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Erinn Kelley-Siel, Director  
Department of Human Services  
500 Summer St. NE  
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Dear Ms. Edlund and Ms. Kelley-Siel:

We have completed audit work of the Medicaid federal program at the Department of Human Services (department) and Oregon Health Authority (authority) for the year ended June 30, 2013.

<u>CFDA Number</u>	<u>Program Name</u>	<u>Audit Amount</u>
93.777, 93.778	Medicaid Cluster	\$ 3,481,257,957
93.777, 93.778	Medicaid Cluster (ARRA)	\$ 26,979,195

This audit work was not a comprehensive audit of your federal program. We performed this federal compliance audit as part of our annual Statewide Single Audit. The Single Audit is a very specific and discrete set of tests to determine compliance with federal funding requirements, and does not conclude on general efficiency, effectiveness, or state-specific compliance issues. The Office of Management and Budget (OMB) Circular A-133 identifies internal control and compliance requirements for federal programs. Auditors' review and test internal controls for all federal programs selected for audit and perform specific audit procedures only for those compliance requirements that are direct and material to the federal program under audit. For the year ended June 30, 2013, we determined whether each agency substantially complied with the following compliance requirements relevant to the federal program.

<b>Compliance Requirement</b>	<b>General Summary of Audit Procedures Performed</b>
Activities Allowed or Unallowed	Determined whether federal monies were expended only for allowable activities.
Allowable Costs/Cost Principles	Determined whether charges to federal awards were for allowable costs and that indirect costs were appropriately allocated.
Cash Management	Confirmed program costs were paid for before federal reimbursement was requested, or federal cash drawn was for an immediate need.
Eligibility	Determined whether only eligible individuals and organizations receive assistance under federal programs, and amounts provided were calculated in accordance with program requirements.
Matching, Level of Effort, Earmarking	Determined whether the minimum amount or percentage of contributions or matching funds was provided, the specified service or expenditure levels were maintained, and the minimum or maximum limits for specified purposes or types of participants were met.
Reporting	Verified the agency submitted financial and performance reports to the federal government in accordance with the grant agreement and that those financial reports were supported by the accounting records.
Special Tests and Provisions	Determined whether the agency complied with the additional federal requirements identified by the OMB.

Each agency management is responsible for establishing and maintaining effective internal control over compliance with program requirements. In planning and performing our audit, we considered each agency's internal control over compliance with requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on each agency'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 each agency'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 a 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. *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.

Our consideration of internal control over compliance was for the limited purpose described above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. As discussed below, we identified certain deficiencies in internal control over compliance that we consider to be material weaknesses and significant deficiencies.

#### MMIS Key Edits Should be Periodically Tested

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Allowable Costs / Cost Principles
Type of Finding:	Material Weakness

The Oregon Health Authority (authority) is responsible for managing the Medicaid Management Information System (MMIS), which processed over \$2 billion in Medicaid federally funded claims during fiscal year 2013. To ensure payments from the MMIS are made in accordance with state and federal regulations, MMIS contains numerous edits to prevent improper payments.

Our audit of the Medicaid Cluster for fiscal year 2012 identified that certain edits related to age and gender were not functioning as intended, allowing claims totaling over \$500,000 in fiscal year 2012 to be paid that should have been rejected for additional review to ensure claims were appropriate. Additionally, we found the authority only reviews new MMIS edits and does not perform testing of key system edits currently in operation to ensure they are still functioning as intended.

In response to the prior year finding, the authority requested a change to MMIS to address the age and gender edits that were not functioning. This change was not implemented by the end of fiscal year 2013 and the authority did not perform additional review of the fiscal year 2012 or 2013 claims that should have been rejected to verify those claims were appropriate. According to the authority, although it had developed a plan to address the testing of prior edits in operation, adequate resources were not available and the plan was not fully implemented during fiscal year 2013, as intended. In addition, the plan did not adequately identify and test key system edits.

**We recommend** authority management develop a plan that identifies key MMIS edits and implement procedures to periodically test key system edits to ensure they are functioning as intended. **We also recommend** management review the claims that should have been rejected by the age and gender restriction panel edits to verify those claims are appropriate.

#### ADP Risk Analyses and System Security Review Procedures Need Strengthening

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Special Tests and Provisions; ADP Risk Analyses and Security Reviews
Type of Finding:	Significant Deficiency; Non-compliance

Federal regulation (45 CFR § 95.621) prescribes that states are responsible for the security of all operational Automatic Data Processing (ADP) systems involved in the administration of health and human service programs, including Medicaid. ADP requirements include establishing a security plan, biennially reviewing ADP system security installations involved in program administration, and establishing and maintaining a program for conducting periodic risk analyses, which include performing risk analyses whenever significant system changes occur.

Prior year findings, dating back to fiscal year 2007, indicate that the Oregon Health Authority (authority) has not devoted sufficient resources to fully comply with the federal requirement to perform ADP risk analyses and system security reviews. Inquiries with the authority during fiscal year 2013 revealed the following:

- The authority does not have a documented security plan addressing federally required components. The authority, however, does conduct vulnerability scans of the Medicaid Management Information System (MMIS) software at least every three years with the most recent scan performed in August 2012.
- The authority has not conducted reviews of the ADP system security installation on a biennial basis. The most recent review conducted over the MMIS system was in April

2011. Further, the authority has not conducted any other system security installation reviews of the other systems involved in the administration of the Medicaid program.

- The authority does not have a formalized risk analysis program in place to address all systems involved with the administration of the Medicaid program. The authority obtained a SSAE 16 Type II review of the MMIS from a third party for the audit period, which focused on user access and system security. The authority did not obtain a review of the several additional systems employed to administer the Medicaid program.

Without conducting ADP risk analyses and security reviews in accordance with federal regulations, the authority is less able to determine whether systems administering the Medicaid program are adequately safeguarding program assets and maintaining program integrity.

**We recommend** authority management develop a security plan that addresses all federally required components, develop and implement a formalized risk analysis program, and ensure system security reviews are conducted timely for all applicable systems involved in the administration of the Medicaid program.

#### Medicaid Payments Not Sufficiently Supported

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP 05-1305OR5ADM; 2013
Compliance Requirement:	Eligibility; Allowable Costs / Cost Principles
Type of Finding:	Significant Deficiency; Non-Compliance
Questioned Costs	\$79

Federal regulations require certain conditions be met for the Department of Human Services (department) to receive Medicaid funding for medical claims, including a written and signed application. In addition, for certain clients in community based care, the department calculates a client liability, which is a share of their monthly cost of care.

We tested 79 fiscal year 2013 Medicaid claims and found the following:

- For two clients, the department could not locate and provide applications. Through review of available documentation, we were able to determine that the clients were eligible for Medicaid.
- For one client, the social security benefits documented by the department in the client file and used to calculate the client's liability did not agree to the income per the Social Security Administration. The use of an inaccurate income amount resulted in the client liability being calculated as \$20 per month less than it should have been beginning in January 2013. This error resulted in known questioned costs of \$75.

- For one client, the department incorrectly entered the client's income in the system used to calculate client liability. This keying error resulted in the client's liability being calculated as \$1 per month less than it should have been beginning in January 2013. This error resulted in known questioned costs of \$4.

**We recommend** department management strengthen controls to ensure sufficient documentation is maintained to demonstrate compliance with federal requirements, and ensure the client liability is calculated accurately.

Required Provider Screening Not Documented

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Special Tests and Provisions; Provider Eligibility
Type of Finding:	Significant Deficiency; Non-Compliance

Federal regulations require the Oregon Health Authority (authority) to screen all Medicaid enrolled providers 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).

During our review, we found that 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. Providers not screened in accordance with federal requirements could be ineligible for Medicaid funds, which would require the authority to repay the federal government for any funds the authority awarded to the ineligible providers.

**We recommend** authority management maintain evidence of the initial and renewing database checks for enrolled providers.

Provider Eligibility Documentation Not Maintained

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Special Tests and Provisions; Provider Eligibility
Type of Finding:	Material Weakness; Material Non-Compliance
Questioned Costs:	\$434,435

As part of the Medicaid cluster, provider eligibility requirements differ depending upon the type of services provided; all providers, however, are subject to specified database checks and are required to sign an adherence to federal regulations agreement (agreement). State requirements also include a background check for providers such as homecare workers, personal care providers, and adult foster homes. The Department of Human Services (department) is responsible for determining the eligibility of these Medicaid providers.

We tested 50 providers receiving Medicaid funds during fiscal year 2013 and found the department could improve its documentation supporting provider eligibility. Specifically we found:

- The department could not provide evidence of required database checks for 17 providers. We were able to verify these providers were eligible to provide services.
- For three providers the department could not locate the agreements, resulting in questioned costs of \$15,697.
- For one provider the department could not locate the background check, resulting in \$1,532 in questioned costs.
- For six providers the department could not locate their provider file; therefore, neither an agreement nor evidence of a background check was available, resulting in questioned costs of \$417,206.

**We recommend** department management strengthen controls to ensure all documentation supporting a provider's eligibility determination is retained. For current providers with missing documentation, we recommend the department verify they are eligible to provide services.

Incorrect Federal Medical Assistance Percentage Rate Used

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP 05-1305OR5ADM; 2013
Compliance Requirement:	Matching
Type of Finding:	Significant Deficiency; Non-Compliance
Questioned Costs	\$35,983

The Federal Medical Assistance Percentage (FMAP) rates are used to determine the amount of federal matching funds a state can claim for allowable Medicaid expenditures. These rates are updated yearly by the federal government and are effective October 1. According to federal regulations, the Department of Human Services (department) should use the FMAP rate in effect when the transaction is processed.

For transactions processed by the state’s accounting system, instead of another system such as MMIS, the department creates new transaction coding that should be used by staff to apply the FMAP rate in effect. We tested 43 Medicaid transactions processed by the accounting system. For two transactions processed in October 2012, the department used the coding for the prior FMAP rate, which had not been inactivated. Based on these results, we performed procedures to identify other transactions inappropriately using prior year coding and found two additional transactions. As the FMAP rate decreased in fiscal year 2013 from the prior year, the department incorrectly claimed \$35,983 as federal expenditures for the four transactions. At the time of our inquiry, the department had not identified or corrected these transactions.

**We recommend** department management correct the transactions processed with this incorrect coding. **We also recommend** department management ensure system coding is appropriately updated to allow only current FMAP rates to be used.

Nursing Facility Provider Health and Safety Standard Surveys Not Performed Timely

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Special Tests & Provisions; Provider Health and Safety Standards
Type of Finding:	Significant Deficiency; Non-Compliance

According to federal regulations, the Department of Human Services (department) must conduct surveys of nursing facilities receiving federal monies to determine compliance with applicable federal requirements. The survey should include prescribed health and safety standards and occur at a survey interval of no greater than 15 months.

We reviewed 25 of the 145 nursing facilities receiving federal monies to verify the department performed the surveys and at an interval not exceeding 15 months. For 3 of the 25 facilities,

the surveys were not completed within the 15 month interval, but were two to three months late.

According to the department, the reviews were not completed timely due to limited staffing resources. Without completing surveys in the time frame stipulated by federal regulations, there is an increased risk that Medicaid clients could receive substandard care.

**We recommend** management develop a plan based on current resources to ensure the timely completion of provider health and safety standard surveys for nursing facilities.

Nursing Facility Audit Procedures Should Be Improved

Program Title and CFDA Number:	Medicaid Cluster (93.777, 93.778)
Federal Award Numbers and Year:	05-1205OR5MAP, 05-1205OR5ADM; 2012 05-1305OR5MAP, 05-1305OR5ADM; 2013
Compliance Requirement:	Special Tests and Provisions; Long Term Care Facility Audits
Type of Finding:	Material Weakness; Material Non-Compliance

Federal regulations require the Department of Human Services (department) 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 of a sample of nursing facility financial statements.

We met with department staff responsible for ensuring the annual reviews are performed and found that documented procedures for performing the annual reviews did not exist. The department indicated that the process for fiscal year 2013 included a desk review of all nursing facilities. This review consisted of verifying the financial statements submitted by the nursing facilities were complete. The department then performed a more detailed full review of selected nursing facilities. Full reviews included ensuring adjustments were made to limit or exclude certain expenditures used in calculating the annual payment rate for nursing facilities. Full reviews were subject to supervisory review and approval.

We sampled 25 of 129 nursing facilities to verify the department's process was followed. Our sample consisted of 9 full reviews and 16 desk reviews. Based on our testing, we identified the following:

- For one facility, a full review was not completed as required per the department's methodology. When we reviewed the facility in accordance with the department's process, we found expenditure adjustments were not made.
- For two of the full reviews, it was unclear why the expenditure adjustments were not made during the course of the review.

- There was no documentation of supervisory review and approval related to the full reviews conducted.

Additionally, we found that desk reviews did not include a review of adjustments that could affect the annual payment rate. For example, under the fiscal year 2013 process, desk reviews performed did not include a review of certain expenditures the department had identified should be excluded or subject to limits.

**We recommend** department management document procedures for completing annual reviews and strengthen the process for conducting desk reviews to include reviewing and making adjustments that could affect the annual payment rate. **We also recommend** department management ensure full reviews are completed and adequately documented and evidence of supervisory review and approval is retained.

### **Prior Year Findings**

In prior fiscal years, we have reported significant deficiencies for the Medicaid program. These findings can be found in the Statewide Single Audit Report for the fiscal year ended June 30, 2012; see Secretary of State audit report number 2013-07. During fiscal year 2013, the authority and the department made progress in correcting these findings. The findings below will be reported in the Statewide Single Audit Report for the fiscal year ended June 30, 2013, with a status of partial corrective action taken.

Finding Title	Prior Year Finding No.
Required Disclosures Missing From Provider Agreements	11-17
Required Provider Screening Not Documented	12-29
Provider Eligibility Documentation Not Maintained	12-30
Procedures are Needed for Nursing Facility Audits	12-31
Medicaid Payments Not Sufficiently Supported	12-33
Periodic Reviews of MMIS Edits are Needed	12-34

The significant deficiencies and material weaknesses, along with your responses, will be included in our Statewide Single Audit Report for the fiscal year ended June 30, 2013. 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 response 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:

Tina Edlund, Acting Director  
Oregon Health Authority  
Erinn Kelley-Siel, Director  
Department of Human Services  
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- 1) Your agreement or disagreement with the finding. If you do not agree with an 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 name(s) of the contact person(s) responsible for corrective action.

Please provide your written response by Thursday, April 3, 2014.

The purpose of this communication is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

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

Sincerely,  
OREGON AUDITS DIVISION

Kelly L. Olson, CPA  
Audit Manager

cc: Suzanne Hoffman, OHA Chief Operating Officer  
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