

Office of the Secretary of State

Kate Brown
Secretary of State

Brian Shipley
Deputy Secretary of State



Audits Division

Gary Blackmer
Director

255 Capitol St. NE, Suite 500
Salem, OR 97310

(503) 986-2255
fax (503) 378-6767

March 12, 2013

Dr. Bruce Goldberg, Director
Oregon Health Authority
500 Summer Street NE
Salem, Oregon 97301-1097

Erinn Kelley-Siel, Director
Department of Human Services
500 Summer Street NE
Salem, Oregon 97301-1097

Dear Dr. Goldberg and Ms. Kelley-Siel:

We have completed audit work of the Medicaid federal program at the Department of Human Services (department) and the Oregon Health Authority (authority) for the year ended June 30, 2012.

This audit work was not a comprehensive audit of the Medicaid program. We performed this audit work as part of our annual statewide single audit. The audit work performed allowed us, in part, to achieve the following objectives: (1) determine whether the department and the authority have complied with laws, regulations, contracts or grants that could have a direct and material effect on the Medicaid program and (2) determine whether the department and the authority have effective internal controls over compliance with the laws, regulations, contracts and grants applicable to the Medicaid program. We audited the Medicaid federal program to determine whether the department and the authority substantially complied with the relevant federal requirements.

<u>CFDA Number</u>	<u>Program Name</u>	<u>Audit Amount</u>
93.777, 93.778	Medicaid Cluster	\$ 3,023,216,000
93.720, 93.777, 93.778	Medicaid Cluster (ARRA)	52,152,236

In planning and performing our audit, we considered the department and authority's internal control over compliance with requirements that could have a direct and material effect on the Medicaid program to determine the auditing procedures for the purpose of expressing our opinion on the department and authority's compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the department and authority's 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 with a type of compliance requirement of the federal program on a timely basis. A material weakness in internal control over compliance is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the paragraph above and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, we identified certain deficiencies in internal control over compliance that we consider to be significant deficiencies. A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Significant Deficiencies

Required Provider Screening Not Documented

Program Title and CFDA Number:	Medicaid Cluster (93.720; 93.777; 93.778)
Federal Award Number and Year:	05-1205OR5MAP; 2012, 0512OR5ADM; 2012, 05-1105OR5MAP; 2011, 05-1105OR5ADM; 2011
Compliance Requirement:	Special Tests and Provisions; Provider Eligibility
Type of Finding:	Significant Deficiency, Non-Compliance
Questioned Costs:	\$0

In March 2011, the Affordable Care Act went into effect requiring all new providers and providers reactivating after a break in service be subject to screening. As a result, the Department of Human Services (department) and the Oregon Health Authority (authority) both perform initial verification screening by ensuring providers are not listed in any of the following four federal databases: the Social Security Administration's Death Master File (DMF), the National Plan and Provider Enumeration System (NPPES); the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). In addition, the department and the authority must review LEIE and EPLS at least monthly to ensure no enrolled providers are listed.

During our review, we found that both the department and the authority did not maintain adequate documentation of their provider screenings. Authority management stated all required database checks were occurring; however, documentation of those checks was not

maintained and the authority was unable to provide other documentation demonstrating its compliance with the required screening. The department has written procedures in place to ensure the required database checks occur and requires documentation of the checks be maintained. During our testing, we identified nine new providers that were subject to the initial database checks; the department was unable to provide documentation showing they checked the EPLS database prior to enrolling the provider. Providers not screened in accordance with the Act could be ineligible for Medicaid funds, which would require the department and authority to repay the federal agency for those funds.

We recommend that authority management maintain evidence of the initial and monthly database checks for enrolled providers and we recommend department management maintain evidence of the initial EPLS database checks.

Provider Eligibility Documentation Not Maintained

Program Title and CFDA Number:	Medicaid Cluster (93.720; 93.777; 93.778)
Federal Award Number and Year:	05-1205OR5MAP; 2012, 0512OR5ADM; 2012, 05-1105OR5MAP; 2011, 05-1105OR5ADM; 2011
Compliance Requirement:	Special Tests and Provisions; Provider Eligibility
Type of Finding:	Significant Deficiency, Non-Compliance
Questioned Costs:	\$41,554

As part of the Medicaid cluster, states may obtain a waiver to provide home and community-based care to eligible individuals. Under this waiver, the Department of Human Services (department) has created the Client-Employed Provider (CEP) Program, which provides eligible individuals with hourly or live-in services supplied by homecare workers. For a provider to be eligible to enroll in the CEP Program, the provider must meet certain requirements, including submitting a CEP Program application, signing a provider enrollment agreement, completing the criminal records check process, providing proof of right to work in the United States (form I-9) and attending a mandatory orientation.

We found the department could improve its documentation supporting provider eligibility. Specifically, we found the following.

- The department could not locate a CEP Program application for one provider.
- The department could not locate the file for one provider, resulting in \$13,761 in questioned costs.
- One provider file did not include documentation of a signed provider enrollment agreement or of attending the mandatory orientation, resulting in \$10,752 in questioned costs.
- The department could not provide documentation of the right to work for one provider, resulting in \$4,743 in questioned costs.
- The department was unable to provide documentation of both form I-9 and a completed criminal records check for one provider, resulting in \$12,298 in questioned costs.

We recommend that department management strengthen controls to ensure that all documentation to support a provider's eligibility determination is retained and verify that providers with missing documentation are eligible to provide services.

Procedures are Needed for Nursing Facility Audits

Program Title and CFDA Number:	Medicaid Cluster (93.720; 93.777; 93.778)
Federal Award Number and Year:	05-1205OR5MAP; 2012, 0512OR5ADM; 2012, 05-1105OR5MAP; 2011, 05-1105OR5ADM; 2011
Compliance Requirement:	Special Tests and Provisions; Inpatient Hospital and Long-Term Care Facility Audits
Type of Finding:	Significant Deficiency, Non-Compliance
Questioned Costs:	\$0

Federal regulations require the Department of Human Services (department) to perform periodic audits of nursing facilities receiving Medicaid funds, with specific audit requirements outlined in Oregon's Medicaid State Plan. The purpose of these audits is to ensure nursing facilities are paid at reasonable rates to cover costs incurred by efficiently and economically operated facilities. According to the State Plan, the department meets this requirement by performing annual reviews on a sample of nursing facility financial statements. Based on the reviews performed in the first year of the biennium, the department determines the biennial payment rate for nursing facilities.

We found that the department could improve procedures and documentation of its nursing facility audits. We met with department staff responsible for reviewing the financial statements to determine the specific procedures the department follows and found the following.

- The department was unable to provide us with a sampling plan for the reviews or a list of the actual reviews completed during the fiscal year.
- The department could not provide complete and updated procedures for performing the reviews.
- Because the period under audit was not a rate setting year, none of the completed reviews were subject to management review.
- We were provided with conflicting information regarding what facilities were reviewed, how many facilities were reviewed, and what the procedures were for review.

Due to these issues, we were unable to determine if the department completed the nursing facility reviews in compliance with department procedures and federal requirements.

We recommend that department management document the procedures for completing the annual reviews of nursing facilities and establish controls to ensure reviews are completed in accordance with these procedures.

ARRA Award Inappropriately Charged

Program Title and CFDA Number: Medicaid Cluster (93.720; 93.777; 93.778)
Federal Award Number and Year: 05-1105OREXTN; 2011, 05-1105ORARRA; 2011
Compliance Requirement: Allowable Costs
Type of Finding: Significant Deficiency, Non-Compliance
Questioned Costs: \$1,432,583

As a part of the American Recovery and Reinvestment Act (ARRA) the department was able to draw down federal funds at an enhanced federal financial participation rate through June 30, 2011. At June 30, 2011 the ARRA award ended for new expenditures but remained open so that the department could process any necessary adjustments.

Our testing of a sample of accounting transactions found that nine transactions were charged to account coding that caused each of the transactions to be charged partially to the ARRA grant. These errors resulted in the department inappropriately drawing down \$1,432,583 in ARRA funding.

We recommend department management implement procedures to ensure the department uses the federal financial participation rate in effect at the time a transaction is recorded and reimburses the federal agency for the overdrawn ARRA funds.

Periodic Reviews of MMIS Edits are Needed

Program Title and CFDA Number: Medicaid Cluster (93.720; 93.777; 93.778)
Federal Award Number and Year: 05-1205OR5MAP; 2012, 0512OR5ADM; 2012, 05-1105OR5MAP; 2011, 05-1105OR5ADM; 2011, 05-1105OREXTN; 2011, 05-11ORARRA; 2011
Compliance Requirement: Activities Allowed/Unallowed; Allowable Costs; Eligibility; Special Tests and Provisions, Provider Eligibility
Type of Finding: Significant Deficiency
Questioned Costs: \$0

The Medicaid Management Information System (MMIS) processes the majority of the State's Medicaid payments. To ensure payments from the MMIS are made in accordance with state and federal regulations, the Oregon Health Authority (authority) has programmed edits into the system to prevent improper payments.

As part of our testing of the Medicaid Cluster, we selected several key edits within the MMIS to verify they were operating as intended. We found certain edits related to age and gender were not functioning as intended, allowing claims totaling over \$500,000 to be paid that should have been rejected for additional review. In addition, state policy requires the authority to complete and document periodic reviews of internal controls, such as the edits in the MMIS, to assure

proper operation. We found that the authority completes these reviews only for new edits and not edits currently in operation.

We recommend management implement procedures to periodically test edits in the MMIS. **We also recommend** management review the claims that should have been rejected by these edits to determine their appropriateness.

Medicaid Payments Not Sufficiently Supported

Program Title and CFDA Number:	Medicaid Cluster (93.720, 73.777, 73.778)
Federal Award Numbers and Year:	05-1205OR5MAP; 2012, 0512OR5ADM; 2012, 05-1105OR5MAP; 2011, 05-1105OR5ADM; 2011, 05-1105OREXTN; 2011, 05-11ORARRA; 2011
Compliance Requirement:	Allowable Costs, Eligibility
Type of Finding:	Significant Deficiency, Non-Compliance
Questioned Cost:	\$680

Federal regulations require that the Department of Human Services (department) meet certain requirements to receive Medicaid funding for medical claims. These requirements include requiring a written application for clients, verifying client reported income, and ascertaining the legal liability of third parties (private health insurance).

During our testing, we found the department could improve its documentation supporting Medicaid payments.

- For three clients, the department was unable to provide documentation or explanation to support the Medicaid payment amount. These errors resulted in known questioned costs of \$680 and likely questioned costs that exceed \$10,000.
- For four clients, neither the application nor the department's case file narration included documentation of whether or not the clients had private health insurance. In these instances, the department used an application for a different program that did not require private health insurance information.
- The department could not provide two applications as one had been destroyed due to its age and the other could not be located.

We recommend department management strengthen controls to ensure documentation is maintained in the case files sufficient to demonstrate compliance with federal requirements.

Unapproved Cost Allocation Plan Statistics

Program Title and CFDA Number:	Medicaid Cluster (93.720, 73.777, 73.778); SNAP Cluster (10.551, 10.561); Temporary Assistance for Needy Families Cluster (93.558, 93.714); Foster Care_Title IV-E (93.658); State Planning and Establishment Grants for the Affordable Care Act (ACA)'s Exchanges (CFDA 93.525)
Federal Award Numbers and Year:	Multiple
Compliance Requirement:	Cost Principles
Type of Finding:	Significant Deficiency; Non-Compliance

The Department of Human Services (department) administers separate federally approved cost allocation plans for both the department and the Oregon Health Authority (authority). The plans outline the allocation methods used to apportion various cost pools to federal programs.

Although federal rules allow for state agencies to make changes to the federally approved plans, the rules require state agencies to promptly notify the federal oversight agency when changes are made that will affect the allocation of costs. At a minimum, state agencies are required to submit an annual statement certifying that their cost allocation plan is not outdated.

While performing testing of the cost allocation process, we identified instances in which the statistics used to allocate costs for June 2012 were not the statistics listed in the applicable federally approved cost allocation plans. According to the department, when changes are made to the plans, the department only communicates those changes to the federal government when subsequent plans are submitted. Currently, the department submits the plans on a biennial basis, but intends to increase the submissions to an annual basis.

Failure to follow the requirements of the federally approved cost allocation plans may result in allocated costs being disallowed by the federal oversight agency.

We recommend the department update the cost allocation plans to reflect current practices and ensure future changes are communicated timely.

Prior Year Findings

In the prior fiscal year, we reported significant deficiencies and non-compliance findings to you in a letter dated March 12, 2012. These findings can also be found in the Statewide Single Audit Report for the fiscal year ended June 30, 2011; see Secretary of State audit report number 2012-08. During fiscal year 2012, the department and the authority made progress in correcting these findings. These findings will be reported in the Statewide Single Audit Report for the fiscal year ended June 30, 2012, with a status of partial corrective action taken. The specific prior year findings still outstanding are listed in the following table:

Federal Compliance Requirement	Finding Title	Prior Year Finding No.
Special Tests and Provisions Eligibility	Automatic Data Process	10-11
Allowable Costs; Eligibility	Incorrect Eligibility Determinations	10-12
Special Tests and Provisions	Medicaid Payments Not Sufficiently Supported	11-15
	Required Disclosures Missing From Provider Agreements	11-17
Cost Principles	Cost Allocation Statistics Incorrectly Calculated	11-19

The significant deficiencies, along with your responses, will be included in our Statewide Single Audit Report for the fiscal year ended June 30, 2012. Including your responses satisfies the federal requirement that management prepare a Corrective Action Plan covering all reported audit findings. Satisfying the federal requirement in this manner, however, can only be accomplished if the responses to each significant deficiency includes the information specified by the federal requirement, and only if the responses are received in time to be included in the audit report. The following information is required for each response:

- 1) Your agreement or disagreement with the finding. If you do not agree with the audit finding or believe corrective action is not required, include in your response an explanation and specific reasons for your position.
- 2) The corrective action planned.
- 3) The anticipated completion date.
- 4) The names of the contact persons responsible for corrective action.

Please respond by March 15, 2013.

This communication is intended solely for the information and use of management, others within the organization, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than the specified parties.

Dr. Bruce Goldberg, Director
Oregon Health Authority
Erinn Kelley-Siel, Director
Department of Human Services
Page 9

We appreciate your staff's assistance and cooperation during this audit. Should you have any questions, please contact Sarah Anderson or me at (503) 986-2255.

Sincerely,
OREGON AUDITS DIVISION

Kelly L. Olson, CPA
Audit Manager

KLO:SAA:nmj

cc: Jim Scherzinger, DHS Chief Operating Officer
Suzanne Hoffman, OHA Chief Operating Officer
Shawn Jacobsen, DHS Interim Controller
Dave Lyda, Chief Audit Executive
Gerold Floyd, Director of Recovery Act Management
Michael J. Jordan, Director, Department of Administrative Services