) The State must submit Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) to the central office (with a copy to the regional office) not later than 30 days after the end of each quarter. (2) This report is the State's accounting of actual recorded expenditures. The disposition of Federal funds may not be reported on the basis of estimates.

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

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

Schedule of Audit Findings

State of Washington
Medicaid

M05-10 The Department of Social and Health Services, Health and Recovery Services Administration (formerly Medical Assistance Administration), has not established sufficient internal controls to support its decisions on eligibility of clients enrolled in Medicaid's Basic Health Plus Program.

Background

Among Medicaid enrollees are children of parents and guardians who participate or who have participated in the state's Basic Health Plan. The Basic Health Plan is designed to provide affordable health insurance to any eligible Washington resident and is administered by the Washington State Health Care Authority. An application for the Basic Health Plan by a parent may also be used as a joint application for Basic Health Plus Program for any child in the household. Children of Basic Health Plan members whose family income meets the net income standards for Basic Health Plus may be eligible for Medicaid benefits. The Health Care Authority provides the insurance coverage under Basic Health Plus, while the Health and Recovery Services Administration (formerly Medical Assistance Administration) pays the premiums.

Federal auditing guidelines require us to follow up on previous years' audit findings to determine if they have been resolved. In our audits of state fiscal years 2001, 2002 and 2003, we reported findings related to weaknesses in the internal control structure in the Administration's management of the Basic Health Plus Program.

- For 2001, we found multiple weaknesses in the internal controls over determining client eligibility. We reviewed 60 client files and found 27 clients (47 percent) exceeded the net income standard for Medicaid eligibility and were not entitled to benefits.

- For 2002, we found that the Administration was restructuring controls and training staff. However, most of the corrective actions did not occur before fiscal year 2002 had ended and the internal control weaknesses that were found in 2001 continued in 2002.

- For 2003, we again reviewed the actions taken by the Administration and found it had made some significant improvements. However, most of the corrective actions did not occur before fiscal year 2003 ended. We also found weaknesses that the Administration had not yet addressed. These included:

    1. For self-employed households, income information was not confirmed with an independent source such as tax returns from the state's Department of Revenue or the Internal Revenue Service. The Department continued to accept self-declarations of income. We reviewed five self-employed clients and found all five were either ineligible for benefits or the Administration could not provide the documentation to substantiate their initial eligibility.

    2. We reviewed five wage-earning clients, as well, and found similar results for three out of the five.

3. The Administration could not provide evidence of procedures that ensured clients were reporting income changes immediately.

4. Administration staff had not achieved its quotas for eligibility reviews.

5. The Administration was not using monthly reports from the Authority informing them of the subscribers who were disenrolled due to noncompliance with the Health Care Authority's recertification process.

- For 2004, the audit liaison systems that the Health Care Authority and the Medical Assistance Administration set up prevented us from obtaining the information and conducting the procedures necessary to complete our audit according to *Generally Accepted Auditing Standards* and in compliance with federal auditing regulations. Due to an agency-imposed scope limitation, we disclaimed an opinion on compliance related to allowable costs and eligibility of Medicaid clients under the Basic Health Plus program.

Description of Condition

In our follow up work for our current audit, we saw some improvement. The Department is no longer accepting declaration of income for its wage-earner clients. However, the Department is not determining if adults other than head-of-household are employed. No improvements have been made for self-employed clients. The Department is not verifying the income of these individuals with an independent source. We found, in most cases, it accepts the client's declaration of income and the Department makes no efforts to determine if the spouse in the household is employed.

For our audit, we selected a valid sample of the 306 clients. We found exceptions for 300 (98 percent) as follows:

- 58 clients in the sample were self-employed. For 56 of these clients, the Department did not have sufficient income documentation to support its determination of eligibility.

- 188 clients in the sample were wage earners. For 184 of these clients, the Department did not have sufficient income documentation to support its determination of eligibility.

- For 60 clients, (20 percent) documentation in the Administration's files was insufficient to determine if these clients were self-employed or wage earners.

For these clients, we also found:

- 27 clients (9 percent) had no applications or incomplete applications on file.

- 13 clients (4 percent) had applications but they were unsigned.

- 10 clients (3 percent) were listed in the Administration's systems but it could provide no documentation on these clients.

- Three clients (1 percent) could not be found in any of the Department's systems other than the payment for their premiums. These are highly susceptible for fraud.

Our computer analysis also revealed clients with family incomes over $75,000 and with less than nine recipients in the household, the threshold for this income level. We found 52 clients with incomes ranging from approximately $75,000 to $140,000. The Department's records reported these households as having eight or less recipients in the family. For these households we found:

- 25 families (48 percent) were at one time enrolled in Basic Health Plus and now are no longer enrolled.

- 25 families (48 percent) were actively enrolled in the program.

- One family (2 percent) would become eligible once a certain amount of medical liability was incurred.

- One family (2 percent) was denied coverage.

Cause of Condition

- The Department reported that it does not verify income from third-party sources such as the Internal Revenue Service, the Department of Revenue and the Employment Security Department because it does not believe the information is accurate for its purposes. The Department believes a client's declaration of income is more up-to-date and thus sufficient.

- The Department reported it does not use the alerts sent by Health Care Authority, informing it of subscribers who have surpassed the income standard for Basic Health and who are disenrolled, because they do not consider these reports to serve any useful function. The Department believes a parent's disenrollment from Basic Health does not affect the child's eligibility for Basic Health Plus.

Effect of Condition

The Department is not complying with federal requirements to verify income with independent sources to ensure that individuals meet the financial and categorical requirements for Medicaid. This noncompliance has resulted in $29,206,364 in actual and projected questioned costs.

Recommendation

We recommend the Department:

- Establish and follow policies and procedures that require staff to corroborate the client's representations and to exercise a level of judgment, care, prudence, determination and activity that a person would reasonably be expected to do when determining eligibility.

- Work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid federal funds must be reimbursed as a result of this noncompliance.

Department's Response

The Department disagrees with this finding. Specific responses to the items under "cause of condition" are listed below.

1. *The auditor states that the Department does not verify income from third party sources. This statement is not accurate. The Department does review the income that is reported on the application/eligibility review provided by the client and follows instructions per agency policy, which requires that workers use any one of the several sources to verify income. These sources include other federal and state agencies' data.*

2. *The auditor reports that families with incomes over $75,000 were actively enrolled in the Basic Health plus program. We disagree with this finding. The Department follows the income methodology set forth in the Washington Administrative Code, A-Z Manual and federal regulations. The auditor has not shared with the Department the eligibility timeframes reviewed,*

or the methods it employed to calculate income. It is the Department's belief that the income amounts asserted by the auditors are incorrect and overstated. The Department assumes the State Auditor's Office (SAO) took an entire year or more from Employment Security Division, which overlapped claims paid, but the Department only looks at prospective income at the time of application or eligibility review. The SAO provided no dates for the period of time they pulled income data.

3. *The auditor states that the Department does not use alerts received from the Health Care Authority (HCA) on subscribers who are disenrolled because the subscriber has surpassed the income standard. As stated in the SFY03 audit response, the HCA does send individual Basic Health member change notices and those notices are acted upon in accordance with existing Medicaid policies regarding changes in household circumstances. Please note that changes in income do not affect a child's eligibility due to the Department's policy of continuous eligibility for up to 12 months.*

4. *The Department partially disagrees with the finding related to applications that are not fully documented. For applications that have unverified social security numbers, where there is no client ID in the system and for some of the incomplete or missing applications, Medical Eligibility Determination Section staff were able to verify the necessary information. Documentation was delivered to the auditor on January 10, 2006 & January 23, 2006, but may have been delivered too late to be included in the audit report.*

5. *For applications that are older than 1998, the application document has been purged from the State's files. We understand the SAO wants to see signed Medicaid applications that cover the period of time claims were paid for these clients, but since this audit review period is for SFY05 (7/04 – 6/05) we note that each of these cases has a current and signed eligibility review that identifies the reported household circumstances from which the current Medicaid eligibility (if the case is still open) was determined.*

Auditor's Concluding Remarks

The Department states it verifies income that is reported on the application/eligibility review provided by the client. We found that, for wage-earners, the Department makes no attempt to ensure all income in the household is reported and verified when individuals apply for Basic Health Plus. For self-employed clients, the Department accepts the client's declaration of income and does not independently verify whether it is correct or whether other adults in the household have income.

When the Department does verify the income of applicants and clients, as in the case of wage earners, we found it only uses a single source, usually pay stubs. By not looking for additional resources through the Employment Security Department, Social Security Administration, Internal Revenue Service and Support Enforcement Agency, or other possible sources of income, the Department may not be aware of an applicant's total income. With the exception of the Internal Revenue Service, the Department's system is interfaced with these other sources of information and thus easily accessed by staff.

We provided the Department with a list of 25 active clients of the Basic Health Plus program whose household income was above $75,000. On January 13, 2006, we provided the Department information we obtained from the Medicaid Management Information System, Health Care Authority and Employment Security Department for these clients. We provided the Department with the dates the information was gathered, the period tested and which month we reviewed in their eligibility system. The Department provided no response to any of this information.

We provided the Department a list of 300 instances in which we questioned eligibility. The Department responded on January 9, 2006, with explanations of why they believed a client was eligible. However, the Department did not provide the State Auditor's Office with evidence to substantiate their assertions. On January 23, 2006, the Department provided us with information on 35 of these individuals. We found documentation proving the eligibility of one of these clients, on whose behalf $1,200 was paid.

The Code of Federal Regulations states that a signed application must be on file for all clients eligible for Medicaid. The Department states that, for applications older than 1998, the document has been purged but eligibility reviews are on file. An eligibility review does not replace an application and does not indicate that the client was eligible at the time of application.

The Department stated that changes in income do not affect a child's eligibility due to the Department's policy of continuous eligibility for up to 12 months. The provision for continuous eligibility for children on Medicaid was an amendment to the state supplemental budget that took effect in April 2005. This condition was not applicable for most of the period under audit, which ended June 30, 2005. However, continuous eligibility is contrary to current federal regulations which state:

> The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility. 42 CFR435.916(c)

Additionally, when state laws and regulations conflict with federal regulations, the Revised Code of Washington 43.20A.550 stipulates that state laws are deemed inoperative:

> . . . Any section or provision of law dealing with the department, which may be susceptible to more than one construction, shall be interpreted in favor of the construction most likely to comply with federal laws entitling this state to receive federal funds for the various programs of the department. If any law dealing with the department is ruled to be in conflict with federal requirements, which are a prescribed condition of the allocation of federal funds to the state, or to any departments or agencies thereof, such conflicting part of chapter 18, Laws of 1970 ex.sess is declared to be inoperative solely to the extent of the conflict.

We reaffirm our finding and our recommendation that the Department establish and follow policies and procedures that ensure the eligibility of clients.

Applicable Laws and Regulations

Title 45, Code of Federal Regulations, Section 92.20(a), states:

> A state must expend and account for grant funds in accordance with state laws and procedures for expending and accounting for its own funds.

Revised Code of Washington 43.88.160(4), states:

> . . . the director of financial management, as agent of the governor, shall:
>
> Develop and maintain a system of internal controls and internal audits comprising methods and procedures to be adopted by each Department that will safeguard its assets, check the accuracy and reliability of its accounting data, promote operational efficiency and encourage adherence to prescribed managerial policies for accounting and financial controls.

The state of Washington Office of Financial Management's *State Administrative and Accounting Manual* addresses basic principles of internal control in Section 20.20.20.a. as follows:

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

The U.S. Office of Management and Budget Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments*, Attachment A, Section C(1)(d), provides that costs are allowable under federal awards if they meet the following criteria:

> 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.

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

> . . . The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

As it pertains to requesting information for the determination of eligibility, Title 42, Code of Federal Regulation, Section 435.948, states in part:

> (a) . . . the agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request -
>
> > State wage information maintained by the SWICA (State Wage Information Collection Agency) during the application period and at least on a quarterly basis. Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA and available under Section 6103(1)(7)(A) of the Internal Revenue Code of 1954 for applicants during the application period and for recipients for whom the information has not previously been requested.
> >
> > Information about benefit and other eligibility related information available from SSA under Titles II and XVI of the Social Security Act for applicants during the application period and for recipients for whom the information has not previously been requested;
> >
> > Unearned income information from the Internal Revenue Service available under Section 6103(l)(7)(B) of the Internal Revenue Code of 1954, during the application period and at least yearly;
> >
> > Unemployment compensation information maintained by the agency administering State unemployment compensation laws (under the provisions of section 3304 of the Internal Revenue Code and section 303 of the Act) as follows:
> >
> > > For an applicant, during the application period and at least for each of the three subsequent months;
> > >
> > > For a recipient that reports a loss of employment, at the time the recipient reports that loss and for at least each of the three subsequent months.
> > >
> > > For an applicant or a recipient who is found to be receiving unemployment compensation benefits, at least for each month until the benefits are reported to be exhausted.
>
> Any additional income, resource or eligibility information relevant to determinations concerning eligibility or correct amount of medical assistance

payments available from agencies in the State or other States administering the following programs as provided in the agency's State plan:

AFDC;
Medicaid;
State-administered supplementary payment programs under Section 1616(a) of the Act;

SWICA;
Unemployment compensation;

Food stamps; and Any State program administered under a plan approved under Title I (assistance to the aged), X (aid to the blind), XIV (aid to the permanently and totally disabled), or XVI (aid to the aged, blind, and disabled in Puerto Rico, Guam, and the Virgin Islands) of the Act.

(b) The agency must request information on applicants from the sources listed in paragraph (a)(1) through (a)(5) of this section at the first opportunity provided by these sources following the receipt of the application. If an applicant cannot provide an SSN at application, the agency must request the information at the next available opportunity after receiving the SSN.

(c) The agency must request the information required in paragraph of this section by SSN, using each SSN furnished by the individual or received through verification

(d) Exception: In cases where the individual is institutionalized, the agency needs to obtain and use information from SWICA only during the application period and on a yearly basis, and from unemployment compensation agencies only during the application period . . .

(e) Exception: Alternate sources.

(1) The Secretary may, upon application from a State agency, permit an agency to request and use income information from a source or sources alternative to those listed in paragraph (a) of this section. The agency must demonstrate to the Secretary that the alternative source(s) is as timely, complete and useful for verifying eligibility and benefit amounts. The Secretary will consult with the Secretary of Agriculture and the Secretary of Labor before determining whether an agency may use an alternate source.

(2) The agency must continue to meet the requirements of this section unless the Secretary has approved the request.

(f) Exception: If . . . SSA determines the eligibility of an applicant or recipient, the requirements of this section do not apply to that applicant or recipient.

The March 2003, U.S. Office of Management and Budget A-133 Compliance Supplement, Section E(1)(b)(2), pages 4-93.778-12 and 4-93.778-13, states the following as it pertains to income verifications for eligibility determination:

There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the state or its designee shall:

(2) Use the income and eligibility verification system (IVES) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration, and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States may also: (1) target the items of information for each data source that are most likely; to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verity the eligibility of all recipients; (2) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and

(3) can exclude unemployment compensation information from the Internal Revenue Service or earning information from Social Security Administration (SSA) that duplicates information received from another source.

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

The auditee shall:

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

The 2005 A-133 compliance supplement sets forth the following with respect to eligibility for individuals for the Medicaid program:

a. The State Medicaid agency or its designee is required to determine client eligibility in accordance with eligibility requirements defined in the approved State plan (42 CFR section 431.10).

b. There are specific requirements that must be followed to ensure that individuals meet the financial and categorical requirements for Medicaid. These include that the State or its designee shall:

(1) Require a written application signed under penalty of perjury and include in each applicant's case records facts to support the agency's decision on the application (42 USC 1320b-7(d); 42 CFR sections 435.907 and 435.913).

(2) Use the income and eligibility verification system (IEVS) to verify eligibility using wage information available from such sources as the agencies administering State unemployment compensation laws, Social Security Administration (SSA), and the Internal Revenue Service to verify income eligibility and the amount of eligible benefits. With approval from HHS, States may use alternative sources for income information. States also: (a) may target the items of information for each data source that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments, and a State is not required to use such information to verify the eligibility of all recipients; (b) with reasonable justification, may exclude categories of information when follow-up is not cost effective; and (c) can exclude unemployment compensation information from the Internal Revenue Service or earnings information from SSA that duplicates information received from another source (42 USC 1320b-7(a); 42 CFR sections 435.948(e) and 435.953).

(3) Require, as a condition of eligibility, that each individual (including children) requesting Medicaid services furnish his or her social security account numbers (SSN) and the

State shall utilize the SSN in the administration of the program. The State shall not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA. If the applicant cannot recall the SSN or has not been issued a SSN, the agency must assist the applicant in completing an application for an SSN and either send the application to SSA or, if there is evidence that the applicant has been previously issued a SSN, request SSA to furnish the number. A State may give a Medicaid identification number to an applicant who, because of well-established religious objections, refuses to obtain a SSN. In redetermining eligibility, if the case record does not contain the required SSN, the agency must require the recipient to furnish the SSN (42 CFR section 435.920(b)) (42 USC 1320b-7(a)(1); 42 CFR sections 435.910 and 920).

(4) Verify each SSN of each applicant and recipient with SSA to insure that each SSN furnished was issued to that individual and to determine whether any others were issued (42 CFR sections 435.910(g) and 42 CFR 435.920).

(5) Document qualified alien status if the applicant or recipient is not a U.S. citizen (42 USC 1320b-7d).

(6) Redetermine the eligibility of Medicaid recipients with respect to circumstances that may change (e.g., income eligibility), at least every 12 months. The agency may consider blindness and disability as continuing until the review physician or review team determines that the recipient's blindness or disability no longer meets the definition contained in the plan. There must be procedures designed to ensure that recipients make timely and accurate reports of any changes in circumstances that may affect their eligibility. The State must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his or her eligibility (42 CFR section 435.916).

c. Qualified aliens, as defined at 8 USC 1641, who entered the United States on or after August 22, 1996, are not eligible for Medicaid for a period of five years, beginning on the date the alien became a qualified alien, unless the alien is exempt from this five-year bar under the terms of 8 USC 1613. State must provide Medicaid to certain qualified aliens in accordance with the terms of 8 USC 1612(b)(2), provided that they meet all other eligibility requirements. States may provide Medicaid to all other otherwise eligible qualified aliens who are not barred from coverage under 8 USC 1613 (the five-year bar). All aliens who otherwise meet the Medicaid eligibility requirements are eligible for treatment of an emergency medical condition under Medicaid, as defined in 8 USC 1611(b)(1)(A), regardless of immigration status or date of entry.