

# State of Washington

## ***General***

***Code:*** S1Medicaid-SA22  
***Name:*** State of Washington  
***Group:*** Single Audit  
***Type:*** S1-Agency, Commission, or Board  
***Location:*** State  
***Scope:***

## ***Team***

***Lead:***  
***Manager:*** Ronni Copeland

## **Procedures**

### **D.2.PRG - Activities Allowed/Unallowed and Cost Principles - ProviderOne**

***Procedure Step:*** Controls - ProviderOne  
***Prepared By:*** KE, 5/22/2023  
***Reviewed By:*** SAG, 5/22/2023

Purpose/Conclusion.*
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This work was performed for the ACFR in TeamMate file S1Washington-FS22 at D.4 Human Services, "Controls - ProviderOne" was signed off and prepared by Chian Lee on 08/31/2022 and reviewed by Scott Bills on 10/31/2022. It is copied here for ease of reference. No alterations were made to the information or data other than as it relates to the issue/recommendation issued as part of the ACFR that is not applicable to the SWSA.

**Purpose:**

To gain an understanding of internal controls.

**Conclusion:**

We gained an understanding of internal controls as documented in the record of work done. The ACFR audit identified an issue related to general controls over the ProviderOne system by the vendor CNSI as the SOC report only provides coverage for six months of the fiscal year, which they, independently of the SWSA, issued a management letter for.

Testing Strategy:

**The following procedures are required for all material systems:**

1. List the financial statement balances and relevant assertions addressed by the understanding.
2. Gain an understanding of the internal control process, identify how transactions are recorded in AFRS, identify key controls over relevant assertion(s), and note any control weaknesses.
  - In gaining an understanding of controls, consider the overall understanding of COSO elements as documented in the "Entity-wide COSO Evaluation" step as they relate to this particular system.
  - Identify controls systems covering all relevant assertions for all significant classes of transactions.
  - Standards require the auditor to gain an understanding of the significant accounting system(s) that contain key controls over significant classes of transactions included in the line item.
  - Control systems identified in this step must match the Matrix and have a separate control understanding documented.
  - Talk with the CAFR Specialist or CAFR AIC if you identify different systems than the ones anticipated in the Matrix.

**For each material system, auditors must document:**

- Business processes relevant to financial reporting of the relevant assertion for the material balance. Processes should encompass automated and manual procedures by which transactions or events are identified or initiated, authorized as needed, recorded, processed and corrected as needed.
- Original accounting records and how records are rolled-up to intermediary ledgers and transferred to the general ledger (AFRS) or financial statements.
- Detailed descriptions of key controls. Effective key controls provide reasonable assurance that material misstatements in relevant assertions will be prevented or detected and corrected timely. If there is not a key control designed to address a relevant assertion, a

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significant deficiency likely exists. Depending on the magnitude and likelihood of potential effects and any compensating controls, the deficiency may represent a material weakness.

- **A brief outline of the transaction flow from beginning to end.**
- **An expanded description of key controls.**

“Key controls” refer to the few controls that together provide reasonable assurance that material misstatements will be prevented or detected and corrected. This is contrasted with ancillary or supporting controls, which – although helpful and recommended – would provide less than reasonable assurance by themselves.

The focus of the write-up is on the key controls. Key controls should be specifically identified (as “key controls”) in the write-up. This can be done in whatever way the auditor prefers, so long as it is obvious. Details that the auditor should document regarding key controls may include:

- When (or how often) is the control applied
- Who or what initiates the control
- Who performs the control
- To the extent needed, the experience, knowledge and attitude of the person applying the control
- Detailed description of the control process or activity. For example, if the control is a review: what exactly is reviewed, what is the reviewer looking at or for and what are the reviewer’s criteria?
- How the key control is documented or evidenced
- If not obvious from the description, how the control prevents or timely detects and corrects misstatements
- Any alternative processing or exceptions to the normal process
- What happens when misstatements or issues are identified by the control

The “transaction flow” refers to the process by which transactions are initiated, authorized, recorded, processed and reported (as applicable). Outlining the transaction flow gives context to key controls, especially how transactions become subject to controls in the first place. If a control inherently ensures that all applicable transactions are included (ex: bank reconciliation where the assertion is existence), the auditor may decide to just start the write-up with the initiation of the control procedure and go from there.

Elements of the transaction flow are defined informally as follows:

- *Initiation:* How are transactions initiated?
- *Authorization:* How are transactions and accounting record maintenance authorized?
- *Recording:* How are transactions or balances identified and recorded in financial accounting systems?
- *Processing:* How are the transactions or balances processed after they are recorded (if at all)? Processing may be manual or automated and may occur at a subsidiary system level or at the general ledger level.
- *Reporting:* How are records translated into the financial statements? This part of the transaction flow extends the understanding to the actual financial statements that the audit is opining on. Since we already document an understanding of the financial reporting process in

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general, it is usually enough to simply reference this overall understanding. However, if there are important steps unique to the covered balances, it may be more appropriate to mention them here.

Although transaction flow is a good way to think about understanding and documenting a control system, auditors should not worry too much about documenting “each element, in order” because often elements may be combined, not noticeable, not applicable or occur in a different order.

Guidance/Criteria:

### **ADDITIONAL BACKGROUND**

Auditors should consider the following background information and resources when performing work on this area.

**SAO Audit Policy [2310](#) - Reporting Identified Audit Issues**

**SAO Audit Policy [6230](#) – Understanding Internal Control and Assessing Control Risk**

Record of Work Done:

Internal controls in ProviderOne address the following balance(s):

- **General Fund - Human Service**
- **Governmental Activities - Human Services Expenses**

Expenditures for a large number of Human Service programs including Medicaid, food stamps and TANF. Most programs are on a cost sharing basis with the Federal Government.

For the following assertions:

- **Rights and Obligations** - Medicaid/social service payments may not be made to eligible providers, for eligible recipients, or for allowable services
- **Valuation** - Medicaid/social service payments may not be made at correct rates
- **Completeness** - Medicaid/social service payments may not be completely rolled up to AFRS from ProviderOne

Medicaid / social service payments may not be made to eligible providers, for eligible recipients, for allowable services, and at correct rates. Also, payments may not be completely rolled-up to AFRS from ProviderOne. ProviderOne is the Medicaid payments system. A lack of service organization's internal control audit for the ProviderOne system could lead to inaccurate payments, misuse, loss of misuse, loss or

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misappropriation of public funds, or payments not properly made only to eligible recipients for allowable (authorized) services.

### **General Control**

Health Care Authority confirms that general controls are in place at CNSI by requiring a biennial Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit to occur at the vendor, which occurs on even fiscal years in a biennium. We obtained the SOC report [[CNSI ProviderOne SOC 2 Type 2 Final Report 2022](#)] which examined the effectiveness of controls within the ProviderOne system. IT Audit reviewed the report as described in [[Key Control #1-4 \(Automated\) - ProviderOne System Checks](#)]. The report covered the effectiveness of controls throughout the period of January 1, 2022 through June 30, 2022, and IT Audit concluded that:

"Based upon our review of the completed audit report, we have assurance CNSI had appropriate general controls in place during the six month period included in the review. However, since the report only covers half of fiscal year 2022, we do not have assurance covering a majority of our audit period and we are unable to rely on the controls tested above for the entire period. Due to this, we cannot consider the prior year audit exception completely resolved."

**The ACFR audit identified an issue for the 6-month period of coverage, which they, independently of the SWSA, issued a management letter for.**

The attachments and workprocess flows below have been confirmed to be up-to-date by Jennifer Robinson, Applications Manager - ProviderOne.

### **Gain an Understanding of Internal Controls**

The Medicaid Management Information System (MMIS) is the mechanized Medicaid benefit claims processing and information retrieval system required for Medicaid unless this requirement is waived by the Secretary. The Medicaid program is highly dependent on this system and the internal controls and security of MMIS are germane to the proper operation of the Medicaid program. Washington State's MMIS is ProviderOne. The Health Care Authority (HCA) contracted with the vendor Client Network Services, LLC. (CNSI) to develop ProviderOne to process state Medicaid payments. On May 9, 2010, the ProviderOne system went live, replacing the legacy Medicaid Management Information System (MMIS) as the State's primary provider payment processing system.

Since May 9, 2010, ProviderOne has been processing payments for managed care, hospital, medical, dental, medical supplies, vision, and nursing home claims in "Phase 1". Since January 15, 2015, social service provider payments, such as adult family home, assisted living home and home care agency claim payments, have been processed through ProviderOne instead of the Social Services Payment System (SSPS) in "Phase 2". Additionally, W2 social service provider payments were transferred from SSPS to IPOne, a new online billing system for W2 providers, as of March 2016. W2 provider payments, such as self-employed individual provider payments, have been processed through IPOne instead of the Social Services Payment System (SSPS) since March 2016.

Payments initiated from ProviderOne can originate from two different subsystems: Claims and Managed Care. Medical or social service claim payments to providers are processed through Claims; managed care monthly premiums are paid to Managed Care Organizations (MCO) through

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Managed Care. Premium assistances are paid to insurance organizations or clients through TPL.

HCA has implemented system edits in ProviderOne to adjudicate medical/social service claims and managed care monthly premium payments. These system edits allow HCA to automate the process of determining whether a claim should be paid. Essentially, the edits contain all the rules of the Medicaid program. A summary of the adjudication process and when edits are utilized can be seen in attached [\[Claims Adjudication Flowchart\]](#).

Some of the key attributes of a claim that are checked by the edits include:

- The provider is eligible to provide the specific service covered by the plan to the specific beneficiary (**Key Control #1 (Automated) - Provider Eligibility, Rights and Obligations**)
- The beneficiary is eligible for the particular category of service at the time it was rendered (**Key Control #2 (Automated) - Beneficiary Eligibility, Rights and Obligations**)
- The allowed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by a certain percentage (**Key Control #3 (Automated) - Payment Reasonableness, Valuation**)
- The procedure codes are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by the State Plan (**Key Control #4 (Automated) - Valid Codes, Rights and Obligations**)

When processing claims, ProviderOne relies on information included in various subsystems such as:

- **Provider** – contains provider information to determine eligibility related to the claim
- **Client** – contains client information to determine eligibility related to the claim
- **Third Party Liability (TPL)** - contains information of third parties who are liable for Medicaid clients since Medicaid is not the primary payer for claims
- **Rate Setting** – contains procedure codes and associated payment limits (procedure codes are created in the Reference subsystem and the rate is attached within Rate Setting); fee schedules containing the rates are uploaded, reviewed, and approved by internal staff (Rate setting is described below as it addresses the valuation assertion for claims and monthly payments).
- **Prior Authorization (PA)** – certain procedures require authorization by the agency before a procedure can be provided to a client; this subsystem contains the authorization if it has been completed
- **Social Services** - social service payments require an authorization for services to be approved in the system prior claims being processed; this subsystem contains the authorizations related to each social service client.

A visual flowchart of ProviderOne subsystems and their relationship during medical claims processing can be seen at [\[P1 Subsystem Flowchart\]](#)

Much of the information included in the above subsystems comes from completely separate systems that interface with ProviderOne. Some of these external systems include the:

- Automated Client Eligibility System (ACES), which contains client financial eligibility for various programs

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- Comprehensive Assessment Reporting Evaluation (CARE) system, which contains client functional eligibility for social service clients
- Agency Contracts Database (ACD), which contains written contracts related to social service providers (among other contracts for the Department of Social and Health Services).

The interfaces for CARE and ACD were added to ProviderOne in FY15, as they relate to social service clients and providers. A diagram showing the connections between these systems can be seen at [\[ProviderOne Interfaces Diagram\]](#). An interface diagram with the inclusion of IOne can be seen at [\[IOne\\_HighLevel\\_Interfaces\]](#).

CNSI of Gaithersburg, MD, operates the ProviderOne system. CNSI serves as the fiscal agent responsible for operation and maintenance of the ProviderOne mainframe claims processing operation. HCA confirms general controls are in place at CNSI by requiring a biennial Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit to occur at the vendor.

### **Rate Adjustment (Valuation)**

Fee-for-service and managed care premium payment rate factors are uploaded into ProviderOne. Ed Hicks' team is responsible for the fee-for-service rate uploads and Sam Trimble's area operates the managed care capitation rate factors.

For managed care, HCA pays a monthly premium rate to manage care organizations (MCOs) based on a rate per member per month (PMPM). There are about ten different rate templates for various medical and behavioral contracts as well as three rate templates for different foundational community support (FCS) contracts. There are five factors used to calculate the rates: base rate factor (BRF), age group factor (AGF), geographic region factor (GRF), risk adjust factor (ADF), and qualitative adjust factor (ADF). Pending on the managed care program they may use all or some of the rate factors. Ideally, HCA would like two months from the time a rate change is requested before it is uploaded and executed in ProviderOne. This time is required to adequately review changes, test for errors, receive proper approvals, and update ProviderOne.

For fee-for-service, HCA directly pays providers for services rendered on qualified Medicaid members. The number of items to review is not as complicated as managed care so rate turnaround time is usually about 48 hours. (target rate for quality control)

Managed care and fee-for-service follow the same process for inputting updated fee schedules into ProviderOne. For managed care, the rate changes will have a significantly larger number of line items to update compared to fee-for-service. Also, fee-for-service has rate updates more frequently than managed care. Rate data update requests are always input into ProviderOne via file upload (Excel spreadsheet) received from the business area.

The rate change process begins with the System Operations and Implementation Unit (SOIU) receiving a rate update request via a ServiceNow ticket through a shared inbox and are triaged for assignment to Information Technology Specialist (ITS) staff within SOIU. Each -ServiceNow ticket has a number that is used to track the progress of these requests. ITS staff first review the information provided to ensure it is complete. The review is only limited to data validation such as number formats and date ranges, etc. The ITS staff member then uploads the provided file into the ProviderOne User Acceptance Testing (UAT) environment. This allows them to verify that the file uploads appropriately before attempting to upload the file into production. ProviderOne has processing controls to help ensure the rate data uploaded is complete and valid. Updates that

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do not meet programmed edits will suspend to an error file that is reviewed by the ITS. If errors are identified, ITS staff notify the business area to make corrections and submit a new file attachment to the -ServiceNow ticket. Prior to uploading, Sam will also provide the business unit with a computed Rate Report for review. Once correct and successfully uploaded, ITS reviews the data and additionally compares the number of records in the source data to the number of records uploaded to ProviderOne. If everything processes appropriately, ITS then uploads the file into the production environment and the data goes through the same processing controls as in the UAT. When successfully uploaded, all rate updates will have an "In Review" status listed.

ITS then updates and sends the -ServiceNow ticket to Heidi DeVries, IT Specialist who acts as an internal quality assurance for -ProviderOne Operations (P1O). She reviews the rate data for accuracy and to ensure the requested changes conforms to medical related coding information which was provided to HCA from the Centers for Medicare and Medicaid Services (CMS). HCA's vendor for ProviderOne, CNSI, obtains these types of files from the CMS website and then uploads them to ProviderOne. HCA will also upload reference data based upon decisions made by its own Policy Division. Heidi reviews all relevant information and determines whether to approve or reject the changes. Each rate's status reflects her decision. She then updates the -ServiceNow ticket and sends it back to the ITS for closure, or closes the ticket herself.

Once approved, the system attaches dates to the rates data, including the effective date (when the rate was approved), the start date (when the new rate takes effect), and the end date. ProviderOne also has internal edits which will cause the claim calculation to fail out if data is invalid. After confirming the test runs produced correct results, P1O will push the rate changes to production **(Key Control #5 (manual), Rate upload review prior to production - Valuation)**. When new rates are uploaded into the system, the previous data's effective dates are automatically updated to prevent payments outside of the correct to and from values. There are a select few certain general charge modes which are entered behind the scenes by the ProviderOne vendor, CNSI. For these items, ITS staff will run tests to verify that value output correctly corresponds to the associated rate.

### **How transactions are recorded in AFRS:**

Using the details included in a claim, system edits will verify eligibility and allowability of the claim based upon related information included in each of the above subsystems. This also allows the system to determine the type of claim. In this way, ProviderOne adjudicates all claims and assigns AFRS account codes to each transaction. When all the account codes are assigned, the Claims subsystem validates the assignment which includes checks for blank values, valid account codes, and AFRS table edits. As account code and table edits are updated in AFRS, there is an automated interface between AFRS and ProviderOne to update them in ProviderOne. If the transaction passes the edits in the subsystem, it is put into an Available for OFIN (Oracle Financials) status.

On a weekly basis, the Claims and Managed Care subsystems transactions are imported into the OFIN subsystem. It is within this subsystem that the Accounts Payable and Accounts Receivable netting and other processes occur to prepare the financial portion of the transactions to be sent to AFRS in batches. Transactions are sent via interface to AFRS for payment. AFRS and OST issue payments and sends a Warrant Wrap file to ProviderOne where OFIN and the original transactions are updated with the Warrant/EFT Number and Paid Date.

Accounting staff performs daily reconciliation between ProviderOne Batch Reconciliation Report 1280 and the AFRS Batch Interface log to verify



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the batches sent from ProviderOne are received and processed in AFRS. Payment will not be made unless hard edits in ProviderOne are satisfied for validity of the claim and the provider based on the information in ProviderOne.

Transactions other than Managed Care or Claim payments, are sent to AFRS daily. These daily files include PHIPP/ESI payments and cash applications in TPL and Drug Rebate.

### DSHS

We met with Rick Meyer, External Audit Liaison, and Gwendolyn Dain, Program Services Manager, to update our understanding of DSHS procedures and processes regarding ProviderOne.

DSHS primarily relies on HCA for **rights and obligations (see Automated controls #1-4) and valuation (Key Control #5)** as HCA is the owner of ProviderOne. DSHS fiscal staff perform a similar daily reconciliation (**Key Control #6 P1 to AFRS Reconciliation, Completeness**) between ProviderOne report 1280 and AFRS Batch Interface log reports to ensure that batches are sent from ProviderOne to AFRS in their entirety. To track the reconciliation process, an Excel workbook is created at the beginning of the month to document this process daily. The reconciliation process begins with Ngan Nguyen, Fiscal Analyst 3, first accessing the ProviderOne system and running a ProviderOne batch reconciliation report (Financial Report #1280). The P1 batch report specifies agency, batch date, batch type, batch number, batch count (count of all batched transactions), and batch amount. The ProviderOne batch type is categorized as "AH" (ProviderOne warrant payment) or "AI" (ProviderOne warrant cancellation). She will take a screen shot of this report and paste it into the Excel workbook noted above with a new worksheet for each day of the month. Ngan then accesses the AFRS - Batch Interface (BI) system and then runs an AFRS batch interface report. The AFRS batch report also specifies agency, batch type, batch number, batch count, and batch amount. Ngan will take a screen shot of this AFRS report and paste it to the same worksheet as the ProviderOne batch reconciliation report. Laura verifies on the AFRS batch report that the batch date, batch number, batch count, and batch amount shown in the AFRS report matches to the ProviderOne batch report. If the batch item on both reports match, Ngan will electronically sign the top of the worksheet where it says "Reviewer" for this batch date.

If there is a discrepancy between the two reports, Ngan will send a copy of the worksheet with the two compared reports to Cheri Wright, Medicaid Accounting Manager, at HCA to resolve the issue. Documentation of the communication and resolution is also stored on the tab for the daily reconciliation.

### Key controls are as follows:

- Key Control #1 (Automated): ProviderOne verifies that the provider is eligible to provide the specific service covered by the plan to the specific beneficiary. **(Right & Obligations)**
- Key Control #2 (Automated): ProviderOne verifies that the beneficiary was eligible for the particular category of service at the time it was rendered. **(Rights & Obligations)**
- Key Control #3 (Automated): ProviderOne verifies that the allowed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage. **(Valuation)**

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- Key Control #4 (Automated): ProviderOne verifies that all coded data items consisting of procedure codes are within the valid code set HIPAA Transactions and Code Sets (TCS) and are covered by the State Plan. **(Rights & Obligations)**
- Key Control #5 (Manual): Health Care Authority reviews and approves the input of fee schedules into ProviderOne prior to being available for payment in processing in the system. **(Valuation)**
- Key Control #6 (Manual): Both DSHS and HCA agency fiscal staff perform a daily reconciliation of ProviderOne to AFRS by verifying the batch data shown in the AFRS batch report matches the ProviderOne batch report **(Completeness)**

### Noted Weaknesses are as follows:

None

### D.3.PRG - Activities Allowed/Unallowed and Cost Principles - Supported Living

*Procedure Step:* A-B. Control Understanding - CARE Client Assessment Process And Rate Setting

*Prepared By:* LS, 4/17/2023

*Reviewed By:* RJC, 4/18/2023

Purpose/Conclusion.

#### Purpose:

To gain an understanding of the internal controls the agency has in place to provide reasonable assurance that Federal awards are expended only for allowable activities and that expenditures charged to the Federal award are allowable and in accordance with the applicable cost principles.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

#### Source:

Teresa Boden, Quality and Compliance Office Chief  
Erin Fatland, Joint Requirements Unit Manager  
Blaise Sciurba, Care Assessment Program Manager  
Valerie Kindschy, Waiver Residential Unit Manager  
Kenneth Callaghan, Technical Rates Manager  
Saif Hakim, Office Chief  
Geoff Nisbet, Audit Liaison  
Rick Meyer, External Audit Compliance Manager

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### Conclusion:

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

Testing Strategy:

### **Step 1: Assess Inherent Risk (IR)**

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

#### Review scope of work

Allowable Activities - Determine which activities and types of costs are specifically allowed or unallowed, by reviewing the following:

1. Medicaid State Plan
2. Part 4 of the Compliance Supplement that applies to your audit period.
3. Any additional program guidelines or handbooks.
4. If above information is not available, look to the federal regulations (contact the single audit specialist if you need assistance with this).

Requirements for Cost Principles are found 2 CFR 200, Subpart E.

***Please be familiar with these requirements as not all are listed below; only parts emphasized in the Compliance***

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*Supplement are listed below.*

### **Direct Costs**

Payroll Expenditures: When payroll costs are selected for our single audit, our focus is on whether the portion of payroll charged to the program (allocation) is supported by appropriate time and effort and meets the cost principles. Note that awarding agencies may require specific forms of documentation to support payroll charged to its award.

Compensated Absences (leave cash-outs or accrual): The entity may include employees' use of leave (which is included in their regular salary payments). If the entity charges any **leave cash-outs** or the **accrual of leave** to the grant, there are special rules, see extra guidance in the policy tab. There is a high risk the costs are unallowable.

Non-Payroll Expenditures: Generally, auditors should test internal controls and compliance for non-payroll expenditures when those costs are quantitatively material (5%) to the program.

Automated Controls: If you identify key internal controls that are automated, consult with the SWSA Supervisor or SWSA AIC to determine whether to request automated control work from Team IT audit.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated,*

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*authorized, recorded, processed and reported.*

Gain an understanding of the internal control process and identify the key internal controls that are effective in ensuring:

- (a) Activities Allowed: grant funds are used only for allowable activities (this may include review of expenditures, program monitoring, preparing the reimbursement requests, establishment of programs);
- (b) Cost Principles: direct and indirect costs charged to the grant comply with the cost principles set forth in 2 CFR 200 Subpart E (this may or may not be the same control activity for (a) shown above)

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

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Otherwise, assess control risk as "high." If preliminary control risk is "HIGH" a finding must be issued.

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with Supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from the IT audit is expected, please inform the Medicaid Supervisor.***

Guidance/Criteria:
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### INTERNAL CONTROL UNDERSTANDING

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

See also A-133, Subpart E, \_\_.500(c)

### B. ALLOWABLE COSTS/COST PRINCIPLES

#### **Applicability of OMB Cost Principles Circulars**

The following OMB cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by: (1) States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I); (2) institutions of higher education; and (3) non-profit organizations. Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services' 45 CFR part 74, appendix E). The cost principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal Government or indirectly through a pass-through entity.

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The circulars describe selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in the form of grants, contracts, and other agreements.

The applicable cost principles circulars are as follows:

**OMB Circular A-87, “Cost Principles for State, Local, and Indian Tribal Governments.”**

**OMB Circular A-21, “Cost Principles for Educational Institutions.”** - All institutions of higher education are subject to the cost principles contained in OMB Circular A-21, which incorporates the four Cost Accounting Standards Board (CASB) Standards and the Disclosure Statement (DS-2) requirements as described in OMB Circular A-21, sections C.10 through C.14 and Appendices A and B.

The cost principles articulated in the OMB cost principles circulars are in most cases substantially identical, but a few differences do exist. These differences are necessary because of the nature of the Federal/State/local/non-profit organizational structures, programs administered, and breadth of services offered by some grantees and not others. Exhibit 1 of this part of the Supplement, Selected Items of Cost, lists the treatment of the selected cost items in the different circulars.

**Compliance Requirements - Allowability of Costs - General Criteria (applicable to both direct and indirect costs)**

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.
- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program, project, department, or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.

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- **Consistency** - Costs must be given consistent treatment through application of those generally accepted accounting principles appropriate to the circumstances. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an indirect cost.
- **Conformity to Laws, Regulations and Sponsored Agreements** - Costs must conform to any limitations or exclusions set forth in the circulars, Federal laws, State or local laws, sponsored agreements, or other governing regulations as to types or amounts of cost items.
- **Transactions that Reduce or Offset Direct or Indirect Costs** - Costs must be net of all applicable credits that result from transactions that reduce or offset direct or indirect costs. Examples of such transactions include purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments for overpayments or erroneous charges.
- **Costs Documentation** - Costs must be documented in accordance with OMB Circular A-110 for non-profit organizations and institutions of higher education or the A-102 Common Rule for State, local and Indian tribal governments.

### **Compliance Requirements - Indirect Costs**

Indirect costs are those costs that benefit common activities and, therefore, cannot be readily assigned to a specific direct cost objective or project. Three different types of indirect cost rates can be approved by the cognizant agency for indirect cost negotiation: predetermined, fixed, and provisional/final.

- **Predetermined rates** - rates established for the current or multiple future period(s) based on current data (usually data from the most recently ended fiscal year, known as the base period). Predetermined rates are not subject to adjustment, except under very unusual circumstances.
- **Fixed rates** - rates based on current data in the same manner as predetermined rates, except that the difference between the costs of the base period used to establish the rate and the actual costs of the current period is carried forward as an adjustment to the rate computation for a subsequent period.
- **Provisional rates** - temporary rates used for funding and billing indirect costs, pending the establishment of a final rate for a period.



## State of Washington

Sometimes award-specific indirect cost rates are negotiated that are different from those set forth in negotiated rate agreements. Terms and conditions in an award specific to indirect cost rates take precedence over indirect cost rates set forth in negotiated agreements.

**See the appropriate circular for audit guidance.**

Record of Work Done.:
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### **Inherent Risk of Noncompliance**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are considered areas of higher risk by the oversight agency (**CMS**)
- Since the Supported Living (**SL**) program is a waiver-based service, DDA has a large degree of subjectivity in carrying out the program objectives
- The compliance requirements are susceptible to fraud and abuse

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

##### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine which activities and costs are allowed or unallowed. We identified the following:

## State of Washington

### A. Activities Allowed or Unallowed

6. *Home and Community-Based Services (HCBS)* - A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Social Security Act. States must operate their HCBS programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Supported Living is an option under the Home and Community Based Services Core and Community Protection waivers.

Supported Living services support Medicaid clients to live in their own homes with one to three other people and receive instruction and support delivered by contracted service agencies (providers). Supported Living clients pay their own rent, food and other personal expenses.

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We requested the internal controls from the Department. Geoff Nisbet- Audit Liaison, provided us with the Department's response: [DDA FY22 SL audit Internal Controls response](#)

### **CARE Client Assessment Process**

On January 18, 2023 we met with the following DSHS/DDA staff to gain an understanding of the CARE Client

## State of Washington

### Assessment process:

- Teresa Boden, Quality and Compliance Office Chief
- Erin Fatland, Joint Requirements Unit Manager
- Blaise Sciurba, Care Assessment Program Manager
- Valerie Kindschy, Waiver Residential Unit Manager
- Geoff Nisbet, Audit Liaison
- Rick Meyer, External Audit Compliance Manager

Teresa walked us through the assessment process each Supported Living client receives. These assessments are outlined in [WAC 388-828](#), The Division of Developmental Disabilities (DDD) Assessment. WAC 388-828-1500 details when reassessments need to be done (annually and when there is a significant change that may affect client need for support). DDA also has the "CARE LTC Assessor's Manual" that provides guidelines for how to apply standards, clinical judgment and “best practices” for assessing, developing care plans, determining eligibility, and authorizing services for long-term care (Supported Living) clients.

Clients are assessed for the levels of support through an assessment completed in the Department’s Comprehensive Assessment Reporting Evaluation (**CARE**) system and is facilitated by a Case Resource Manager (**CRM**), together with the client, his or her family members, guardians, necessary supplemental accommodation (**NSA**), and other care providers who are familiar with the client’s needs. Clients receive assessments when they become a client of DDA and at minimum, annually after that. In addition, clients receive an assessment when a significant change in their condition occurs or a change in their household composition occurs.

There are two types of assessments, but both collect the same information. The difference is the level of formality. A directed assessment is required every 5 years. The directed assessment requires each question to begin with, "What supports do you need to be successful to..." The conversational assessment is not as regimented and is used the years the direct assessment is not required. The assessment includes a series of questions pertaining to the

## State of Washington

client's needs and functional abilities. The questions asked of the client and/or guardian, family, NSA, and other care providers in the Support Assessment section are not medically based but are designed to evaluate the type of services a client would need to live independently and the frequency with which these services would be needed by the client. Topics addressed in the Support Assessment include Home Living, Community Living, Lifelong Learning, Employment Activities, Behavioral Supports, among others.

Another section of the assessment is called the Service Level Assessment and is used to document items like health and medication needs, pain management, and personal care supports. Questions are also asked to garner information from the client about their ability to perform activities of daily living (ADLs). As part of this assessment process, the CRM also includes various notes explaining unique needs, and/or behaviors of the client that may have an impact on the amount of assistance they would require to live independently and within the community.

The support intensity scale is designed to be administered in a standardized uniform way. The Department informed us that all DDA assessors are all educated professionals. Each assessor must prove proficiency in administering the CARE assessment, and case managers are shadowed and observed every year. The Department maintains an access database of assessor's qualifications to ensure that the CARE client assessment is being administered in a standard, uniform way (**Key Control #1 - Monitoring**).

Once the initial assessment is complete, the CARE system processes a preprogrammed algorithm (as outlined in WAC 388-828-9700) to determine the client's general level of need. The CARE system has 7 levels (number 1 through 6, with a level 3A and level 3B.) Clients rated level 4 and above require 24-hour support and assistance to function within the Community.

We received further clarification regarding clients rated a level 6 and their support needs. Clients rated level 6 are in the community protection program and require 24-hour support. Residential services must provide safeguards and structures that protect the community from behaviors that endanger people and property and the rights of others. Each client's assistance is based on their needs and may include door alarms engaged during sleeping hours and line of site supervision.

Beginning January 1, 2019, the amount and type of instruction and support services a client receives is based on

## State of Washington

the client's assessed needs that are identified during the client's assessment and Person-Centered Service Planning process. Once the assessment has identified a residential service level, a DDA resource manager conducts a rate assessment with the supported living providers to determine the tier level where the client will be placed. The provider is accountable to the Department to meet the client's needs that were identified in the Person-Centered Service Plan.

After the rate assessment is completed, a Plan Action Notice (**PAN**) is created and authorizations are updated (mainly moving the coverage date a year out to continue services). The Person-Centered Service Plan and summary of the assessment along with the PAN are sent to the client and guardian/Power of Attorney to be signed. Thirty days after an assessment, the CRM does a 30 day follow-up meeting.

After the client's need is assessed, the client is assigned a Resource Manager (**RM**). Once the RM receives the client to his or her caseload, they meet with the client, his or her family members and/or guardian, and current care givers to gain a better understanding of the type of residence and the geographical location the client would prefer to live. Based on these preferences and availability of provider agencies with the resources to assist the client, a placement with a provider agency is agreed upon and placement is finalized.

### **Rate Setting and Re-Assessment Process**

On January 24, 2023 we met with the following DSHS/DDA staff to gain an understanding of the CARE Client Assessment process:

- Teresa Boden, Quality and Compliance Office Chief
- Erin Fatland, Joint Requirements Unit Manager
- Blaise Sciurba, Care Assessment Program Manager
- Valerie Kindschy, Waiver Residential Unit Manager
- Kenneth Callaghan, Technical Rates Manager
- Saif Hakim, Office Chief

## State of Washington

- Geoff Nisbet, Audit Liaison
- Rick Meyer, External Audit Compliance Manager

The Administration's Resource Managers are primarily tasked with rate setting. When an RM receives a client following the selection of a suitable residence, they conduct a rate assessment meeting with a representative from the selected service provider. This meeting begins the process of setting tier level of care and rate of pay for the provider. Prior to the meeting, the RM and the agency representative reviews the client's assessment and the generic residential level that was assigned to the client in the CARE system.

With these levels pre-determined, the RM uses the CARE system to note where extra help is required by the client and also where additional clients in the home would allow the provider to share some of the client's supports. For example, hours could be shared during night hours or at meal time when the caregiver supports could be shared. These shared hours/supports are termed "Economies of Scale" (EOS) by the Department. Additionally, hours are adjusted when a client requires 2 to 1 care. For example, two employees are required to provide a specific support, such as turning a client at night. The Economies of Scale is used to calculate these adjustments and requires the RM to provide a written explanation for any changes.

### *Residential Rates for Developmental Disabilities (RRDD)*

Once the rate assessment is completed in CARE, the RM logs into RRDD (where the rate information has automatically populated from CARE) to initiate the approval process. The rate is submitted by the RM to the Resource Manager Administrator or designee and is forwarded to the Program Manager for approval, and then sent to the rate analyst for verification to ensure that the rate matches the level of care as determined in the CARE assessment (**Key Control #2 - Control Activities**). The system is updated and automatically sends an exhibit to the RM who forwards it to the supported living agency. The exhibit is a contract addendum detailing the approved rate for each client within the agency. To be finalized, this exhibit must be signed by both parties.

After the rate analyst delivers the final approval, a batch ticket is automatically created and sent to an Outlook shared folder where the rate analyst then enters it on a master batch ticket to be sent to HCA. This is sent twice a

## State of Washington

month.

Every two weeks, the designated Analyst transmits the batch to the Health Care Authority (**HCA**) who operates and manages ProviderOne. When the batch is successfully transmitted, the analyst receives an automatic confirmation and job ticket number from HCA indicating the batch has been successfully uploaded. To claim a payment, providers log into the system and since ProviderOne pays a daily rate for each client, they are allowed to claim daily payments as often as once a week although most claim every couple of weeks and some claim monthly. When the provider makes a claim, an invoice is processed and a warrant is issued to the provider for the amount of the claim.

### *Service delivery*

The amount and type of instruction and support services a client receives is based on the client's assessed needs that are identified during the client's assessment and Person-Centered Planning process. The Department's tiered rate system gives providers the flexibility to determine how they will deliver supports identified in the client's service plan. The Department stated it pays providers for outcomes and providers are accountable for ensuring the elements of the plan are implemented and identified supports are provided.

### *Household or Cluster concept*

The Department allows providers to “cluster” clients or households together in order to set schedules and account for service delivery for a group of clients. The cluster concept helps agencies provide cost efficient service delivery by scheduling shared hours with other clients. For example, two clients who lived together could each be assessed to receive 24-hours of care per day but a provider could schedule one care giver to cover a night shift when the clients were asleep. This is an example of shared hours, or economies of scale.

### *Re-Assessment and Monitoring of Client Care*

After a client's initial placement in a home, a 30-day re-evaluation of the client is performed by the CRM. This assessment requires the CRM to visit the client's place of residence and interview the client, his or her family

## State of Washington

members, roommates, and care providers to ensure the living situation is comfortable for all residents of the household. If necessary, the client's assessment will then be adjusted as necessary based on this visit. If a client's situation changes before the 90 days or at any other time, a new assessment can also be requested by the client, their family, any care provider or any DSHS employee. During FY22 these visits had been made remotely due to the COVID-19 pandemic. D.3 Supported Living - ID of C CARE Client Assessment

Rate reassessment can occur at any time. Rate is secondary process, the primary process is client assessment of needs. More of a QA process. Whenever there is a change in the client need, the process is the exact same approval process. Client needs change all the time, living situations change, and a new assessment is generated.

Absent any changes in the client's condition or a specific request for re-evaluation, clients will receive an annual re-assessment by their CRM. During the re-assessment process, the client's living situation is observed and necessary changes to needs or required assistance are made.

### **Key Internal Controls**

**Key Control #1** -The Department maintains an access database of assessor's qualifications to ensure that the CARE client assessment is being administered in a standard, uniform way (**Monitoring**).

**Key Control #2** - The rate is submitted by the RM to the Resource Manager Administrator or designee and is forwarded to the Program Manager for approval, and then sent to the rate analyst for verification to ensure that the rate matches the level of care as determined in the CARE assessment (**Control Activities**).

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

### **D.3.PR.G - Activities Allowed/Unallowed and Cost Principles - Supported Living**

**Procedure Step:** A-B. Control Understanding - Residential Care Services Certification & Investigation



# State of Washington

**Prepared By:** LS, 3/23/2023

**Reviewed By:** RJC, 4/15/2023

## Purpose/Conclusion:

### **Purpose:**

To gain an understanding of the internal controls the agency has in place to provide reasonable assurance that Federal awards are expended only for allowable activities and that expenditures charged to the Federal award are allowable and in accordance with the applicable cost principles.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

### **Source:**

Rick Meyer, External Audit Compliance Manager

### **Conclusion:**

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

## Testing Strategy:

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

***Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

#### **Review scope of work**

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Allowable Activities - Determine which activities and types of costs are specifically allowed or unallowed, by reviewing the following:

1. Medicaid State Plan
2. Part 4 of the Compliance Supplement that applies to your audit period.
3. Any additional program guidelines or handbooks.
4. If above information is not available, look to the federal regulations (contact the single audit specialist if you need assistance with this).

Requirements for Cost Principles are found 2 CFR 200, Subpart E.

***Please be familiar with these requirements as not all are listed below; only parts emphasized in the Compliance Supplement are listed below.***

### **Direct Costs**

Payroll Expenditures: When payroll costs are selected for our single audit, our focus is on whether the portion of payroll charged to the program (allocation) is supported by appropriate time and effort and meets the cost principles. Note that awarding agencies may require specific forms of documentation to support payroll charged to its award.

Compensated Absences (leave cash-outs or accrual): The entity may include employees' use of leave (which is included in their regular salary payments). If the entity charges any **leave cash-outs** or the **accrual of leave** to the grant, there are special rules, see extra guidance in the policy tab. There is a high risk the costs are unallowable.

Non-Payroll Expenditures: Generally, auditors should test internal controls and compliance for non-payroll expenditures when those costs are quantitatively material (5%) to the program.

Automated Controls: If you identify key internal controls that are automated, consult with the SWSA Supervisor or

## State of Washington

SWSA AIC to determine whether to request automated control work from Team IT audit.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the internal control process and identify the key internal controls that are effective in ensuring:

- (a) Activities Allowed: grant funds are used only for allowable activities (this may include review of expenditures, program monitoring, preparing the reimbursement requests, establishment of programs);
- (b) Cost Principles: direct and indirect costs charged to the grant comply with the cost principles set forth in 2 CFR 200 Subpart E (this may or may not be the same control activity for (a) shown above)

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood

## State of Washington

of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.

2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you’ve signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with Supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from the IT audit is expected, please inform the Medicaid Supervisor.***

Guidance/Criteria.\*

### INTERNAL CONTROL UNDERSTANDING

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

## State of Washington

See also A-133, Subpart E, \_\_.500(c)

### **B. ALLOWABLE COSTS/COST PRINCIPLES**

#### **Applicability of OMB Cost Principles Circulars**

The following OMB cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by: (1) States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I); (2) institutions of higher education; and (3) non-profit organizations. Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services' 45 CFR part 74, appendix E). The cost principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal Government or indirectly through a pass-through entity. The circulars describe selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in the form of grants, contracts, and other agreements.

The applicable cost principles circulars are as follows:

**OMB Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments."**

**OMB Circular A-21, "Cost Principles for Educational Institutions."** - All institutions of higher education are subject to the cost principles contained in OMB Circular A-21, which incorporates the four Cost Accounting Standards Board (CASB) Standards and the Disclosure Statement (DS-2) requirements as described in OMB Circular A-21, sections C.10 through C.14 and Appendices A and B.

The cost principles articulated in the OMB cost principles circulars are in most cases substantially identical, but a few differences do exist. These differences are necessary because of the nature of the Federal/State/local/non-profit organizational structures, programs administered, and breadth of services offered by some grantees and not others.

## State of Washington

Exhibit 1 of this part of the Supplement, Selected Items of Cost, lists the treatment of the selected cost items in the different circulars.

### **Compliance Requirements - Allowability of Costs - General Criteria (applicable to both direct and indirect costs)**

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.
- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program, project, department, or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.
- Consistency - Costs must be given consistent treatment through application of those generally accepted accounting principles appropriate to the circumstances. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an indirect cost.
- Conformity to Laws, Regulations and Sponsored Agreements - Costs must conform to any limitations or exclusions set forth in the circulars, Federal laws, State or local laws, sponsored agreements, or other governing regulations as to types or amounts of cost items.
- Transactions that Reduce or Offset Direct or Indirect Costs - Costs must be net of all applicable credits that result from transactions that reduce or offset direct or indirect costs. Examples of such transactions include purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments for overpayments or erroneous charges.
- Costs Documentation - Costs must be documented in accordance with OMB Circular A-110 for non-profit organizations and institutions of higher education or the A-102 Common Rule for State, local and Indian tribal

## State of Washington

governments.

### **Compliance Requirements - Indirect Costs**

Indirect costs are those costs that benefit common activities and, therefore, cannot be readily assigned to a specific direct cost objective or project. Three different types of indirect cost rates can be approved by the cognizant agency for indirect cost negotiation: predetermined, fixed, and provisional/final.

- Predetermined rates - rates established for the current or multiple future period(s) based on current data (usually data from the most recently ended fiscal year, known as the base period). Predetermined rates are not subject to adjustment, except under very unusual circumstances.
- Fixed rates - rates based on current data in the same manner as predetermined rates, except that the difference between the costs of the base period used to establish the rate and the actual costs of the current period is carried forward as an adjustment to the rate computation for a subsequent period.
- Provisional rates - temporary rates used for funding and billing indirect costs, pending the establishment of a final rate for a period.

Sometimes award-specific indirect cost rates are negotiated that are different from those set forth in negotiated rate agreements. Terms and conditions in an award specific to indirect cost rates take precedence over indirect cost rates set forth in negotiated agreements.

**See the appropriate circular for audit guidance.**

Record of Work Done.
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### **Inherent Risk of Noncompliance**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are considered areas of higher risk by the oversight agency (CMS)
- Since the Supported Living (SL) program is a waiver-based service, DDA has a large degree of subjectivity in carrying out the program objectives
- The compliance requirements are susceptible to fraud and abuse

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

# State of Washington

## **Gather Information**

### **Step 2**

#### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine which activities and costs are allowed or unallowed. We identified the following:

#### **A. Activities Allowed or Unallowed**

6. *Home and Community-Based Services (HCBS)* - A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Social Security Act. States must operate their HCBS programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Supported Living is an option under the Home and Community Based Services Core and Community Protection waivers.

Supported Living services support Medicaid clients to live in their own homes with one to three other people and receive instruction and support delivered by contracted service agencies (providers). Supported Living clients pay their own rent, food and other personal expenses.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We requested the internal controls from the Department. Geoff Nisbet- Audit Liaison, provided us with the Department's response: DDA FY22 SL audit Internal Controls response

## **Residential Care Services (RCS) Certification and Investigation**

DDA verifies client care through DSHS's RCS unit that certifies Supported Living agencies. RCS investigates and records any complaints or allegations as well as conducts a certification evaluation every two years and if passed, they will issue agency certifications (**Key Control #1 - Control Activities**). The investigation team issues citations for any issues they find via a "Statement of Deficiencies" (SOD) form and DSHS performs steps that require the provider to correct issues within a limited time period as outlined by WAC 388-101-3160. Continued/repeated citations or lack of response to issues noted will result in a provider receiving sequentially stronger sanctions up to, and including, certification revocation and removal of the clients. When issues are identified, they are communicated to the DDA Regional Administrator (RA) through a call or meeting. The RA will coordinate with the RMA for follow-up steps, typically technical support. Policy 11.06, Client and Provider Overpayments, and D18-012 Management Bulletin address processes for recovering overpayments and loss



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of client funds after an overpayment or loss is identified.

## **Key Internal Controls**

**Key Control #1** - RCS conducts a certification evaluation every two years to ensure supported living agencies are following service plans and providing adequate care (**Control Activities**).

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

## **D.3.PRG - Activities Allowed/Unallowed and Cost Principles - Supported Living**

**Procedure Step:** A-B. Control Understanding - Cost Report and Payroll Verification

**Prepared By:** LS, 3/23/2023

**Reviewed By:** RJC, 4/15/2023

Purpose/Conclusion:

### **Purpose:**

To gain an understanding of the internal controls the agency has in place to provide reasonable assurance that Federal awards are expended only for allowable activities and that expenditures charged to the Federal award are allowable and in accordance with the applicable cost principles.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

### **Source:**

Valerie Kindschy, Waiver Residential Unit Manager

Kenneth Callaghan, Technical Rates Manager

Tod Johnson, Cost Reimbursement Analyst

Saif Hakim, Office Chief

Geoff Nisbet, Audit Liaison

Rick Meyer, External Audit Compliance Manager

### **Conclusion:**

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

Testing Strategy:

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### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

#### Review scope of work

Allowable Activities - Determine which activities and types of costs are specifically allowed or unallowed, by reviewing the following:

1. Medicaid State Plan
2. Part 4 of the Compliance Supplement that applies to your audit period.
3. Any additional program guidelines or handbooks.
4. If above information is not available, look to the federal regulations (contact the single audit specialist if you need assistance with this).

Requirements for Cost Principles are found 2 CFR 200, Subpart E.

***Please be familiar with these requirements as not all are listed below; only parts emphasized in the Compliance Supplement are listed below.***

#### **Direct Costs**

Payroll Expenditures: When payroll costs are selected for our single audit, our focus is on whether the portion of

## State of Washington

payroll charged to the program (allocation) is supported by appropriate time and effort and meets the cost principles. Note that awarding agencies may require specific forms of documentation to support payroll charged to its award.

Compensated Absences (leave cash-outs or accrual): The entity may include employees' use of leave (which is included in their regular salary payments). If the entity charges any **leave cash-outs** or the **accrual of leave** to the grant, there are special rules, see extra guidance in the policy tab. There is a high risk the costs are unallowable.

Non-Payroll Expenditures: Generally, auditors should test internal controls and compliance for non-payroll expenditures when those costs are quantitatively material (5%) to the program.

Automated Controls: If you identify key internal controls that are automated, consult with the SWSA Supervisor or SWSA AIC to determine whether to request automated control work from Team IT audit.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the internal control process and identify the key internal controls that are effective in

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ensuring:

- (a) Activities Allowed: grant funds are used only for allowable activities (this may include review of expenditures, program monitoring, preparing the reimbursement requests, establishment of programs);
- (b) Cost Principles: direct and indirect costs charged to the grant comply with the cost principles set forth in 2 CFR 200 Subpart E (this may or may not be the same control activity for (a) shown above)

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with Supervisor to discuss the identified internal***

## State of Washington

***controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from the IT audit is expected, please inform the Medicaid Supervisor.***

Guidance/Criteria.7

### **INTERNAL CONTROL UNDERSTANDING**

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

See also A-133, Subpart E, \_\_.500(c)

### **B. ALLOWABLE COSTS/COST PRINCIPLES**

#### **Applicability of OMB Cost Principles Circulars**

The following OMB cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by: (1) States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I); (2) institutions of higher education; and (3) non-profit organizations. Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services' 45 CFR part 74, appendix E). The cost principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal Government or indirectly through a pass-through entity. The circulars describe selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in

## State of Washington

the form of grants, contracts, and other agreements.

The applicable cost principles circulars are as follows:

**OMB Circular A-87, “Cost Principles for State, Local, and Indian Tribal Governments.”**

**OMB Circular A-21, “Cost Principles for Educational Institutions.”** - All institutions of higher education are subject to the cost principles contained in OMB Circular A-21, which incorporates the four Cost Accounting Standards Board (CASB) Standards and the Disclosure Statement (DS-2) requirements as described in OMB Circular A-21, sections C.10 through C.14 and Appendices A and B.

The cost principles articulated in the OMB cost principles circulars are in most cases substantially identical, but a few differences do exist. These differences are necessary because of the nature of the Federal/State/local/non-profit organizational structures, programs administered, and breadth of services offered by some grantees and not others. Exhibit 1 of this part of the Supplement, Selected Items of Cost, lists the treatment of the selected cost items in the different circulars.

**Compliance Requirements - Allowability of Costs - General Criteria (applicable to both direct and indirect costs)**

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.
- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program, project, department, or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.
- Consistency - Costs must be given consistent treatment through application of those generally accepted accounting principles appropriate to the circumstances. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an

## State of Washington

indirect cost.

- **Conformity to Laws, Regulations and Sponsored Agreements** - Costs must conform to any limitations or exclusions set forth in the circulars, Federal laws, State or local laws, sponsored agreements, or other governing regulations as to types or amounts of cost items.
- **Transactions that Reduce or Offset Direct or Indirect Costs** - Costs must be net of all applicable credits that result from transactions that reduce or offset direct or indirect costs. Examples of such transactions include purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments for overpayments or erroneous charges.
- **Costs Documentation** - Costs must be documented in accordance with OMB Circular A-110 for non-profit organizations and institutions of higher education or the A-102 Common Rule for State, local and Indian tribal governments.

### **Compliance Requirements - Indirect Costs**

Indirect costs are those costs that benefit common activities and, therefore, cannot be readily assigned to a specific direct cost objective or project. Three different types of indirect cost rates can be approved by the cognizant agency for indirect cost negotiation: predetermined, fixed, and provisional/final.

- **Predetermined rates** - rates established for the current or multiple future period(s) based on current data (usually data from the most recently ended fiscal year, known as the base period). Predetermined rates are not subject to adjustment, except under very unusual circumstances.
- **Fixed rates** - rates based on current data in the same manner as predetermined rates, except that the difference between the costs of the base period used to establish the rate and the actual costs of the current period is carried forward as an adjustment to the rate computation for a subsequent period.
- **Provisional rates** - temporary rates used for funding and billing indirect costs, pending the establishment of a final rate for a period.

Sometimes award-specific indirect cost rates are negotiated that are different from those set forth in negotiated rate agreements. Terms and conditions in an award specific to indirect cost rates take precedence over indirect cost rates set forth in negotiated agreements.

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**See the appropriate circular for audit guidance.**

Record of Work Done:

## **Inherent Risk of Noncompliance**

### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are considered areas of higher risk by the oversight agency (CMS)
- Since the Supported Living (SL) program is a waiver-based service, DDA has a large degree of subjectivity in carrying out the program objectives
- The compliance requirements are susceptible to fraud and abuse

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

## **Gather Information**

### **Step 2**

#### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine which activities and costs are allowed or unallowed. We identified the following:

#### **A. Activities Allowed or Unallowed**

6. *Home and Community-Based Services (HCBS)* - A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Social Security Act. States must operate their HCBS programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Supported Living is an option under the Home and Community Based Services Core and Community Protection waivers.

Supported Living services support Medicaid clients to live in their own homes with one to three other people and receive instruction and support delivered by contracted service agencies (providers). Supported Living clients pay their own rent, food and other personal expenses.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control



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environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We requested the internal controls from the Department. Geoff Nisbet- Audit Liaison, provided us with the Department's response: DDA FY22 SL audit Internal Controls response

### Cost Report

On January 24, 2023 we met with the following DSHS/DDA staff to gain an understanding of the CARE Client Assessment process:

- Valerie Kindschy, Waiver Residential Unit Manager
- Kenneth Callaghan, Technical Rates Manager
- Tod Johnson, Cost Reimbursement Analyst
- Saif Hakim, Office Chief
- Geoff Nisbet, Audit Liaison
- Rick Meyer, External Audit Compliance Manager

The Department issued a new Policy 6.04 in January 2019 and updated in July 2019, based on its new tiered rate system, see: DDA Policy 6.04 - Billing, Payment, and Cost Reporting. The policy states that providers must submit an annual Cost Report and details how the Cost Report is to be prepared and submitted along with what costs qualify for settlement. On January 24, 2023, we met with Tod Johnson, Cost Analyst- MSD, and Kenneth Callaghan, Rates Manager- MSD to learn about the reconciliation process used by Rate Analysts to settle the tiered rate payments as outlined in provider contracts to the cost reports. Also at the meeting were Saif Hakim, Valerie Kindschy, and Megan Kwak from DDA.

On March 22, 2023 Rick Meyer sent the worksheet the Department uses to track their progress reconciling the Cost Reports see: CY21 Cost Report and Payroll Verification Summary. From this spreadsheet, we found the Department received cost reports from all of the 140 Supported Living providers for CY21 (one Supported Living provider started 2/8/21 and was not required to have a cost report). We also noted 132 of the 140 Desk Review checklists were completed prior to June 30, 2021.

The Department requires cost reports from all supported living providers. Desk review checklists are completed for each provider by Department staff to ensure the cost report is reasonable, allowable, and completed accurately (**Key Control #1 - Control Activities**). The Cost Report is the entire multi-worksheet Excel file for each Supported Living agency. During payroll verification, the Department selects providers to review 2-3 randomly selected months of detailed supporting documents for ISS expenditures claimed on the Cost Report. No documentation is submitted with the provider cost reports until the associated provider is selected for payroll verification by DDA staff. The providers are required to submit an excel spreadsheet documenting expenditures for their cost report.

### *Reconciliation*

The first step in analyzing the cost report is to reconcile the rates for each client under a supported living provider from RRDD to the payments made to the

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provider in ProviderOne. This process is to ensure the proper payment is paid out to the supported living provider based on the contract terms. The cost analyst runs a report using the Department's Rate File and RRDD database to populate the contracted allowable payments. The rate file and RRDD details the tiered rate payment for each client who is assessed to receive services during the year. This payment is broken into sub categories including direct ISS tiered rate payment and the transportation and administrative components. The cost analyst then runs a ProviderOne payment report and compares what the provider was actually paid with what the provider should have been paid under the contract. If there is a variance between these, the cost analyst looks at it closer to determine the cause and takes appropriate steps to remedy the variance. Once the reconciliation is complete, the analysis of the cost report can begin.

### *Settlement*

In the cost report submitted by the supported living provider, the cost analyst will complete the top portion of Schedule G on tab, "G - ISS Settlement" based on the information from the reconciliation performed above. This includes three categories: 1.) total ISS reimbursement, 2.) nurse delegation, staff add on, and COCA cost of care adjustment, and 3.) staff and purchased professional services. Since DDA does not settle on the administrative payment to providers, it is not included in this analysis. The bottom portion of this worksheet auto-populates a summary of the ISS staff payroll and allowable administrator ISS payroll (regular and overtime) submitted by the provider on Schedule B on tab, "B - ISS Payroll Expenses." At the very bottom of Schedule G is the total preliminary net settlement amount. If the net settlement amount is a positive number, the cost analyst begins the cost settlement process. The cost analyst sends an email notification to the provider's Resource Manager Administrator (**RMA**) who works with the provider regarding the overpayment issue. The provider receives a copy of the Settlement Report via US mail and once the issue is agreed upon between the RM and provider, the overpayment is submitted to the Department's Office of Financial Recovery with a confirmation to the assigned cost analyst.

### *Overtime and Fringe Benefits - No Maximum Amount Allowed*

We noted that overtime expenses are allowed to be included in the ISS gross payroll that is used to determine the net settlement amount. When we inquired with the Department about this, they confirmed that overtime is not factored into the tiered rate paid to providers. We determined that there is an issue with allowing providers to include overtime pay in the settlement. If provider payroll expenditures is to correlate to allowable activities (and fulfillment of contract obligations) being performed, then allowing overtime in payroll expenditures inflates services that were provided by agency since less work will be provided for overtime pay (which is time and a half pay) compared to regular pay.

### **Payroll Verification (formerly referred to as: Audit of Providers) -- A portion of the overall Cost Report Audit**

We received the ISS payroll verification procedure (see: [ISS Payroll Review Instructions](#)) and an example of the checklist with review (see: [Cost Report Audit - Rates analyst checklist](#)).

On January 24, 2023, we had a meeting with Department staff to verify our prior understanding of the Cost Report and Payroll Verification. The Department informed us that the Cost Report is the entire multi-worksheet Excel file for each Supported Living agency. During payroll verification, the Department selects providers to review 2-3 randomly selected months of detailed supporting documents for ISS expenditures claimed on the Cost Report. The Department randomly selects supported living providers for payroll verification to ensure proper rates are being charged for supported living services (**Key Control #2 - Monitoring**). The Department requests two months of a providers' payroll unless they submit their payroll records quarterly, in which case the Department would review three months of supporting documentation. This process starts in early Spring when Kenneth Callghan randomly selects providers. The providers are notified of their selection after the provider submits its cost report. DDA randomly selects two months or a quarter to be reviewed.

During our understanding it was noted that the Department was moving towards a risk based approach of determining which supported living providers were

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going to be selected for payroll verification. We were informed that the baseline of payroll verification is always going to start with who wasn't audited, and then additional providers would be included based on their evaluated risk. Department policy is changed on the contract cycle, this change is estimated to be effective July 2023.

In the Spring of 2022, the Department randomly chose 66 of the 140 Supported Living providers for Payroll Verification.

Tod explained to us that each Payroll Verification is completed in a non-standard way depending upon what documentation the agency provides. Each cost analyst will import the payroll documentation either into the Cost Report Excel Workbook or will link a PDF separately if the agency provided a PDF or Word document.

The Cost Analyst will review the gross payroll, overtime, paid time off, employer paid time off, etc on the documentation received from the agency. They will compare the employee names and job descriptions to determine if the payroll is ISS/Non-ISS or both. They start with the General Ledger and ensure that all payroll is correctly allocated appropriately.

When the Cost Analyst has completed the entire Cost Report Audit, including the Payroll Verification, it is sent to Ken Callaghan, MSD Technical Rates Manager. Ken initials the checklist indicating he agrees with the entire cost report and payroll verification has been completed correctly. This is then logged in the tracking sheet. They then send a notification to OFR to collect a settlement if one is due. The settlement letter indicates either a zero or the amount for repayment.

During our meeting we asked how many Supported Living Providers there are and how many payroll verifications were completed.

During FY22 there were 140 Supported Living Providers and 66 had completed Payroll Verifications.

66 Payroll Verifications Completed/140 Supported Living Providers = 47.1% of the SL Providers were audited/ had payroll verified.

***Employee bonuses are not built into the tiered rate yet the Department allows it under the fringe benefits category on the cost report. DDA policy does not prohibit providers from distributing bonuses without limit to its employees. As a result, many providers are issuing significant bonuses to employees and applying it as ISS expenditures. Bonus payments to ISS employees should not be an allowable expenditure since the tiered rate does not factor this in its structure. Furthermore, not having a limit on the bonus amount creates an opportunity for supported living agencies to not provide proper care to clients while still expending its revenue from the Department (Control Weakness).***

Note: Since these providers are contractors, we reviewed the FY21 contract between DSHS and the supported living providers to determine the expected level of supporting documentation required to be retained by the provider for payments received, see [Sample Contract](#). We noted that the provider is required to complete the annual cost report (p.14). There are no specific requirements about retaining documents to support the non-ISS portion of the payment. Therefore, we will focus our activities allowed review on the ISS portion of the payment.

### **Key Internal Controls**

**Key Control #1** - The Department randomly selects supported living providers for payroll verification to ensure proper rates are being charged for supported living services (**Monitoring**)

The overall program control risk will be assessed at [A-B. Control Understanding - Summary of Controls](#).

### **D.3.PR.G - Activities Allowed/Unallowed and Cost Principles - Supported Living**

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**Procedure Step:** A-B. Control Understanding - Quality Assurance Review

**Prepared By:** LS, 3/23/2023

**Reviewed By:** RJC, 4/15/2023

### Purpose/Conclusion:

**Purpose:**

To gain an understanding of the internal controls the agency has in place to provide reasonable assurance that Federal awards are expended only for allowable activities and that expenditures charged to the Federal award are allowable and in accordance with the applicable cost principles.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

**Source:**

Valerie Kindschy, Waiver Residential Unit Manager

Kenneth Callaghan, Technical Rates Manager

Tod Johnson, Cost Reimbursement Analyst

Teresa Boden, Quality and Compliance Office Chief

Lori Gianetto Bare, Residential Quality Assurance Unit Manager

Saif Hakim, Office Chief

Geoff Nisbet, Audit Liaison

Rick Meyer, External Audit Compliance Manager

**Conclusion:**

The overall program control risk will be assessed at A-B. Control Understanding - Summary of Controls.

### Testing Strategy:

## Step 1: Assess Inherent Risk (IR)

### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

***Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

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### Step 2: Gather Information

#### Review scope of work

Allowable Activities - Determine which activities and types of costs are specifically allowed or unallowed, by reviewing the following:

1. Medicaid State Plan
2. Part 4 of the Compliance Supplement that applies to your audit period.
3. Any additional program guidelines or handbooks.
4. If above information is not available, look to the federal regulations (contact the single audit specialist if you need assistance with this).

Requirements for Cost Principles are found 2 CFR 200, Subpart E.

***Please be familiar with these requirements as not all are listed below; only parts emphasized in the Compliance Supplement are listed below.***

#### **Direct Costs**

Payroll Expenditures: When payroll costs are selected for our single audit, our focus is on whether the portion of payroll charged to the program (allocation) is supported by appropriate time and effort and meets the cost principles. Note that awarding agencies may require specific forms of documentation to support payroll charged to its award.

Compensated Absences (leave cash-outs or accrual): The entity may include employees' use of leave (which is included in their regular salary payments). If the entity charges any **leave cash-outs** or the **accrual of leave** to the grant, there are special rules, see extra guidance in the policy tab. There is a high risk the costs are unallowable.

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Non-Payroll Expenditures: Generally, auditors should test internal controls and compliance for non-payroll expenditures when those costs are quantitatively material (5%) to the program.

Automated Controls: If you identify key internal controls that are automated, consult with the SWSA Supervisor or SWSA AIC to determine whether to request automated control work from Team IT audit.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the internal control process and identify the key internal controls that are effective in ensuring:

(a) Activities Allowed: grant funds are used only for allowable activities (this may include review of expenditures, program monitoring, preparing the reimbursement requests, establishment of programs);

(b) Cost Principles: direct and indirect costs charged to the grant comply with the cost principles set forth in 2 CFR 200 Subpart E (this may or may not be the same control activity for (a) shown above)

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**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as **“LOW”** when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with Supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from the IT audit is expected, please inform the Medicaid Supervisor.***

Guidance/Criteria.*
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### **INTERNAL CONTROL UNDERSTANDING**

Documentation should address the five components of internal control per SAS 78 (control environment, risk

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assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

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See also A-133, Subpart E, \_\_.500(c)

### **B. ALLOWABLE COSTS/COST PRINCIPLES**

#### **Applicability of OMB Cost Principles Circulars**

The following OMB cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by: (1) States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I); (2) institutions of higher education; and (3) non-profit organizations. Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services' 45 CFR part 74, appendix E). The cost principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal Government or indirectly through a pass-through entity. The circulars describe selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in the form of grants, contracts, and other agreements.

The applicable cost principles circulars are as follows:

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**OMB Circular A-21, "Cost Principles for Educational Institutions."** - All institutions of higher education are subject to the cost principles contained in OMB Circular A-21, which incorporates the four Cost Accounting Standards Board (CASB) Standards and the Disclosure Statement (DS-2) requirements as described in OMB



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Circular A-21, sections C.10 through C.14 and Appendices A and B.

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### **Compliance Requirements - Allowability of Costs - General Criteria (applicable to both direct and indirect costs)**

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.
- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program, project, department, or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.
- Consistency - Costs must be given consistent treatment through application of those generally accepted accounting principles appropriate to the circumstances. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an indirect cost.
- Conformity to Laws, Regulations and Sponsored Agreements - Costs must conform to any limitations or exclusions set forth in the circulars, Federal laws, State or local laws, sponsored agreements, or other governing regulations as to types or amounts of cost items.
- Transactions that Reduce or Offset Direct or Indirect Costs - Costs must be net of all applicable credits that result from transactions that reduce or offset direct or indirect costs. Examples of such transactions include purchase

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discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments for overpayments or erroneous charges.

- Costs Documentation - Costs must be documented in accordance with OMB Circular A-110 for non-profit organizations and institutions of higher education or the A-102 Common Rule for State, local and Indian tribal governments.

### **Compliance Requirements - Indirect Costs**

Indirect costs are those costs that benefit common activities and, therefore, cannot be readily assigned to a specific direct cost objective or project. Three different types of indirect cost rates can be approved by the cognizant agency for indirect cost negotiation: predetermined, fixed, and provisional/final.

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- Provisional rates - temporary rates used for funding and billing indirect costs, pending the establishment of a final rate for a period.

Sometimes award-specific indirect cost rates are negotiated that are different from those set forth in negotiated rate agreements. Terms and conditions in an award specific to indirect cost rates take precedence over indirect cost rates set forth in negotiated agreements.

**See the appropriate circular for audit guidance.**

Record of Work Done:
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### **Inherent Risk of Noncompliance**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance

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requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are considered areas of higher risk by the oversight agency (**CMS**)
- Since the Supported Living (**SL**) program is a waiver-based service, DDA has a large degree of subjectivity in carrying out the program objectives
- The compliance requirements are susceptible to fraud and abuse

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

#### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine which activities and costs are allowed or unallowed. We identified the following:

#### A. Activities Allowed or Unallowed

6. *Home and Community-Based Services (HCBS)* - A state may obtain a waiver of statutory requirements to provide an array of HCBS which may permit an individual to avoid institutionalization primarily through 1915(c) of the Act (42 CFR Part 441, Subpart G). States may also offer HCBS under their state plan under authority provided by section 1915(i) of the Social Security Act. States must operate their HCBS programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, states must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Supported Living is an option under the Home and Community Based Services Core and Community Protection

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waivers.

Supported Living services support Medicaid clients to live in their own homes with one to three other people and receive instruction and support delivered by contracted service agencies (providers). Supported Living clients pay their own rent, food and other personal expenses.

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We requested the internal controls from the Department. Geoff Nisbet- Audit Liaison, provided us with the Department's response: [DDA FY22 SL audit Internal Controls response](#)

### **Quality Assurance Review**

On January 26, 2023 we met with the following staff:

- Valerie Kindschy, Waiver Residential Unit Manager
- Kenneth Callaghan, Technical Rates Manager
- Tod Johnson, Cost Reimbursement Analyst
- Teresa Boden, Quality and Compliance Office Chief
- Lori Gianetto Bare, Residential Quality Assurance Unit Manager
- Saif Hakim, Office Chief

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- Geoff Nisbet, Audit Liaison
- Rick Meyer, External Audit Compliance Manager

DDA's Residential Quality Assurance Unit has one employee, Donna Pearson, who provides technical assistance and consultation to certified community residential providers in two areas:

- **Support of clients reviews:** Review of supports provided to clients to determine whether providers are delivering supports as identified in clients' Person-Centered Service Plans (PCSPs). The PCSP is the state's primary instruction to the provider for the provision of contracted services. This review process started in 2019 when the ISS hour driven rate system was changed to the person-centered assessment driven tiered rate system. The quality assurance review includes review of a sample of clients supported by community residential providers. PCSPs are reviewed and compared to staff schedules, provider documentation, and interviews with staff and clients to determine whether supports listed in clients' PCSPs align with the supports provided. Reviews include a sample of clients across multiple homes and different service levels.

The program staff implemented a secondary review process that has been very successful. The secondary reviews are performed by four staff members. In addition to support of client reviews, DDA staff are also conducting support service reviews. In these reviews, they are looking at personal service plan and any tasks given to the provider. This is very individualized monitoring, due to it being based off of the personalized service plans. When performing these reviews, the provider is asked to provide documentation of care for one week in time, randomly selected. DDA perform interviews with the individuals providing direct support to clients. If any issues are identified, the provider is worked with to make any corrections. The issues identified are sometimes due to the care plan being wrong, or staff not having a proper care plan in place to begin with. DDA staff work with the provider until supports issues are changed or corrected.

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- **Management of client funds reviews:** Review of provider practices to determine compliance with requirements outlined in WAC 388-101D and DDA policy. The reviews examine management of client funds for a sample of clients. Client financial losses may be identified during this process.

Management of client reviews were not done during the audit period. Individualized provider trainings occurred instead. For any new providers a new special provider training was provided.

The quality assurance staff provides thorough, written feedback following both types of reviews, and requests a written plan documenting the provider's plan for correction. The quality assurance staff monitors to ensure all providers submit the written plan. For client financial losses discovered by the quality assurance staff, the provider must provide proof of reimbursement.

In FY22 DDA conducted six support of client reviews. Three additional staff were hired in 2022, and DDA has plans to increase the number of providers reviewed since they have more staff to conduct the reviews.

### Contract Monitoring

Headquarters quality assurance staff and regional resource managers and quality assurance staff monitor providers' performance in relation to their contract to ensure compliance. Resource managers' contract monitoring activities are documented in the Residential Agency Tracking Database and include visits to clients' homes. The database also tracks when training is provided, what follow-up, and the results from evaluations. The number of monitoring visits is determined by various factors including the number of incident reports and technical assistance requests from the provider.

Case managers (CRMs) visit clients' homes when performing the annual DDA assessment. CRMs monitor that clients are receiving the services according to their person-centered service plan and for changes needed to address health and welfare needs (**Key Control #1 - Monitoring**). This monitoring frequency depends upon the need of the

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client but must occur at least every six months. The monitoring typically includes a conversation with the client and/or their legal representative. For part of FY21, these visits were suspended due to the COVID-19 pandemic. DDA resumed in-person visits in the fall of 2021.

During case managers' monitoring of services, the frequency of services and the amount of each service are reviewed to ensure the client's assessed needs are addressed. This monitoring is documented in CARE.

A question on DDA's Quality Compliance Coordinator annual review confirms that CRMs completed plan monitoring. This annual QCC review includes a sample of client files. For waiver and Community First Choice clients, the sample size is set to have a confidence level of 95% and an error rate of + or – 5%. For Roads to Community Living clients, the sample size is 100%.

Action on noncompliance falls upon RCS. They have the ability to take enforcement action if needed. RCS has the ability to perform contract action, but they only do so in extreme situations. Contracts are only terminated if they have to be. Providers can not be easily shut down unless there is a place to put clients.

The Residential Quality Assurance program manager conducts a quarterly survey to obtain information about clients' inclusion in the community. The survey is based on a random selection of 350 clients and includes clients in the supported living program.

Every six months the Residential Quality Assurance Program Manager requests current Individual Instruction and Support Plans (IISPs) and information on progress toward IISP goals for the clients identified in the above survey. This is done in order to review the IISPs for compliance with WAC and DDA policy 5.08 (Individual Instruction and Support Plan and Risk Summary), as well as to ensure progress is being tracked for habilitative goals.

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## **Key Internal Controls**

**Key Control #1** - Case managers (CRMs) visit clients' homes when performing the annual DDA assessment. CRMs monitor that clients are receiving the services according to their person-centered service plan and for changes needed to address health and welfare needs (**Monitoring**).

The overall program control risk will be assessed at CY21 Cost Report and Payroll Verification Summary.

### **D.3.PRG - Activities Allowed/Unallowed and Cost Principles - Supported Living**

***Procedure Step:*** A-B. Control Understanding - Summary of Controls

***Prepared By:*** LS, 3/23/2023

***Reviewed By:*** RJC, 4/15/2023

Purpose/Conclusion.*
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#### **Purpose:**

To gain an understanding of the internal controls the agency has in place to provide reasonable assurance that Federal awards are expended only for allowable activities and that expenditures charged to the Federal award are allowable and in accordance with the applicable cost principles.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

#### **Source:**

Saif Hakim, Residential and Day Programs Office Chief, DDA

Geoff Nisbet, Audit Liaison, DDA

Kenneth Callaghan, Rates Manager, Management Services Division

Rick Meyer, External Audit Liaison, DSHS

Tod Johnson, Cost Analyst, MSD

#### **Conclusion:**

Based on our understanding of internal controls over Activities Allowed and Cost Principles, we found the agency does not have adequate internal controls to



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prevent material noncompliance. Therefore we assess **preliminary control risk as high and will report a finding for a material weakness at F1\_S1Washington\_SA22\_DSHS-M03\_Activities Allowed\_Supported Living**. No internal control testing is necessary in this instance.

Testing Strategy:

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

***Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

#### Review scope of work

Allowable Activities - Determine which activities and types of costs are specifically allowed or unallowed, by reviewing the following:

1. Medicaid State Plan
2. Part 4 of the Compliance Supplement that applies to your audit period.
3. Any additional program guidelines or handbooks.
4. If above information is not available, look to the federal regulations (contact the single audit specialist if you need assistance with this).

Requirements for Cost Principles are found 2 CFR 200, Subpart E.

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*Please be familiar with these requirements as not all are listed below; only parts emphasized in the Compliance Supplement are listed below.*

### **Direct Costs**

**Payroll Expenditures:** When payroll costs are selected for our single audit, our focus is on whether the portion of payroll charged to the program (allocation) is supported by appropriate time and effort and meets the cost principles. Note that awarding agencies may require specific forms of documentation to support payroll charged to its award.

**Compensated Absences (leave cash-outs or accrual):** The entity may include employees' use of leave (which is included in their regular salary payments). If the entity charges any **leave cash-outs** or the **accrual of leave** to the grant, there are special rules, see extra guidance in the policy tab. There is a high risk the costs are unallowable.

**Non-Payroll Expenditures:** Generally, auditors should test internal controls and compliance for non-payroll expenditures when those costs are quantitatively material (5%) to the program.

**Automated Controls:** If you identify key internal controls that are automated, consult with the SWSA Supervisor or SWSA AIC to determine whether to request automated control work from Team IT audit.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably*

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*addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the internal control process and identify the key internal controls that are effective in ensuring:

- (a) Activities Allowed: grant funds are used only for allowable activities (this may include review of expenditures, program monitoring, preparing the reimbursement requests, establishment of programs);
- (b) Cost Principles: direct and indirect costs charged to the grant comply with the cost principles set forth in 2 CFR 200 Subpart E (this may or may not be the same control activity for (a) shown above)

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less

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than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with Supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from the IT audit is expected, please inform the Medicaid Supervisor.***

Guidance/Criteria.†

### INTERNAL CONTROL UNDERSTANDING

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

See also A-133, Subpart E, \_\_.500(c)

### B. ALLOWABLE COSTS/COST PRINCIPLES

#### **Applicability of OMB Cost Principles Circulars**

The following OMB cost principles circulars prescribe the cost accounting policies associated with the administration of Federal awards by: (1) States, local governments, and Indian tribal governments (State rules for expenditures of State funds apply for block grants authorized by the Omnibus Budget Reconciliation Act of 1981 and for other programs specified in Appendix I); (2) institutions of higher education; and (3) non-profit organizations. Federal awards administered by publicly owned hospitals and other providers of medical care are exempt from OMB's cost principles circulars, but are subject to requirements promulgated by the sponsoring Federal agencies (e.g., the Department of Health and Human Services' 45 CFR part 74, appendix E). The cost

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principles applicable to a non-Federal entity apply to all Federal awards received by the entity, regardless of whether the awards are received directly from the Federal Government or indirectly through a pass-through entity. The circulars describe selected cost items, allowable and unallowable costs, and standard methodologies for calculating indirect costs rates (e.g., methodologies used to recover facilities and administrative costs (F&A) at institutions of higher education). Federal awards include Federal programs and cost-type contracts and may be in the form of grants, contracts, and other agreements.

The applicable cost principles circulars are as follows:

**OMB Circular A-87, “Cost Principles for State, Local, and Indian Tribal Governments.”**

**OMB Circular A-21, “Cost Principles for Educational Institutions.”** - All institutions of higher education are subject to the cost principles contained in OMB Circular A-21, which incorporates the four Cost Accounting Standards Board (CASB) Standards and the Disclosure Statement (DS-2) requirements as described in OMB Circular A-21, sections C.10 through C.14 and Appendices A and B.

The cost principles articulated in the OMB cost principles circulars are in most cases substantially identical, but a few differences do exist. These differences are necessary because of the nature of the Federal/State/local/non-profit organizational structures, programs administered, and breadth of services offered by some grantees and not others. Exhibit 1 of this part of the Supplement, Selected Items of Cost, lists the treatment of the selected cost items in the different circulars.

**Compliance Requirements - Allowability of Costs - General Criteria (applicable to both direct and indirect costs)**

The general criteria affecting allowability of costs under Federal awards are:

- Reasonable and Necessary - Costs must be reasonable and necessary for the performance and administration of Federal awards.
- Allocable - Costs must be allocable to the Federal awards under the provisions of the cost principles or CASB Standards, as applicable. A cost is allocable to a particular cost objective (e.g., a specific function, program,

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project, department, or the like) if the goods or services involved are charged or assigned to such cost objective in accordance with relative benefits received.

- **Consistency** - Costs must be given consistent treatment through application of those generally accepted accounting principles appropriate to the circumstances. A cost may not be assigned to a Federal award as a direct cost if any other cost incurred for the same purpose in like circumstances was allocated to the Federal award as an indirect cost.
- **Conformity to Laws, Regulations and Sponsored Agreements** - Costs must conform to any limitations or exclusions set forth in the circulars, Federal laws, State or local laws, sponsored agreements, or other governing regulations as to types or amounts of cost items.
- **Transactions that Reduce or Offset Direct or Indirect Costs** - Costs must be net of all applicable credits that result from transactions that reduce or offset direct or indirect costs. Examples of such transactions include purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds or rebates, and adjustments for overpayments or erroneous charges.
- **Costs Documentation** - Costs must be documented in accordance with OMB Circular A-110 for non-profit organizations and institutions of higher education or the A-102 Common Rule for State, local and Indian tribal governments.

### **Compliance Requirements - Indirect Costs**

Indirect costs are those costs that benefit common activities and, therefore, cannot be readily assigned to a specific direct cost objective or project. Three different types of indirect cost rates can be approved by the cognizant agency for indirect cost negotiation: predetermined, fixed, and provisional/final.

- **Predetermined rates** - rates established for the current or multiple future period(s) based on current data (usually data from the most recently ended fiscal year, known as the base period). Predetermined rates are not subject to adjustment, except under very unusual circumstances.
- **Fixed rates** - rates based on current data in the same manner as predetermined rates, except that the difference between the costs of the base period used to establish the rate and the actual costs of the current period is carried forward as an adjustment to the rate computation for a subsequent period.

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- Provisional rates - temporary rates used for funding and billing indirect costs, pending the establishment of a final rate for a period.

Sometimes award-specific indirect cost rates are negotiated that are different from those set forth in negotiated rate agreements. Terms and conditions in an award specific to indirect cost rates take precedence over indirect cost rates set forth in negotiated agreements.

**See the appropriate circular for audit guidance.**

Record of Work Done.
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### CARE Client Assessment Process And Rate Setting

**Key Control #1** -The Department maintains an access database of assessor's qualifications to ensure that the CARE client assessment is being administered in a standard, uniform way (**Monitoring**).

**Key Control #2** - The rate is submitted by the RM to the Resource Manager Administrator or designee and is forwarded to the Program Manager for approval, and then sent to the rate analyst for verification to ensure that the rate matches the level of care as determined in the CARE assessment (**Control Activities**).

### Residential Care Services Certification & Investigation

**Key Control #3** - RCS conducts a certification evaluation every two years to ensure supported living agencies are following service plans and providing adequate care (**Control Activities**).

### Cost Report and Payroll Verification

**Key Control #4** - The Department randomly selects supported living providers for payroll verification to ensure proper rates are being charged for supported living services (**Monitoring**)

The Cost Report is the entire multi-worksheet Excel file for each Supported Living agency. During payroll verification, the Department selects providers to review 2-3 randomly selected months of detailed supporting documents for ISS expenditures claimed on the Cost Report. No documentation is submitted with the provider cost reports until the associated provider is selected for payroll verification by DDA staff. The providers are required to

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submit an excel spreadsheet documenting expenditures for their cost report.

### Quality Assurance Review

**Key Control #5** - Case managers (CRMs) visit clients' homes when performing the annual DDA assessment. CRMs monitor that clients are receiving the services according to their person-centered service plan and for changes needed to address health and welfare needs (**Monitoring**)

### **Control Weakness**

Key controls 1, 2, 3, and 5 are considered programmatic monitoring activities unrelated to fiscal activity of the supported living program. Key control #4 is the primary control that addresses any fiscal activity of supported living providers. Providers are not required to submit supporting documentation with their cost report and are only required to submit payroll records upon DDA payroll verification. The cost report is comprised of provider generated data of services provided. We do not consider key control #4 to be sufficient to detect fiscal noncompliance per activities allowed, and therefore the supporting programmatic controls also do not impact the fiscal oversight of supported living funds.

**Evaluation of Results:** Control deficiencies were identified.

1. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **more than remote** and the magnitude of potential noncompliance is **material**.
2. Guidance from the CMS management letter requests the Department have a payment review process that occurs more frequently than one time a year. Also the state should ensure payments to providers meet the requirements for allowable activities and cost principles along with confirming payments are adequately supported with documentation. Applying this criteria to the internal controls we reviewed, we conclude the Department does not have adequate internal controls to ensure payments to supported living providers are adequately documented and supported. While the Department has several key controls, they primarily



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address programmatic aspects of supported living.

### **Preliminary Control Risk Assessment**

#### **Step 4**

HIGH - Internal control design is not likely to be effective to prevent or detect non-compliance with grant requirements. We will report a **material weakness** in accordance with 2 CFR §200.516(1) at

F1 S1Washington SA22 DSHS-M03 Activities Allowed Supported Living .

#### **E.1.PRG - Eligibility**

*Procedure Step:* HCA Eligibility Overview

*Prepared By:* AMG, 3/6/2023

*Reviewed By:* RJC, 5/30/2023

Purpose/Conclusion.*
----------------------

#### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

#### **Source:**

Melissa Rivera, Medical Program Specialist  
Margaret Clay, OMEP Deputy Section Manager  
James Brackett- Medical Program Specialist  
Cindy Raves, Internal Auditor  
Shaunie Mcleod, Medical Program Specialist - CHIP

#### **Conclusion:**

We gained an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations

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receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

Testing Strategy:

Guidance/Criteria:

Record of Work Done:

To determine initial eligibility for Medicaid, an individual must complete an application in the HealthPlan Finder. Once the information is submitted in the HealthPlan Finder it is sent to the Rule engine, which is a system that runs side by side with ACES, which will review the information submitted against various eligibility rules to determine eligibility. Once eligibility is determined, the rules engine sends the results back to HealthPlan Finder and ProviderOne. HealthPlan Finder will inform the applicant of their eligibility determination, which can include Apple Health (Washington's Medicaid program) among other health plan options. ProviderOne will open the applicant's cases allowing them to begin claiming benefits.

MAGI based eligibility information is verified in accordance with CMS approved MAGI-Based Eligibility Verification Plan. See: [Washington Verification Plan \(medicaid.gov\)](https://www.wa.gov/medicaid/eligibility/verification-plan). HCA accepts self-attested income with post-eligibility verification. When completing their application in HealthPlan Finder, an individual is required to submit their SSN. HealthPlan Finder uses Equifax to confirm if the SSN is valid. If SSN does not match, an error message is created, which allows the applicant to review the application to ensure they input correct information. If SSN is invalid, the individual is unable to get Medicaid. If an individual does not have a SSN and is not currently in the process of applying for a SSN, they will need to mark the box that best describes their situation. There are five potential scenarios where this would be allowable, listed below:

- SSN Application Pending
- Religious Objection
- Domestic Violence
- Adoption/Foster Care
- Undocumented Alien

Any of these scenarios selected will create an error code for staff to review. Staff will request additional information to ensure an individual is able to receive Medicaid services.

An individual attests to their citizenship status when they complete their application in HealthPlan Finder. HealthPlan Finder has a web-based connection with

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Systematic Alien Verification for Entitlements Program (SAVE), which is an electronic database administered by the U.S. Citizenship and Immigration Services which verifies the citizenship status of applicants. All states are required to use this system. An individual also provides their household size when they are completing their application in HealthPlan Finder. If the individual is a tax filer, the information is compared to the most recent tax return. If the individual is a non tax filer, the applicant's self attestation of their household size is accepted.

Eligibility determinations are completed for new and renewal applications for MAGI services. Eligibility renewal reviews take place annually for all clients.

**Initial applications are completed by the applicant utilizing HealthPlan Finder (HPF). Once the application is completed, electronic verification sources confirm income, immigration status and Social Security Number (SSN) (Automated Key Control #1- Control Activities)**

- **Income:** Individuals that apply for Apple Health attest to their income and once their application is submitted, the Federal HUB determines whether this income is reasonably compatible with a 0% threshold with the MAGI-income standard for the Apple Health program they are approved on.
- **Citizenship/Immigration:** Individuals attest to their immigration status when applying for Apple Health and this information is verified through Systematic Alien Verification for Entitlements Program (SAVE) when the application is submitted.
- **SSN:** Individuals attest to their social security number when applying for Apple Health and if they don't provide it, they attest to a good cause reason for not providing their SSN. Their SSN is verified through a match with the federal government.

### Post Eligibility Review

If the federal systems are unable to verify the income, citizenship/immigration or SSN provided on an application, a tickler is created which informs HCA staff that a post eligibility review needs to be completed on the application. **HCA staff will follow-up and verify each unverified requirement through the uses of state systems or reaching out to the applicant to provide additional information. (Key Control #2- Control Activities)**

The processes and procedures utilized by HCA staff vary based on which requirement or requirements need to be verified. Each process and procedure for each requirement is documented below:

### **Income:**

When an individual applying for or renewing Washington Apple Health (WAH) has attested income which is incompatible with the State and/or Federal cross-match, the MEDS Verification Program (MVP) generates a Post Eligibility Review request the following day. Post eligibility reviews are assigned in the order they are received, based on the date of application/renewal. Based on an income cross match with the federal HUB, approximately 73% of households are automatically sent a letter requesting proof of 60 days of household income due within 15 calendar days. These applications/renewals are prioritized and are worked 7-10 days following the income request due date. Assignments and validations are documented in the MVP system by the lead worker or supervisor.

Once HCA staff receives a request for a Post Eligibility Review for unverified income, the staff will attempt to verify income using the following systems/processes:

- Employment Security Department (ESD)
- SOLQ

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- TALX
- If unable to verify income in these systems, HCA staff requests verification of income from the client such as wage stubs.

Once HCA staff has verified income, they manually input the data into the MVP income worksheet and then eligibility is determined based on MAGI methodology.

For additional details pertaining to the procedures related to verifying income, see: [MAGI Internal Control Assessment](#)

*Note: Due to the Coronavirus Pandemic, the Authority has stated that they are not terminating clients due to income. Therefore, if a client had a change of income during this time, the Authority will not terminate them unless the client requests termination.*

### **Citizenship/Immigration:**

When an individual applying for or renewing WAH has attested citizenship or immigration status unverified via cross match with SAVE, a tickler is created in Barcode. HCA staff will be assigned the case either through grabbing it from the queue or getting the case as a result of a client call or email. Once HCA staff is assigned a case they will review the tickler, ACES narrative and SAVE verification history, if they have access, and HealthPlan Finder (**HPF**). After they complete this initial review they will check Barcode, WebAx and HPF to see if any documents have been submitted.

#### **If no verification provided:**

- Reviews HPF message center for the Important Deadline to Submit verification letter (EE001)
  - If letter has been sent and client has not met Reasonable Opportunity Period (**ROP**) (90 days)- HCA staff resets tickler to ensure client gets the full ROP and will follow up on the tickler when it comes due.
  - If letter has been sent and client has met ROP - HCA staff will terminate coverage.
  - If letter was not sent - HCA staff will send EE-005 request for information letter from HPF and forward tickler out to self for 17 days

#### **If verification provided:**

- Compare attestation against verification provided and update HPF and sign application to get an updated determination
  - If federally verified, HCA staff will confirm WAH eligibility result is correct and narrate actions in ACES online.
  - If federally unverified, HCA staff will submit a request for SAVE verification and forward tickler to self for 14 days and update the ACES narrative to include the SAVE ID
    - If SAVE response is undocumented or Deferred Action for Childhood Arrivals (**DACA**), update information in HPF and system will determine eligibility
    - If Save response is U.S. Citizen, update information in HPF and system will determine eligibility

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- If Save response is Lawfully Present Qualified or Non-Qualified, HCA staff will input Eligibility Statement Code Box in HPF and system will determine eligibility
- HCA staff will confirm WAH Eligibility result is correct in ACES online and narrate actions in ACES online. (Note: If system determines client is not eligible for WAH, HCA staff sends General Notice (EE-013) from HPF to include appropriate termination standard text and sets a QA flag to prevent WAH/MAGI approval)

For additional details pertaining to the procedures related to verifying citizenship, see: Citizenship and Immigration Procedures FINAL

### SSN:

When an individual applying for or renewing WAH has an attested SSN that does not federally verify or does not provide a SSN, the client's AU is pended in ACES and a tickler is generated in Barcode. The system will generate either a MGPA or MGNS tickler based on whether the SSN just needs to be verified (**MGPA**) or if the SSN and income both need to be verified (**MGNS**). HCA staff will be assigned a case by either grabbing it from the queue or getting the case as a result of getting a client call or email. Once HCA staff has been assigned a case, they will review the tickler, ACES narrative and HPF. After initial review, they will review Barcode, WebAx and HPF to see if any documents have been submitted.

- If SSN has been submitted, HCA staff updates HPF with number and narrates actions in ACES online
- If SSN has not been submitted, HCA staff will review demographic information in ACES Online to determine if client is under the age 1 and
  - If the client's mother was active on WAH in the month of birth, staff updates mother as pregnant in HPF and with pregnancy due date as client's date of birth and then narrates actions in ACES online
  - If the client's mother was not active on WAH in the month of birth, staff updates Blank SSN reason to "They applied for a Social Security Number" and narrates actions in ACES online
- If SSN has not been submitted and client is over the age of 1, staff reviews message center in HPF to confirm an Important Deadline to Submit Information letter (EE001) was generated and contains correct verification information, if
  - The letter did not generate, staff create an Information Request Letter (EE005) for required verification with due date in 15 days, set tickler to self for 17 days and narrates action in ACES online.
  - The letter did generate, staff terminates coverage and narrates actions in ACES online.

For additional details pertaining to the procedures related to verifying SSN, see: Citizenship and Immigration Procedures FINAL

### Monitoring

It is important for post eligibility reviews to be completed by HCA staff timely to ensure only eligible clients are receiving MAGI services. Each requirement, income, citizenship/immigration and SSN has a different time line, as documented below:

- Income: HCA has set a goal to complete all post-eligibility reviews as they pertain to income within sixty days. However, this deadline is not included in the state plan and is not a formalized agreement with CMS. For this audit, we will look at the length of time it takes HCA

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staff to complete post eligibility reviews as they pertain to income, we will not issue exceptions if past the sixty days. However, if HCA staff failed to complete verification prior to the start of a new renewal period, we will consider those exceptions.

- Citizenship/Immigration: HCA must verify citizenship/immigration status within 90 days and has an additional five days for mailing. However, as a result of the 95 days taking a client into another month, HCA could pay for 120 days of Medicaid coverage for ineligible clients which is allowable.
- SSN: HCA must verify SSN within 90 days and has an additional five days for mailing. However, as a result of the 95 days taking a client into another month, HCA could pay for 120 days of Medicaid coverage for ineligible clients which is allowable.

All of these post eligibility review assignments are held in the Barcode system. Once a week, supervisors pull a pending inventory report showing the workload inventory, which includes the oldest assignments that need to be worked. Based on the information provided in this report, supervisors will shift workload priorities accordingly. **(Monitoring)**

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- *Note: During a Non-Public Health Emergency year this would be considered a key internal control, however, due to the Public Health Emergency (PHE), the Authority is not performing Post Eligibility reviews. HCA stated starting in January of 2020, clients could fill out the 1135 waiver which gave them more time to gather information for the eligibility process. In addition, for cases processed after 3/18/2020, Medicaid cases fell under the regulatory protections of the federal FFCRA and CARES Acts through the end of the federal public health emergency of COVID-19. HCA has put a temporary hold on post eligibility requirements for current clients. The Agency also received emergency declaration blanket waivers for Health Care providers that states when the blanket 1135 waivers are in effect, they have a retroactive effective date of March 1, 2020, through the end of the emergency declaration. See full document, [WA-1135-waiver-request from governor](#). We do not expect to see post-eligibility reviews during the audit period.*
- 

### E.1.PRG - Eligibility

**Procedure Step:** DSHS Eligibility Overview

**Prepared By:** AMG, 3/6/2023

**Reviewed By:** RJC, 5/30/2023

Purpose/Conclusion.\*

**Purpose:**

# State of Washington

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

## **Source:**

Audit Liaisons:

Geoff Nisbet, Public Records Program Manager

Laura Holloway, ALTSA QA Administrator

Rick Meyer, External Audit Compliance Manager

## **Statutory Eligibility Process (DDA requirement only):**

- Lonnie Keesee, Eligibility and Payment Systems Unit Manager
- William Nichol, Intake and Eligibility Program Manager
- Shaw Seaman, Communications, Eligibility, Payment and Training Office Chief
- Jaime Bond, Interim Office Chief, Program & Policy Development
- Rick Meyer, External Audit Compliance Manager

## **Financial Eligibility Process:**

DDA

- Marcell Birdsall, LTC Specialty Unit Manager
- Jaime Bond, Interim Office Chief, Program & Policy Development
- Rick Meyer, External Audit Compliance Manager
- Ann Vasilev, Waiver Services Unit Manager

ALTSA

- Jennifer Ferguson, Office Chief, Financial Eligibility & Policy
- Lori Rolley, Financial Service Policy Analyst
- Rob Peters, Financial Program Manager
- Julia Mosier, Office Chief
- Kristian Rodriquez, QA Policy Program Manager

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## Functional Eligibility process:

### DDA

- Jaime Bond, Interim Office Chief, Program & Policy Development
- David Harding, QCC Unit Manager
- Teresa Boden, Quality and Compliance Office Chief
- Erin Fatland, Joint Requirements Unit Manager
- Rick Meyer, External Audit Compliance Manager
- Ann Vasilev, Waiver Services Unit Manager
- Melissa Randles, Acting State Plan Services Unit Manager
- Manipon Manivanh, Community First Choice Program Manager

### ALTSA:

- Rachelle Ames, Care Management Unit Manager
- Paula Renz, AAA Specialist
- Mark Towers, New Freedom Program Manager/AAA Specialist
- Kristian Rodriguez, QA Policy Program Manager
- Victoria Nuesca, CFC Program Manager
- Sandy Spiegelberg, Enhanced Services Facilities Program Manager
- Dustin Campbell, Home and Community Services Waiver Program Manager

## Conclusion:

We gained an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

Testing Strategy:



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Guidance/Criteria:

Record of Work Done:

## Statutory Eligibility Process (DDA requirement only):

An individual is determined statutorily eligible to receive services if they are eligible to be a DDA client; the requirements of which are outlined in WAC 388-823. In brief, an individual is eligible for DDA services if they have a disability which is attributable to:

- Intellectual Disability
- Cerebral Palsy
- Epilepsy
- Autism or
- Another neurological or other condition similar to intellectual disability that:
  - Originated before the individual turned age 18
  - Is expected to continue indefinitely and
  - Results in substantial limitation to an individual's intellectual and adaptive functioning

Individuals wishing to apply for DDA eligibility must submit an application packet. The application packet contains:

- Request for DDA Eligibility
- Consent Form
- Notice of Privacy Practices for Client Confidential Information
- Documents that support that you have a developmental disability (though if unable to attain we will assist) and
- Voter Registration form (for applicants 18 years or older)

If a client is determined to be statutorily eligible upon initial application, the determination does not continue indefinitely. DDA clients are required to be re-evaluated at the following times:

AGE	CONDITION	EXPIRATION CRITERIA	REVIEW CRITERIA
3 YOA, prior to 4th B-Day	All conditions or developmental delays	Expiration effective 4th birthday, unless an eligibility determination was made after the 3rd	None

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		birthday.	
9 YOA prior to 10th B-Day	All conditions or developmental delays	Expiration effective on 10th B-Day	None
19 YOA	All Conditions	All Conditions	If you are age 19 and your most recent determination was completed before your 16th B-Day
19 YOA prior to 20th B-Day	Another neurological or other condition similar to Intellectual Disability	None	When academic delays were used as evidence of substantial limitations
At any age	All conditions	None	Prior to authorization of paid services when you are not currently receiving paid services and your current eligibility determination was prior to June 1, 2005
At any age	All conditions	None	If evidence was insufficient, in error, or fraudulent; or new information becomes available that does not support your eligibility

Current clients who have a statutory eligibility determination that is about to expire based on the information in the above table and who wish to continue as a DDA eligible client must reapply for DDA statutory eligibility status and submit a current application packet. If a statutorily eligible determination is made for a new applicant and the person requests services, the individual is assigned to a case manager to assess for un-met needs. If a current client is re-determined statutorily eligible, the client's current case manager continues services.

The statutory eligibility determination process occurs when a potential or current client submits an application to become DDA eligible.

In order for an individual to become a client of DDA, they need to apply for DDA eligibility by submitting an application packet and supporting documentation (as requested in the packet). Applications are available on the DSHS website, and regional and local DDA Offices. Once submitted, the application is forwarded to an intake and eligibility worker who reviews the packet to ensure it is complete. Complete applications are those that include the required forms, and evidence of a qualifying condition and substantial limitations. Clients/guardians are also required to submit release of information authorizations for health and school records. If there is missing information, the worker contacts the client and/or guardian and requests additional information. The worker may also contact the school district where the individual attended school or other service providers where the client is seen by assistant or medical personnel.

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The worker reviews the records to ensure the statutory requirements to become a DDA client are met. Specifically, the worker reviews for the following:

- Attestation the applicant is a Washington state resident
- Evidence the applicant's disability existed prior to age 18
- Evidence of a qualifying condition
- Evidence of substantial limitations (Substantial limitation criteria varies according to the qualifying condition)

The worker has 30 days from receiving the last piece of requested documentation before making a determination. If the worker does not have sufficient information to determine whether the applicant is eligible and has not received all requested documentation, DDA may deny the applicant's eligibility after 90 days from the date of receiving a new application. Staff will work with the applicant to obtain any required documentation and will extend the 90 day time frame as needed.

The DDA case worker enters the result of their application review into the CARE system under a "Current DDD Determination" tab. There are two sub-folders; one is the "Evidence Tracking" tab where the worker documents the type of evidence and documents used to make the determination. The second tab is for eligibility decisions and calls for the worker to document their decision by including the date of their decision, the original date the client is eligible, the expiration date of their decision and the next review date, if applicable. The worker also documents the disability or condition that makes the client statutorily eligible, whether the condition existed prior to age 18, the official diagnosis and the qualifying instrument that allowed the worker to make the determination.

**An intake and eligibility worker reviews and evaluates the application packet and supporting documentation from health care providers, schools, and other support professionals to determine if the applicant meets statutory eligibility requirements under WAC 388-823 and documents this review in CARE. (Key control #1-control activities)**

### Financial Eligibility Process:

Financial eligibility determinations are completed for new and renewal applications for services. Eligibility renewal reviews take place annually for SSI-related clients (NOTE: for clients on SSI, the federal government determines eligibility so the financial unit relies on that determination. As such, in our testing populations, if clients are on SSI, we will test if they have been federally verified for SSN and citizenship but we will also rely on the federal government financial eligibility determination). Initial applications require documentation for bank accounts, trusts, life insurance etc.

For renewal (annual) applications, documentation isn't requested except for new resource/income types or if the client has included resources/income on the application that are over the resource/income limit. New and renewal applications and all supporting documentation is scanned and stored electronically in the Department's Document Management System (**DMS**) within Barcode.

When a client is first verified, their SSN and citizenship is verified in ACES through the nightly cross match with SSA. If either the SSN or citizenship is not federally verified through this cross match the worker follows up with the client to receive and review manual documentation such as social security card, birth certificate, passport etc. They add a copy of this documentation to Barcode.

Public Benefits Specialists (PBS) review the application in Barcode and determine if it is for a new determination or re-determination (re-determinations require less documentation.) PBS will review the application, supporting documentation, and complete data checks with various external financial systems and source

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documentation (in Barcode) to determine whether the client is financially eligible to receive services, including checks on Social Security Number, citizenship, income, resources and date of death.

These systems include:

- ACES-Online application - when a client is originally set-up, ACES runs a cross match nightly and federally verifies the Social Security Number and citizenship of the client. If either are not federally verified, the PBS follows up with the client to receive physical documentation, such as social security card.
- LexisNexis - LexisNexis is a private information clearing house where public records from a myriad of sources are compiled and made available on a subscription basis. PBS use LexisNexis to identify assets that may not have been declared or assets that may have been recently liquidated. LexisNexis pulls all public records available in the United States. LexisNexis reports are generally not requested for clients who are minor children.
- SOLQ (Social Security Administration) - accessible through the ACES mainframe system. Used to verify the client's SSN, date of birth, address, whether or not the client is disabled (important if the applicant is under 65 years of age), and what date they began receiving social security. Also, if the client has their social security placed into a bank account, the PBS is able to verify that the client has a bank account and what type of account the payments are placed in.
- SDX - used to verify clients' SSI income, history, and methods of payments. If direct deposit is indicated, workers will be alerted of bank accounts that the clients have.
- BENDEX - used to verify OSDI income, history, and methods of payments. If direct deposit is indicated, workers will be alerted of bank accounts that the clients have. This can be used to verify Medicare eligibility.
- TPX - can access the DRSM system which the workers use to verify retirement income.
- TALX - for clients who reported employment income, quarterly wages or unemployment income can be checked on this website
- PARIS – provides the following information quarterly about benefits active ACES clients may be receiving from other states such as Veteran's Administration (VA), Department of Defense (DOD), and Interstate Match files
- County Assessor websites - accessible through the county website of the HCSOs particular county. Able to view property owned by the client and determine whether there are any discrepancies in the information provided by the client on their application.
- Asset Verification System (AVS) - used to verify client financial institutional accounts as of the first of the month from anywhere from three months to five years (for initial application).
- NGTS/UTAB - used to verify unemployment benefits issued by the Employment Security Division.
- SAVE - verify immigration documents for documented non-citizens.
- WHALES- used to verify Washington State birth, death, marriage, and divorce records

There is also a system that the HCSO workers cannot access directly. but can request information from CSO workers who have direct access -

- SEMS (support enforcement) - for clients who report income from child support. The amount received can be verified through this system.

For an initial application, once all documentation has been reviewed and verified, PBS will contact the client and set up a phone interview. (If the client is active

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on Medicaid, no interview is required.) During the interview, the worker will verify all information that was provided on the application with the client or their representative, and ask any additional questions the worker has about the information provided on the application. After the phone interview, the worker will send a letter (Form 0023-02, created in ACES-Online) to the client regarding the status of their application and what documentation, if any, is still required. Depending on the results of their searches, PBS can request the clients provide bank statements from anywhere from three months to five years (for initial application). Assuming the client submitted the application with all required forms correctly completed, workers are expected to process applications within 45 days. 60 days are allowed for clients who are waiting to receive their disability determination. Additional days may be allowed if there is an accepted reason for not meeting standard of promptness. Note: For CFC only applications, no phone interview is necessary if the application is clear and doesn't raise any questions for the PBS's. Phone interviews are usually necessary for transfer of assets and other long-term care issues, typically not CFC only clients.

The PBS is informed when a client dies, either by the case manager receiving a notification from a family member or provider about the deceased client or through the nightly data link between ACES and SSA. Once the case manager receives notification, they input the date of death in CARE, which then ends the authorization in ProviderOne. Once ACES receives notification from SSA of the death, ACES ends the financial eligibility RAC code for that client in ProviderOne, which then ends the authorization in ProviderOne. For example, if ProviderOne receives a notification to cancel from ACES, but it does not receive a notification from CARE to cancel, it will stop payments and a tickler will be created to inform the case manager that a mismatch has occurred and needs to be corrected to reinstate payment if applicable.

### COVID

In response to the COVID-19 Public Health Emergency, self-attestation for all eligibility criteria (excluding SSN, citizenship and immigration status) would be allowed to determine eligibility if verification was not available, see public health emergency declaration at . On page 24, under Medicaid Waivers-Approval-it states "1135 waivers can be used to implement a range of flexibilities." . Also see the Governors 1135 waiver requesting flexibilities beginning on page 13 (page numbered on bottom - 11) at Section 1135 Waiver Flexibilities - Washington Coronavirus Disease 2019 (March 15, 2020 Communication) .

In addition, to comply with section 6008 of the Families First Coronavirus Response Act, Medicaid will not be terminated except if a client requests termination, is no longer a Washington State resident, or the client dies. Marcell stated during COVID, they aren't terminating services unless requested, death, change residence.

We reached out to the Department for clarification on the 90 day extension for extra documentation. Jennifer Ferguson, Office Chief, Financial Eligibility & Policy, stated that there were 2 types of extensions that have implemented during the public health emergency:

1. In Barcode, they created a new tickle type (CSAT) in response to the PHE. It defaults to a 90 day follow-up. They initially chose 90 days because the federal PHE declaration is in 90 day increments and staff would need to act post-PHE.
1. For client request letters and follow-ups on traditional verification requests, the follow-up can be set from 12 – 30 days based on what documentation is needed and how much time the client requested. This can be extended if more time is requested from the client.
2. During the PHE, the state is required to maintain access to medicaid. If a client does not respond to the request for review at the end of their certification period, HCA is automatically extending the certification period for 3 months/90 days in order to comply with the MOE to maintain access to medicaid. The client will be sent another request for review approximately 45 days prior to the end of their “new” certification period.

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**Financial Eligibility workers review the application, supporting documentation and complete data checks with various external financial systems and source documentation (in Barcode) to determine if the client is financially eligible to receive services including checks on Social Security number, citizenship, income, resources. (Key Control #2-control activities)**

Functional Eligibility process:

## **DDA**

CARE is the tool used by Case Resource Managers (CRMs) to document a client's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a client will receive, and develop a plan of care (person-centered service plan).

CARE assessment:

CARE gathers all the information about what supports a client needs to successfully live in the community and calculates a customized level of care based on the information. Once the assessment in CARE is complete, algorithms within CARE determine what programs the client is eligible for and what level of service the client is eligible for.

The assessment has three distinct sections:

### 1) Support assessment

During the support assessment section, the assessment directs the case manager to inquire about what kind of support a client needs in order to be successful in performing daily life tasks. This phase determines whether the client is eligible and includes the following areas:

- Home Living Activities
- Community Living Activities
- Lifelong Learning
- Employment
- Health and Safety
- Social Activities
- Protection and Advocacy
- Exceptional Medical and Behavioral support needs
- Protective Supervision needs

### 2) Service level assessment

During the service level assessment section, the assessor inquires about what kind of support the client had in the look back period with performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) specifically.

After completing the support assessment section and the service level section, the CRM consults with respondents who may not have been present at the time of the assessment to validate/verify the information received or gather additional information. Afterwards, they finalize comments throughout all the tabs in CARE and finish all details. The final section the CRM must complete is the Person Centered Service Plan. Once the assessment and person-centered service plan is completed by the CRM, the assessment is moved to "current" status in CARE.

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### 3) Service Amount Calculation

CARE runs an algorithm to determine whether the client is eligible and what level of service the client requires. The case manager then discusses the results with the client and works with them to select a qualified provider(s) of the client's choice. If the client disagrees with the case manager's decision, the client may appeal the decision.

NOTE: Clients are informed about their right to request additional support hours via an Exception To Rule (ETR) if they do not believe their CARE assessed hours are sufficient. CRMs document the requested amount and the justification information received from the client in the CARE system and submit the requests electronically to an ETR committee at DDA headquarters for a decision. The decision is recorded in the CARE system.

At this point, the assessment is final. A time stamp is created on the assessment main page in CARE called the "completion date" (the date the assessment was moved from pending status to current status). Once the assessment has been completed in CARE, the system automatically generates the next person-centered service plan due date a year from the completion date. The CRM then sends the person centered service summary which includes a signature page, and a Planned Action Notice (**PAN**) to the individual. The service summary informs the client of the services they are eligible for, the amount of the services, and what tasks are assigned to what provider. The signature page includes four signature lines (client, client representative, CRM and provider). The PAN informs the individual of the plan effective date and informs them of timelines pertinent to appealing Department decisions regarding their functional eligibility and level of service.

Each CRM has a caseload. This caseload is assigned to the CRM in CARE. Assessment deadlines are tracked automatically in CARE and case managers are notified by a tickler feature that sends a notification to the case manager's "tickler inbox" when assessments are coming due. If the CRM prefers, CARE also has a reporting feature that will show the CRM all of the assessment deadlines in their caseload. For reassessments, the reassessment must be conducted before the expiration date in the current plan.

#### Signatures:

The CRM sends the service summary signature page with their signature on it. The client/legal rep provider must sign the signature page and return it to the case manager within 60 days of the assessment completion date. Per 42 CFR 441.50, the signature page must be finalized and agreed to in writing by the individual and be signed by all individuals and providers responsible for its implementation.

The signature page must be signed by the participant unless they have a legal guardian/power of attorney designation as determined by the courts or are under the age of 18 (which must be designated in CARE under collateral contacts) The legal representative/parent for a child over 18 can sign the signature page if the legal representative/parent is listed in CARE as "guardian or power of attorney" A parent can sign for a child under age 18. Due to the public health emergency, the Department is accepting verbal signatures for their assessments.

**Case Managers utilize the CARE system to determine a client's eligibility for services and ensure assessments are completed timely and accurately.  
(Key control #3-control activities)**

#### **ALTSA**

Rachelle mentioned before an assessment for functional eligibility occurs, an intake must be completed. Intakes can be initiated via self-referral or referral by a

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provider, nursing home, health benefit exchange etc and by phone, email, fax or walk in. After an intake is complete, a Home and Community Service (HCS) worker will meet with the client to complete the assessment face to face. Currently under federal rules, the state can conduct assessments remotely for CFC clients unless the client specifically request a face to face assessment. This flexibly was used during the COVID-19 pandemic. The assessment is completed in CARE. CARE is the tool used by SSS/CMs to determine a client's functional ability, evaluate what and how much assistance a client will receive and develop the client's plan of care. During the COVID19 pandemic, when the plan period has ended, extended eligibility for one additional year can be made without additional assessment. This extension starts when a RAC override occurs and authorizes the continued services. As part of the RAC override, the user who initiated it needs to document why the override is being implemented. RAC overrides can be authorized by a manager or designee, depending on the office. During this assessment, the CM/SSS inquires about what kind of support the applicant/client has had in the look back period with performing Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Once the assessment in CARE is complete, algorithms within CARE determine what programs the client is eligible for and what level of service the client is eligible for. The HCS worker works with the client to determine what services they would like to implement based on the program they are eligible for. Once the assessment is final, a time stamp is created on the Assessment main page in CARE called the "completion date" (the date the assessment was moved from pending status to current status).

**Case Managers utilize the CARE system to determine a client's eligibility for services and ensure assessments are completed timely and accurately.  
(Key control #3-control activities)**

### E.2.PRG - Eligibility - HCA MAGI

***Procedure Step:*** E. Eligibility - Identification of Key Internal Controls - <add specific area>  
***Prepared By:*** AMG, 3/6/2023  
***Reviewed By:*** RJC, 5/24/2023

Purpose/Conclusion.*
----------------------

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

**Source:**



# State of Washington

Kari Summerour, External Audit and Compliance Manager  
William Sogge, Management Analyst 5, Audit Liaison  
Giovanny Delgado, Medical Program Specialist 3  
Emily Good, Medical Program Specialist 3  
Ariel Pyrttek, Medicaid Eligibility Manager

## **Conclusion:**

Based on our understanding of internal controls over Eligibility, we assessed preliminary control risk as low.

Testing Strategy:

## **Eligibility - Post Uniform Guidance Awards**

### **Step 1: Assess Inherent Risk (IR)**

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Eligibility requirements apply when funds are provided to individuals/participants **and/or** when funds are awarded/passed-through to a subrecipient.

**NOTE:** Follow the steps below if the state agency determines the eligibility of the client. Similarly, follow these steps if a subrecipient determines eligibility, but the state maintains the computer system supporting eligibility determinations and actually pays the benefits to the participant. Otherwise, if a subrecipient determines the eligibility of the client, refer to the procedures under M-Subrecipient Monitoring.

Determine whether there are any specific eligibility requirements in order for individuals to receive financial assistance or services under the program. If the grantee makes awards to subrecipients, determine if there are eligibility requirements the subrecipient must meet to receive the funding. Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that*

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*material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure:

**(1) Participant Eligibility:**

**(a) Status:** recipients receiving services/benefits are eligible for such assistance in accordance with the program/grant contract.

**(b) Service level:** amounts paid to the recipient have been properly calculated in accordance with program requirements.

**(c) Discontinued:** services/benefits are discontinued after recipients are deemed ineligible.

**(2) Quality Control:** Some programs require quality control processes (such as independent double-checks) to obtain assurances about eligibility. If applicable, gain an understanding of controls to ensure the process is completed in accordance with program requirements.

**(3) Subrecipient Eligibility:** subawards were made only to eligible subrecipients.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “LOW” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

# State of Washington

Record of Work Done.

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- Modified Adjusted Gross Income (**MAGI**) eligibility is considered high risk by the Center for Medicare and Medicaid Services (**CMS**)
- Determining client eligibility for MAGI services is a relatively complex area
- Client eligibility is determined based on client statements and then verified as necessary
- Determination of client eligibility must be re-assessed annually under strict time lines
- During FY22, the Covid 19 pandemic has established waivers the Authority is following

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at **HIGH**.

## **Gather Information**

### **Step 2**

#### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Eligibility requirements. See Eligibility for the scope of the Medicaid Eligibility Compliance Requirement. After reviewing the internal control document, see Medicaid Internal Controls - MAGI Response, the Authority included the following:

"During the maintenance of effort provisions of the Families First Coronavirus Response Act of 2020, Washington is mandated to keep all coverage open unless someone dies, fails citizenship/immigration status, moves out of state, or requests closure. Due to these provisions, HCA is only reviewing SSN and immigration cases post eligibility review at this time. Income reviews will resume upon the ending of the public health emergency."

We will take this into consideration as we gain our understanding.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control

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environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

To gain an understanding of the MAGI compliance requirements, we documented our understanding, see [HCA Eligibility Overview](#), we documented the key controls below:

- Eligibility determinations are completed for new and renewal applications for MAGI services. Eligibility renewal reviews take place annually for all clients. **Initial applications are completed by the applicant utilizing HealthPlan Finder (HPF). Once the application is completed, electronic verification sources confirm income, immigration status and Social Security Number (SSN) (Automated Key Control #1- Control Activities)**
- If the federal systems are unable to verify the income, citizenship/immigration or SSN provided on an application, a tickler is created which informs HCA staff that a post eligibility review needs to be completed on the application. **HCA staff will follow-up and verify each unverified requirement through the uses of state systems or reaching out to the applicant to provide additional information. (Key Control #2- Control Activities)**

On November 4, 2022, we met with the following HCA staff to gain an understanding on MAGI and CHIP Eligibility determination:

- Kari Summerour, External Audit and Compliance Manager
- William Sogge, Management Analyst 5, Audit Liaison
- Giovanni Delgado, Medical Program Specialist 3
- Emily Good, Medical Program Specialist 3
- Ariel Pyrttek, Medicaid Eligibility Manager

We asked how the Authority is determining eligibility during FY22, and they stated since the public health emergency (PHE) is still in place during the year, everyone who applies for coverage and self attests that they meet the income requirements, meets the SSN and Citizenship, and Washington state resident requirements is eligible for Medicaid. At the moment, workloads and post eligibility reviews are on hold until the PHE is over. HCA has put a temporary hold on post eligibility requirements for current clients. The Agency also received emergency declaration blanket waivers for Health Care providers that states when the blanket 1135 waivers are in effect, they have a retroactive effective date of March 1, 2020, through the end of the emergency declaration. We do not expect to see post-eligibility reviews during the audit period.

Additionally, we asked the Authority if they will be continuing the periodic review since the PHE is over in Washington starting October 31, 2022. They stated that even though the PHE is ending for the State of Washington, they are going off when the CDC declares the Pandemic over. Therefore all the waivers are still in place during our audit period.

In response to the COVID-19 Public Health Emergency, self-attestation for all eligibility criteria (excluding citizenship and immigration status) would be allowed to determine eligibility if verification was not available.

In addition, to comply with section 6008 of the Families First Coronavirus Response Act, Medicaid will not be terminated except if a client requests termination, is no longer a Washington State resident, or the client dies.

To see all waivers in place during the public health emergency, see [Medicaid and CHIP Covid-19 Perm File](#).

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## Summary of Key Controls

**Key Control #1(Automated)**-Clients complete initial application for Medicaid utilizing HealthPlan Finder which electronically verifies income, immigration status and Social Security Numbers. **(Control Activities)**

**Key Control #2-** HCA staff will follow-up and verify each unverified requirement through the use of state systems or reaching out to the applicant to provide additional information. **(Control Activities)**

## **Evaluation of Results:**

We did not find any control deficiencies.

## Preliminary Control Risk Assessment

### **Step 4**

**LOW** - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## E.3.PRG - Eligibility - DSHS

**Procedure Step:** E. Eligibility - Identification of Key Internal Controls - DSHS

**Prepared By:** AMG, 3/23/2023

**Reviewed By:** RJC, 5/24/2023

Purpose/Conclusion.*
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## **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that only eligible individuals and organizations receive assistance under Federal award programs, that subawards are made only to eligible subrecipients, and that amounts provided to or on behalf of eligible participants were calculated in accordance with program requirements.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the eligibility internal controls for the Developmental Disabilities Administration (DDA) and the Aging and Long-Term Support Administration (ALTSA).

## **Source:**

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## Audit Liaisons:

Geoff Nisbet, Public Records Program Manager  
Laura Holloway, ALTSA QA Administrator  
Rick Meyer, External Audit Compliance Manager  
Jennifer Ullom, Administrative Assistant

## Statutory Eligibility Process (DDA requirement only):

- Joshua Church, Payment Systems and Eligibility Unit Manager
- Lonnie Keesee, Eligibility and Payment Systems Unit Manager
- William Nichol, Intake and Eligibility Program Manager

## Financial Eligibility Process:

### ALTSA

- Jennifer Ferguson, Office Chief, Financial Eligibility & Policy
- Lori Rolley, Financial Service Policy Analyst
- Rob Peters, Financial Program Manager
- Julia Mosier, Office Chief
- Elisa Mancuso, AP/AR Accounting Manager
- Amanda Aseph, Office Chief, Financial Eligibility & Policy

### DDA

- Marcell Birdsall, LTC Specialty Unit Manager
- Danielle Lopez, SHPC 4 - Long Term Care Speciality Unit
- Bridgette Wurtz, LTC, Speciality Program Manager
- Rick Meyer, External Audit Compliance Manager
- Ann Vasilev, Waiver Services Unit Manager

## Functional Eligibility process:

### DDA

- Anthony Blue, Quality Compliance Coordinator Unit Manager

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- Melissa Randles, Acting State Plan Services Unit Manager
- Manipon Manivanh, Community First Choice Program Manager

## ALTSA:

- Rachelle Ames, Care Management Unit Manager
- Kristian Rodriguez, QA Policy Program Manager

## **Conclusion:**

Based on our understanding of internal controls over Eligibility, we assessed preliminary control risk as low.

Testing Strategy:

## **Eligibility - Post Uniform Guidance Awards**

### **Step 1: Assess Inherent Risk (IR)**

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Eligibility requirements apply when funds are provided to individuals/participants **and/or** when funds are awarded/passed-through to a subrecipient.

**NOTE: Follow the steps below if the state agency determines the eligibility of the client. Similarly, follow these steps if a subrecipient determines eligibility, but the state maintains the computer system supporting eligibility determinations and actually pays the benefits to the participant. Otherwise, if a subrecipient determines the eligibility of the client, refer to the procedures under M-Subrecipient Monitoring.**

Determine whether there are any specific eligibility requirements in order for individuals to receive financial assistance or services under the program. If the grantee makes awards to subrecipients, determine if there are eligibility requirements the subrecipient must meet to receive the funding. Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

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*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure:

**(1) Participant Eligibility:**

**(a) Status:** recipients receiving services/benefits are eligible for such assistance in accordance with the program/grant contract.

**(b) Service level:** amounts paid to the recipient have been properly calculated in accordance with program requirements.

**(c) Discontinued:** services/benefits are discontinued after recipients are deemed ineligible.

**(2) Quality Control:** Some programs require quality control processes (such as independent double-checks) to obtain assurances about eligibility. If applicable, gain an understanding of controls to ensure the process is completed in accordance with program requirements.

**(3) Subrecipient Eligibility:** subawards were made only to eligible subrecipients.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

## **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “LOW” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

**Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.**



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Guidance/Criteria:

Record of Work Done:

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- DSHS is a large department serving a large client population. During FY21, DSHS spent over \$3.5 billion (federal only) providing services to its clients. Processing funding in that dollar amount is inherently risky.
- DSHS serves a diverse population of vulnerable clients in all areas of Washington State and services are provided and monitored by staff from different regions. Services are authorized and approved by many staff, making continuity and oversight challenging.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at **HIGH**.

## **Gather Information**

### **Step 2**

#### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Eligibility requirements. See Eligibility for the scope of the Medicaid Eligibility Compliance Requirement.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We documented our understanding, see, DSHS Eligibility Overview, we documented the key controls below:

- Statutory (DDA requirement only)  
Key Control #1-An intake and eligibility worker reviews and evaluates the application packet and supporting documentation from health care providers, schools, and other support professionals to determine if the applicant meets statutory eligibility requirements under WAC 388-823 and documents this review in CARE.

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- Financial  
Key Control #2-Financial Eligibility workers review the application, supporting documentation and complete data checks with various external financial systems and source documentation to determine if the client is financially eligible to receive services including checks on Social Security number, citizenship, income, resources.
- Functional  
Key Control #3-Case Managers utilize the CARE system to determine a client's eligibility for services and ensure assessments are completed timely and accurately.

Additionally, we documented the waivers identified during the PHE at Medicaid and CHIP Covid-19 Perm File

We met with the following staff from November 14, 2022 through November 17, 2022:

Statutory Eligibility Process (DDA requirement only):

- Geoff Nisbet, Audit Liaison
- Joshua Church, Payment Systems and Eligibility Unit Manager
- Lonnie Keese, Eligibility and Payment Systems Unit Manager
- William Nichol, Intake and Eligibility Program Manager

Financial Eligibility Process:

ALTSA

- Laura Holloway, ALTSA QA Administrator and Audit Liaison
- Jennifer Ferguson, Office Chief, Financial Eligibility & Policy
- Lori Rolley, Financial Service Policy Analyst
- Rob Peters, Financial Program Manager
- Julia Mosier, Office Chief
- Elisa Mancuso, AP/AR Accounting Manager
- Amanda Aseph, Office Chief, Financial Eligibility & Policy
- Jennifer Ullom, Administrative Assistant

DDA

- Geoff Nisbet, Audit Liaison and Public Records Program Manager

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- Marcell Birdsall, LTC Specialty Unit Manager
- Danielle Lopez, SHPC 4 - Long Term Care Speciality Unit
- Bridgette Wurtz, LTC, Speciality Program Manager
- Rick Meyer, External Audit Compliance Manager
- Ann Vasilev, Waiver Services Unit Manager

### Functional Eligibility process:

#### DDA

- Geoff Nisbet, Audit Liaison
- Anthony Blue, Quality Compliance Coordinator Unit Manager
- Melissa Randles, Acting State Plan Services Unit Manager
- Manipon Manivanh, Community First Choice Program Manager

#### ALTSA:

- Laura Holloway, ALTSA QA Administrator/Audit Liaison
- Rachelle Ames, Care Management Unit Manager
- Kristian Rodriguez, QA Policy Program Manager
- Jennifer Ullom, Administrative Assistant

We asked the how the Department is determining eligibility during FY22 and they stated since the public health emergency (PHE) is still in place during the year, everyone who applies for coverage and self attests that they meet the income requirements, meets the SSN and Citizenship, and Washington state resident requirements is eligible for Medicaid.

For all home and community based services and waiver, they have 3 requirements for DDA and 2 requirements for ALTSA, Functional, Financial and Statutory. During the PHE, the Department confirmed the following:

- For financial eligibility, the Department confirmed that they are taking self attestations for the income requirement during the PHE. They stated that they extended the review process for 90 days at a time and they can adjust participation. If the client has any changes to income, they cannot be kicked off of services.

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- For functional eligibility, the Department confirmed that the assessments are still being done, however, they can be postponed for up to a year. Additional reassessments can be postponed for up to a year.
- Lastly, for statutory eligibility, they continued to do the assessments.

During the PHE, for ALTSA, there is a team of people that make management bulletins to post any changes made to the compliance requirements.

Additionally, we asked the Authority if they will be continuing the periodic review since the PHE is over in Washington starting October 31, 2022. They stated that even though the PHE is ending for the State of Washington, they are going off when the CDC declares the Pandemic over. Therefore all the waivers are still in place during our audit period.

### **Summary of Key Controls**

Statutory (DDA requirement only)

Key Control #1-An intake and eligibility worker reviews and evaluates the application packet and supporting documentation from health care providers, schools, and other support professionals to determine if the applicant meets statutory eligibility requirements under WAC 388-823 and documents this review in CARE.

Financial

Key Control #2-Financial Eligibility workers review the application, supporting documentation and complete data checks with various external financial systems and source documentation to determine if the client is financially eligible to receive services including checks on Social Security number, citizenship, income, resources.

Functional

Key Control #3-Case Managers utilize the CARE system to determine a client's eligibility for services and ensure assessments are completed timely and accurately.

### **Evaluation of Results:**

We did not identify any control deficiencies.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### **F.1.PRГ - Matching**

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**Procedure Step:** G. Matching - Identification of Key Internal Controls

**Prepared By:** AWW, 12/5/2022

**Reviewed By:** SAG, 12/16/2022

Purpose/Conclusion:

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that Medicaid Matching requirements were met.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

**Source:**

Jill Arlow, Federal Financial Reporting Manager

Laura Roberts, Federal Claims Supervisor

Kari Summerour, External Audit Liaison

William Sogge, External Audit Liaison

**Conclusion:**

Based on our understanding of internal controls over Matching, we assessed preliminary control risk as low.

Testing Strategy:

**Step 1: Assess Inherent Risk (IR)**

**Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the **Inherent and Internal Control Risk**

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**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Review all of the following that apply to your audit period to determine the specific requirements over matching:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

Matching or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. The match may be cash or non-cash such as:

1. Most Common Method: For each allowable program expenditure incurred, the entity only requests the federal portion to be reimbursed (for example 80%), and the remaining portion of the expenditure not reimbursed (for example 20%) is considered the entity's match.
2. In-Kind Contributions: When provided by the entity, these are usually non-cash contributions whose value is agreed upon with the grantor, such as infrastructure and other capital assets.
3. Third-Party In-Kind Contributions: Contributions from the public or other governments may be cash or non-cash and can include the value of volunteer services or employees of other agencies, donated supplies, and loaned equipment.
4. Program Income: Program income can be used as matching funds only with prior written approval from

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the grantor.

Review the following that apply to the audit period:

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure Matching requirements were met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

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### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

*Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.*

Guidance/Criteria.*
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### INTERNAL CONTROL UNDERSTANDING

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

See also A-133, Subpart E, \_\_.500(c)

### G. MATCHING, LEVEL OF EFFORT, EARMARKING Compliance Requirements



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The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program. For programs listed in this Supplement, these specific requirements are in Part 4 - Agency Program Requirements or Part 5 - Clusters of Programs, as applicable.

However, for matching, the A-102 Common Rule (§\_\_\_\_.24) and OMB Circular A-110 (§\_\_\_\_.23) provide detailed criteria for acceptable costs and contributions. The following is a list of the basic criteria for acceptable matching:

- Are verifiable from the non-Federal entity's records.
- Are not included as contributions for any other federally assisted project or program, unless specifically allowed by Federal program laws and regulations.
- Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.
- Are allowed under the applicable cost principles.
- Are not paid by the Federal Government under another award, except where authorized by Federal statute to be allowable for cost sharing or matching.
- Are provided for in the approved budget when required by the Federal awarding agency.
- Conform to other applicable provisions of the A-102 Common Rule and OMB Circular A-110 and the laws, regulations, and provisions of contract or grant agreements applicable to the program.

Matching, level of effort and earmarking are defined as follows:

1. Matching or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. Matching may be in the form of allowable costs incurred or in-kind contributions (including third-party in-kind contributions).
2. Level of effort includes requirements for (a) a specified level of service to be provided from period to period, (b) a specified level of expenditures from non-Federal or Federal sources for specified activities to be maintained from period to period, and (c) Federal funds to supplement and not supplant non-Federal funding of services.
3. Earmarking includes requirements that specify the minimum and/or maximum amount or percentage of the program's funding that must/may be used for specified activities, including funds provided to subrecipients. Earmarking may also be specified in relation to the types of participants covered.

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### **Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by OMB Circular A-133 §\_\_\_.500(c).
2. Matching - Determine whether the minimum amount or percentage of contributions or matching funds was provided.
3. Level of Effort - Determine whether specified service or expenditure levels were maintained.
4. Earmarking - Determine whether minimum or maximum limits for specified purposes or types of participants were met.

Record of Work Done.
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### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

##### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Matching requirements. We identified the following: Per 2 CFR Part 200, Appendix XI Compliance Supplement, "The state is required to pay part of the costs of providing Medicaid services and part of the costs of administering the program. The percentage of federal funding is

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determined based on the amount of the expenditure and the application of the FMAP that is determined for each state using a formula set forth in section 1905(b) of the Social Security Act (42 USC 1396d), or other applicable federal matching rates specified by the statute. In particular, the matching rates for states' administrative expenditures authorized by the Act are found in section 1903(a) of the Act (42 USC 1396b)."

Program background and prior audit finding information are documented at [Overview](#).

### **Understanding of Internal Controls**

#### **Step 3**

##### **Federal Financial Participation (FFP) and Cost Allocation System Overview**

Federal statutes specify the rate of Federal Financial Participation (FFP) at which the state is reimbursed for Medicaid costs. The purpose of a cost allocation system is to ensure that costs are identified and distributed to federal and state funding in an appropriate manner. The Cost Allocation System (CAS) is a mainframe product used to allocate the costs for Federal claim purposes as mandated by Federal regulation. Since July 1, 2003, the system has been integrated with the Agency Financial Reporting System (AFRS); CAS is a subsystem within AFRS.

Values in the cost allocation tables can be added, changed, deleted or inactivated each month. These tables allow AFRS to electronically process all expenditure transactions and automatically distribute the expenditures to its federal and state share. The allocation process begins as transactions are entered into AFRS. Processing edits are used to ensure that only valid account coding is entered into AFRS and to provide a crosswalk from AFRS account coding to cost allocation schedules in CAS. For additional information see the Enterprise System Rates Allocation site at WaTech, <https://watech.wa.gov/allocation/allocation/Enterprise-System-Rates-Allocation> and OFM's page on the Cost Allocation System, <https://ofm.wa.gov/it-systems/agency-financial-reporting-system-afrs/cost-allocation-system-cas>.

Transactions are processed based on their Program Index/Allocation Code combination. The combination of these

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fields determines the final cost objectives and the state/federal split. Each combination of program index and allocation code is used to allocate costs. Once the costs are allocated to a cost objective, they are directly linked to the funding source that will be used for that portion of the expenditure. Cost objectives are the final targets of the cost allocation system's process. They can be identified to the funding source, whether it is federal funds or state funds.

### Matching Process Understanding

On October 14, 2022 we met with the Authority's Federal Financial Reporting (FFR) staff to gain an understanding of the Matching requirement:

- Kari Summerour, External Audit Liaison
- William Sogge, External Audit Liaison
- Jill Arlow, Federal Financial Reporting Manager
- Laura Roberts, Federal Claims Supervisor
- Mary Anderson, Financial Analyst
- Roxanne Smith, Financial Analyst

Jill explained that the Authority is responsible for preparing and maintaining the chart of account and cost allocation plan for matching requirements. While FFR staff may have a specific focus, such as CHIP reporting, the Analyst are cross trained and perform duties as needed. The Authority applies the applicable matching rates (FMAP) to Medicaid expenditures via a cost allocation process in AFRS. Cost objectives (COBJ) and the correlating FMAP rates are entered into AFRS on an annual and periodic basis. AFRS will split the expenditures based on cost objectives and automatically determine federal and state portions with the correlating FMAP rates. Matching rates are provided by the Authority's federal Center for Medicaid and Medicare Services contact or by HCA staff conducting the necessary research to ensure accurate rates are used. Matching rates are also available within award documents for specific waivers or other federal documents. Program Index (PI) and allocation codes are used to determine the COBJs. As an expenditure is processed through ProviderOne, it goes through the cost

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allocation process. The cost allocation process sends the expenditure to AFRS. AFRS splits the expenditure into COBJs and automatically determines the federal/state percentages based on the PI and allocation code used. AFRS splits the expenditure into cost objectives and automatically determines the federal/state percentages based on the program index and allocation code used. **(Information and Communication)** The HCA cost allocation system automatically applies the FMAP rate to Medicaid and CHIP expenditures.

The cost objectives have a specific naming convention. COBJs have five characters encompassing both letters and numbers. The starting letter on the COBJ indicates the focus of the expenditures. The first letter coding used by the FFR team in creation of the CMS-64 and CMS-21 are as follows:

CMS-64 Medical Assistance Program	T; D; N
CMS-64 Admin	U
CMS-64 Electronic Health Records Admin	C; T
CMS-21 CHIP	X; W; N; V; S; Z

The next character is a numeric which indicates the current fiscal year and the last and fifth character will also be a number which relates to the grant year. For example, C0AA9 would be a CHIP expenditure with a grant originating in federal fiscal year (FFY) 2020 and applied to grant award year FFY19. Federal match is based on the Authority's account code structure. Expenditures are both direct and indirect. For those expenditures that are cost allocated, the cost allocation process utilizes edit files, cost objectives, cost allocation schedules and cost allocation bases to allocate costs. These are prepared by staff of the Federal Financial Reporting (FFR) unit, reviewed by the unit's supervisor, entered by unit staff, and the input is checked for accuracy by another unit staff member if the entry is significant in size. Jill explained that FFR had to set up new coding for Covid-19 related funding of programs as part of a standardized process based at the beginning of every federal fiscal year.

The Authority starts getting ready for the COBJ and FMAP cost allocation process in September of each year. A Financial Analyst prepares the cost allocation plan and the Accounting division updates the chart of accounts. The

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Analyst also prepares the edit request form for additions or changes and a Financial Manager verifies and approves the edit request form. Once the form is approved, the Analyst keys the approved COBJ coding on the form into AFRS for chart of account updates. Once the coding is keyed into AFRS, a different Fiscal Analyst from Laura's team reviews the form to verify that submitted edit forms have been keyed accurately into AFRS and ensures the edit workbook is complete. The original copy of the edit request form is filed and is also on the shared network K drive. **Key Control #1: There is segregation of duties between staff members who prepare the cost objective edit request form and who reviews and approves the edit request form. Also, there is a segregation of duties between staff members who enter the updated codes into the system and review the codes in the system. (Control Activities)**

The Federal/State match is reported as part of the CMS-64 report (for a detailed summary of the reporting process, see [L. Reporting - Identification of Key Internal Controls - CMS-64](#)). All expenditures reported on the federal claim are received from AFRS. Most data is allocated as state and federal directly from AFRS; staff do not perform manual allocations. AFRS automatically allocates funds as state and federal. These are entered into the Medicare and Medicaid Budget and Expenditure System (MBES). As part of this process, the FFR staff check for accuracy of allocations for all expenditures. Prior to entry into MBES, FFR staff used to complete a CMS-64 review workbook. Now FFR staff review the actual distribution of Federal and State amounts as compared to the established FMAP rate within FFR's mapping database, and save notes in a comment column. **Key Control #2: Prior to entry into MBES, FFR staff check for allocation accuracy (including the actual distribution of Federal and State amounts as compared to the established FMAP rate to ensure the correct match) for all expenditures using the CMS-64 mapping database. (Control Activities/ Monitoring)** Discrepancies that cannot be resolved are moved to Line 0 in the data worksheet and not included in the MBES input. For items that did not allocate to the correct percentage share, research is conducted and corrections are made by accounting unit staff.

FFR uses a mapping tool that lays out how the coding logic relates to federal reporting. The tool was developed as a hierarchy and all mapping is done in accordance with the hierarchy. With this process FFR can accommodate the

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fact that there are more federal reporting items than coding fields available. The tool is the combined effort of staff in the program area, budget office, and accounting sections. Changes to this tool are the result of discussions by all affected parties. Changes are not made very often, if any change is made, it is done by Laura or a Medicaid Transformation Project (MTP) Analyst with Jill's approval. The CMS-64 preparation process first begins with the Fiscal Analyst pulling statewide accounting information from various agencies (specifically applicable for CHIP which includes the Department of Social and Health Services), as well as the Authority. The Analyst runs an AFRS Expenditure Summary Flexible reports for both agencies. AFRS uses the entry's account coding such as allocation code, program index, and cost objective to determine where the entry needs to be input into the report. A Web Application with SQL Database is updated for T-21 and T-64 by the Authority's Information Technology (IT) staff, which is uploaded for report usage two days after closing (due to cost allocation). In order to prepare the CMS-64 report, the Analyst will then pull the mapped accounting entries from the Mapping Access Database, provided each quarter by IT. They also pull an unmapped summary report and will determine program codes so they can be correctly mapped manually. The Analyst will exclude allocation codes beginning with MX and CX as well as cost objective C\*\*X\*, since these will be moved to line zero to be reported on the CMS-64 (section 107 CHIP expenditures charged to Medicaid). The Fiscal Analyst then performs a reconciliation of the mapped data against the AFRS data. Then they take this information and ensures the Mapping Access Database data reconciles back to AFRS. Any appropriate differences are noted as part of the reconciliation. All other discrepancies are researched and corrected. Testing of controls for the reconciliation of the CMS-64 database report (consisting of unmapped data) report back to the AFRS Medicaid expenditure report to ensure completeness of the data to be mapped has been done as part of Reporting - CMS-64, see L. Reporting - Testing of Key Internal Controls - CMS-64.

Staff in the FFR unit enter the amounts on the appropriate Line and Item in MBES and the federal system computes the federal and state share. **Key Control #3: Prior to submitting a quarterly claim, a reconciliation is done between summary MBES data and HCA data. (Control Activities/ Monitoring)** Any appropriate differences are noted as part of the reconciliation. All other discrepancies are researched and corrected.

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### Summary of Key Controls

Key Control #1: There is segregation of duties between staff members who prepare the cost objective edit request form and who reviews and approves the edit request form. Also, there is a segregation of duties between staff members who enter the updated codes into the system and review the codes in the system. (Control Activities)

Key Control #2: Prior to entry into MBES, FFR staff check for allocation accuracy (including the actual distribution of Federal and State amounts as compared to the established FMAP rate to ensure the correct match) for all expenditures using the CMS-64 mapping database. (Control Activities/ Monitoring)

Key Control #3: Prior to submitting a quarterly claim, a reconciliation is done between summary MBES data and HCA data. (Control Activities/Monitoring Activities)

**Evaluation of Results:** Did you identify any control deficiencies? No control deficiencies were identified.

### Preliminary Control Risk Assessment

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### F.2.PRg - Level of Effort

*Procedure Step:* G. Level of Effort - Identification of Key Internal Controls

*Prepared By:* AMG, 4/10/2023

*Reviewed By:* SAG, 5/25/2023



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Purpose/Conclusion.\*

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that Medicaid Level of Effort requirements were met.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

**Source:**

2022 Annual Comprehensive Financial Report (ACFR) in TeamMate file S1Washington-FS22 at D.4 Human Services, "Controls - ProviderOne"

**HCA:**

- Kari Summerour, External Audit and Compliance Manager
- William Sogge, Management Analyst 5, Audit Liaison
- Giovanni Delgado, Medical Program Specialist 3
- Emily Good, Medical Program Specialist 3
- Ariel Pyrttek, Medicaid Eligibility Manager
- Margaret Clay, OMEP Deputy Section Manager
- Catrina Lucero, Deputy CFO

**DSHS:**

**DDA**

- Jennifer Ullom, Administrative Assistant
- Jamie Bond, Office Chief, Program and Policy Development
- Ann Vasilev, Waiver Services Unit Manager
- Geoff Nisbet, Audit Liaison and Public Records Unit Manager
- Eric Mandt, Assistant Director
- Carla McKnight, Budget Forecast Chief
  - Johnathon Smith, Rates Operation Manager
  - Peter Graham, Chief, Office of Rates
- Laura Holloway, ALTSA, QA Manager, Audit Liaison
- Amanda Aseph, Office Chief, Financial Eligibility and Policy
- Jacqueline Cobbs, Deputy Director of HQ Operations

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- Barbra Hannemann, Medicaid Unit Manager
- Catherine Kinnaman, HCS Director
- Lori Rolley, Senior Financial Policy Analyst
- Maren Turner, Office Chief, Home and Community Programs

### **Conclusion:**

Based on our understanding of internal controls over Level of Effort, we assessed preliminary control risk as low.

Testing Strategy:
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### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Review all of the following that apply to your audit period to determine the specific requirements over matching:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

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Matching or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. The match may be cash or non-cash such as:

1. Most Common Method: For each allowable program expenditure incurred, the entity only requests the federal portion to be reimbursed (for example 80%), and the remaining portion of the expenditure not reimbursed (for example 20%) is considered the entity's match.
2. In-Kind Contributions: When provided by the entity, these are usually non-cash contributions whose value is agreed upon with the grantor, such as infrastructure and other capital assets.
3. Third-Party In-Kind Contributions: Contributions from the public or other governments may be cash or non-cash and can include the value of volunteer services or employees of other agencies, donated supplies, and loaned equipment.
4. Program Income: Program income can be used as matching funds only with prior written approval from the grantor.

Review the following that apply to the audit period:

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated,*

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*authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure Matching requirements were met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria.

### **INTERNAL CONTROL UNDERSTANDING**

Documentation should address the five components of internal control per SAS 78 (control environment, risk assessment, control activities, information and communication, and monitoring).

Refer to Part 6 of the most recent OMB Compliance Supplement for suggestions about the types of controls that could be used for certain compliance areas. Auditor may have to refer to the Compliance Supplement for Part 6.

External Link: <http://www.whitehouse.gov/omb/circulars/index.html>

See also A-133, Subpart E, \_\_.500(c)

### **G. MATCHING, LEVEL OF EFFORT, EARMARKING**

#### **Compliance Requirements**

The specific requirements for matching, level of effort, and earmarking are unique to each Federal program and are found in the laws, regulations, and the provisions of contract or grant agreements pertaining to the program. For programs listed in this Supplement, these specific requirements are in Part 4 - Agency Program Requirements or Part 5 - Clusters of Programs, as applicable.

However, for matching, the A-102 Common Rule (§\_\_\_\_.24) and OMB Circular A-110 (§\_\_\_\_.23) provide detailed criteria for acceptable costs and contributions. The following is a list of the basic criteria for acceptable matching:

- Are verifiable from the non-Federal entity's records.
- Are not included as contributions for any other federally assisted project or program, unless specifically allowed by Federal program laws and regulations.
- Are necessary and reasonable for proper and efficient accomplishment of project or program objectives.
- Are allowed under the applicable cost principles.
- Are not paid by the Federal Government under another award, except where authorized by Federal statute to be allowable for cost sharing or matching.
- Are provided for in the approved budget when required by the Federal awarding agency.

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- Conform to other applicable provisions of the A-102 Common Rule and OMB Circular A-110 and the laws, regulations, and provisions of contract or grant agreements applicable to the program.

Matching, level of effort and earmarking are defined as follows:

1. Matching or cost sharing includes requirements to provide contributions (usually non-Federal) of a specified amount or percentage to match Federal awards. Matching may be in the form of allowable costs incurred or in-kind contributions (including third-party in-kind contributions).
2. Level of effort includes requirements for (a) a specified level of service to be provided from period to period, (b) a specified level of expenditures from non-Federal or Federal sources for specified activities to be maintained from period to period, and (c) Federal funds to supplement and not supplant non-Federal funding of services.
3. Earmarking includes requirements that specify the minimum and/or maximum amount or percentage of the program's funding that must/may be used for specified activities, including funds provided to subrecipients. Earmarking may also be specified in relation to the types of participants covered.

### **Audit Objectives**

1. Obtain an understanding of internal control, assess risk, and test internal control as required by OMB Circular A-133 §\_\_\_.500(c).
2. Matching - Determine whether the minimum amount or percentage of contributions or matching funds was provided.
3. Level of Effort - Determine whether specified service or expenditure levels were maintained.
4. Earmarking - Determine whether minimum or maximum limits for specified purposes or types of participants were met.

Record of Work Done.:
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### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has

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implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- This compliance requirement is new to the Department and the Authority.
- There are multiple Agencies responsible for administering the requirement.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

## **Gather Information**

### **Step 2**

#### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Level of Effort requirements. We identified the following:

American Rescue Plan Act of 2021 (ARP) Section 9817. To demonstrate compliance with the requirement to supplement, not to supplant existing state funds expended for Medicaid HCBS, states must: not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021; preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021. These requirements are commonly referred to as "maintenance of effort" (MOE) requirements for ARP section 9817.

Please note that these requirements do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS, including requirements set forth in Special Terms and Conditions under section 1115 demonstrations and managed care authorities under which states are delivering HCBS. For example, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates through the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than six months post PHE). However, CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

#### Health Care Authority

On March 8, 2023, we met with the following HCA staff to discuss the Eligibility requirement of the Level of Effort requirement regarding Medicaid:

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- Kari Summerour, External Audit and Compliance Manager
- William Sogge, Management Analyst 5, Audit Liaison
- Giovanni Delgado, Medical Program Specialist 3
- Emily Good, Medical Program Specialist 3
- Ariel Pyrtex, Medicaid Eligibility Manager

During the Public Health Emergency (PHE), the authority stated they maintained eligibility for clients as of March 2020. All the requirements to keep clients on home and community based services (HCBS) are documented in the state plan which is submitted to and approved by CMS (**Key Control #1- Control Activities**). During our Eligibility understanding, we identified the following requirements:

- **Income:** Individuals that apply for Apple Health attest to their income and once their application is submitted, the Federal HUB determines whether this income is reasonably compatible with a 0% threshold with the MAGI-income standard for the Apple Health program they are approved on.
- **Citizenship/Immigration:** Individuals attest to their immigration status when applying for Apple Health and this information is verified through Systematic Alien Verification for Entitlements Program (**SAVE**) when the application is submitted.
- **SSN:** Individuals attest to their social security number when applying for Apple Health and if they don't provide it, they attest to a good cause reason for not providing their SSN. Their SSN is verified through a match with the federal government.

The Authority stated that the reason for clients to be discontinued from services during the PHE below:

- The beneficiary requests a voluntary termination of eligibility;
- The beneficiary dies;
- The beneficiary ceases to be a resident of the state; or
- The beneficiary was not validly enrolled, as described above.

Additionally, we met with Margaret Clay, OMEP Deputy Section Manager on March 14, 2023 to gain an understanding on how clients are determined eligible for HCBS services. She stated that if client applied for services through MAGI, they can receive limited base care HCBS, however if the client needs continued care they can become eligible through DDA.

On March 16, 2023 we met with Catrina Lucero, Deputy CFO to gain an understanding on how the Authority set the rates for HCBS. She stated that the rates for these services go through an extensive process that includes a decision package, which is approved by legislation for the budget increase. The Authority will also go through a decision body, for policy review to ensure rates do not decrease. She stated the Authority does not make any changes to the provider rates unless they are approved by legislation.

Additionally a portion of this understanding was gained simultaneously with the state fiscal year 2022 Annual Comprehensive Financial Report (ACFR) in TeamMate file S1Washington-FS22 at D.4 Human Services, "Controls - ProviderOne" was signed off and prepared by Chian Lee on 08/31/2022 and reviewed by Scott Bills on 10/31/2022. It is copied here for ease of reference. No alterations were made to the information or data.



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## **Rate Adjustment (Valuation)**

Fee-for-service and managed care premium payment rate factors are uploaded into ProviderOne. Ed Hicks' team is responsible for the fee-for-service rate uploads and Sam Trimble's area operates the managed care capitation rate factors.

For managed care, HCA pays a monthly premium rate to manage care organizations (MCOs) based on a rate per member per month (PMPM). There are about ten different rate templates for various medical and behavioral contracts as well as three rate templates for different foundational community support (FCS) contracts. There are five factors used to calculate the rates: base rate factor (BRF), age group factor (AGF), geographic region factor (GRF), risk adjust factor (ADF), and qualitative adjust factor (ADF). Pending on the managed care program they may use all or some of the rate factors. Ideally, HCA would like two months from the time a rate change is requested before it is uploaded and executed in ProviderOne. This time is required to adequately review changes, test for errors, receive proper approvals, and update ProviderOne.

For fee-for-service, HCA directly pays providers for services rendered on qualified Medicaid members. The number of items to review is not as complicated as managed care so rate turnaround time is usually about 48 hours. (target rate for quality control)

Managed care and fee-for-service follow the same process for inputting updated fee schedules into ProviderOne. For managed care, the rate changes will have a significantly larger number of line items to update compared to fee-for-service. Also, fee-for-service has rate updates more frequently than managed care. Rate data update requests are always input into ProviderOne via file upload (Excel spreadsheet) received from the business area.

The rate change process begins with the System Operations and Implementation Unit (SOIU) receiving a rate update request via a ServiceNow ticket through a shared inbox and are triaged for assignment to Information Technology Specialist (ITS) staff within SOIU. Each -ServiceNow ticket has a number that is used to track the progress of these requests. ITS staff first review the information provided to ensure it is complete. The review is only limited to data validation such as number formats and date ranges, etc. The ITS staff member then uploads the provided file into the ProviderOne User Acceptance Testing (UAT) environment. This allows them to verify that the file uploads appropriately before attempting to upload the file into production. ProviderOne has processing controls to help ensure the rate data uploaded is complete and valid. Updates that do not meet programmed edits will suspend to an error file that is reviewed by the ITS. If errors are identified, ITS staff notify the business area to make corrections and submit a new file attachment to the -ServiceNow ticket. Prior to uploading, Sam will also provide the business unit with a computed Rate Report for review. Once correct and successfully uploaded, ITS reviews the data and additionally compares the number of records in the source data to the number of records uploaded to ProviderOne. If everything processes appropriately, ITS then uploads the file into the production environment and the data goes through the same processing controls as in the UAT. When successfully uploaded, all rate updates will have an "In Review" status listed.

ITS then updates and sends the -ServiceNow ticket to Heidi DeVries, IT Specialist who acts as an internal quality assurance for -ProviderOne Operations (PIO). She reviews the rate data for accuracy and to ensure the requested changes conforms to medical related coding information which was provided to HCA from the Centers for Medicare and Medicaid Services (CMS). HCA's vendor for ProviderOne, CNSI, obtains these types of files from the CMS website and then uploads them to ProviderOne. HCA will also upload reference data based upon decisions made by its own Policy Division. Heidi reviews all relevant information and determines whether to approve or reject the changes. Each rate's status reflects her decision. She then updates the -ServiceNow ticket and sends it back to the ITS for closure, or closes the ticket herself.

Once approved, the system attaches dates to the rates data, including the effective date (when the rate was approved), the start date (when the new rate takes effect), and the end date. ProviderOne also has internal edits which will cause the claim calculation to fail out if data is invalid. After confirming the test runs

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produced correct results, P10 will push the rate changes to production (**Key Control #2 (manual), Rate upload review prior to production - Valuation**). When new rates are uploaded into the system, the previous data's effective dates are automatically updated to prevent payments outside of the correct to and from values. There are a select few certain general charge modes which are entered behind the scenes by the ProviderOne vendor, CNSI. For these items, ITS staff will run tests to verify that value output correctly corresponds to the associated rate.

## Department of Social and Health Services

On March 7, 2023 and March 13, 2023 we met with the following DSHS staff to discuss the Eligibility requirement of the Level of Effort requirement regarding Medicaid:

### **DDA**

- Jennifer Ullom, Administrative Assistant
- Jamie Bond, Office Chief, Program and Policy Development
- Ann Vasilev, Waiver Services Unit Manager
- Geoff Nisbet, Audit Liaison and Public Records Unit Manager

### **ALTSA**

- Laura Holloway, ALTSA, QA Manager, Audit Liaison
- Amanda Aseph, Office Chief, Financial Eligibility and Policy
- Jacqueline Cobbs, Deputy Director of HQ Operations
- Barbra Hannemann, Medicaid Unit Manager
- Catherine Kinnaman, HCS Director
- Lori Rolley, Senior Financial Policy Analyst
- Maren Turner, Office Chief, Home and Community Programs

During the PHE, the Department stated they maintained eligibility for clients as of March 2020. All the requirements to keep clients on home and community based services (HCBS) are documented in the state plan which is submitted to and approved by CMS (**Key Control #1- Control Activities**). If there were any changes that needed to be made to the eligibility requirements, the Department can do that through a waiver or a State Plan Amendment (SPA). During our Eligibility understanding, we identified the following requirements:

- Statutory Eligibility - Only required for DDA, clients are eligible for services if they meet the following:
  - Intellectual Disability
  - Cerebral Palsy
  - Epilepsy
  - Autism or

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- Another neurological or other condition similar to intellectual disability that:
  - Originated before the individual turned age 18
  - Is expected to continue indefinitely and
  - Results in substantial limitation to an individual's intellectual and adaptive functioning
- Functional Eligibility - Clients are able to get an assessment to determine the level of care they need. During the PHE, the Department is able to extend the redetermination timeline for current enrollees and waive signature requirements.
- Financial Eligibility - Clients are able to self attest to income requirements, however during the PHE, the Department is not considering any changes in income due to the 1135 waiver.

Any changes to eligibility during the PHE was communicated in a management bulletin to ensure staff are aware of any changes. **(Key Control #3 - Information and Communication)**

On March 21, 2023 we met with the following people from DSHS to discuss the rate setting process and how it was maintained during the PHE:

- Eric Mandt, Assistant Director
- Carla McKnight, Budget Forecast Chief
  - Johnathon Smith, Rates Operation Manager
  - Peter Graham, Chief, Office of Rates

The Department stated the rate guidelines are set by legislations for providers however they have the authority to set the rates. The rate team will work with management services to set the rate and those are entered into ProviderOne. To put the rates into ProviderOne, DSHS makes the rates and they are reviewed internally and a helpdesk request is created through HCA to be uploaded in ProviderOne as an approval. HCA will input this information with the proper effective dates for the providers. **(Key Control #4 - Control Activities)**

### **Summary of Key Controls:**

**Key Control #1- Control Activities:** All the requirements to keep clients on home and community based services (HCBS) are documented in the state plan which is submitted to and approved by CMS to ensure the State is including required information to maintain the level of Effort.

**Key Control #2 - Monitoring:** Health Care Authority reviews and approves the input of fee schedules into ProviderOne prior to being available for payment in processing in the system.

**Key Control #3 - Information and Communication:** Changes to eligibility made during the PHE are communicated in a management bulletin to ensure staff are aware of any changes.

**Key Control #4 - Control Activities:** The Department submits a helpdesk request to HCA as an approval to input the new provider rates to ensure the rates are updated with the proper increases.

### **Evaluation of Results:**

We did not identify any control deficiencies.

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## **Preliminary Control Risk Assessment**

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## **G.1.PRG - Reporting - SF-425**

*Procedure Step:* L. Reporting - Identification of Key Internal Controls - SF-425

*Prepared By:* AWW, 2/10/2023

*Reviewed By:* SAG, 2/11/2023

Purpose/Conclusion.*
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that reports submitted to the Federal awarding agency or pass-through entity include all activity of the reporting period, are supported by underlying accounting or performance records, and are fairly presented in accordance with program requirements.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

### **Source:**

Melanie Nevares, Accounting Director

Hana Nguyen, Lead Financial Analyst

Irina Elmer, Financial Analyst

Marci Phillips, Contracts and Grants Administrator

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Amanda Seaunier, General Accounting Supervisor

### **Conclusion:**

Based on our understanding of internal controls over Reporting, we assessed preliminary control risk as low.

Testing Strategy:

**Note:** Financial report testing populations should include all reports covering expenditures occurring during the audit period. For quarterly reports this means we must include the report covering the period ending June 30 even though it is filed after the audit period. For performance or other special types of reports the testing population should include the reports covering the audit period unless the period covered in the report extends past the end of the audit period. For example, if a performance report covers the federal fiscal year it would generally be due Dec 31. In this case we would test the report due during our audit period. If you have any questions regarding determining the scope for a particular report please consult the Medicaid supervisor or AIC(s). For reports submitted quarterly or more frequently, at least two reports should be tested.

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Determine specific reporting requirements by reviewing the reporting instructions for the report being tested. For additional information, review the following that apply to the audit period:

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- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

**NOTE:** The Federal Funding Accountability and Transparency Act (FFATA) report is used to capture and report subaward and executive compensation data for first-tier subawards. Entities are expected to comply with FFATA reporting as applicable, but we are not expected to audit this requirement at this time.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

**Document all grant award numbers with expenditures during the audit period and the amount expended for each.**

Gain an understanding of the grantee's internal controls and identify the key controls to ensure:

Financial Reporting - Financial reports include all activity of the reporting period, are supported by appropriate records, and fairly presented;

Performance & Special Reporting - Reports are completed, timely, and include all required elements and those elements are accurate and supported.

**Evaluation of Results: Did you identify any control deficiencies? If yes, you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.

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### 2. Document the rationale for a LOW or HIGH risk assessment.]

#### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

*Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.*

Guidance/Criteria.:

Record of Work Done.:

#### **INHERENT RISK OF NONCOMPLIANCE**

##### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

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### **Gather Information**

#### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Reporting requirements. We identified the following: *SF-425, Federal Financial Report* – Applicable for expenditure reporting for the administrative costs of the state MFCUs; not applicable for expenditure reporting all other components of the cluster. [Criteria](#)

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We received a copy of the federal fiscal year 2021 (FFY21) MFCU grant award letter (see [FFY21 Award Letter](#)), document number 2101WA5050 MFCU Award Letter. The total FFY21 grant approved budget is \$10,408,529. The grant requires that 75% (\$7,806,400) of the program expenditures be charged to the grant (federal share) and 25% (\$2,602,129) of the program expenditures should be paid by the state.

We also received a copy of the federal fiscal year 2022 (FFY22) MFCU grant award letter (see [FFY22 Award Letter](#)), document number 2201WA5050 MFCU Award Letter. The total FFY22 grant approved budget is \$10,928,960. The grant requires that 75% (\$8,196,720) of the program expenditures be charged to the grant (federal share) and 25% (\$2,732,240) of the program expenditures should be paid by the state.

Calculated indirect costs are also charged to the grants. The indirect rate for FFY21 through FFY23 is 12.3% based



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on the state and local government rate agreement (see [Indirect Cost Rate 4-6-2020](#)). This agreement was finalized on April 6, 2020.

On November 2, 2022 we met with the Office of the Attorney General Medicaid Fraud Control Division (MFCD) to gain an understanding of the internal controls over the SF-425. We met with the following personnel from the Office:

- Melanie Nevares, Accounting Director
- Hana Nguyen, Lead Financial Analyst
- Irina Elmer, Financial Analyst
- Marci Phillips, Contracts and Grants Administrator
- Amanda Seaunier, General Accounting Supervisor

Melanie and Hana explained the expenditures are entered into AFRS by the Office's fiscal division based on invoices and time sheets as they are received. The time sheets are submitted and approved electronically to payroll via HRMS, and later posted to AFRS. Invoices are entered into the AGO Purchase/Payment System which is uploaded to AFRS. During SFY22 Irina started to do work preparing the SF-425, which was previously done by Hana. Hana took over the review, approval, and submitting of the SF-425, which was previously done by Melanie.

### *Cash Draw Down*

A Financial Analyst runs a monthly expenditure summary report and a monthly expenditure detail report from AFRS to determine staff and operating expenditures. Using these reports, they develop the reconciliation spreadsheet by entering the amounts shown on the expenditure reports into the spreadsheet which calculates the amount of indirect and direct costs to be charged to the state and federal grant. The Analyst determines the total dollar of indirect costs to be charged back to the grant by taking the total expenditure dollars (objects A and B - salary and benefits) from AFRS reports and entering those dollar totals into the same spreadsheet noted above

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which then multiplies this total by the approved rate (12.3% for FFY21 and FFY22). The indirect rate is negotiated every 4 years. Once all figures and totals have been determined, the Analyst calculates the federal share by applying the 75% federal/ 25% state split to the total expenditures for that month. The program initially spends 100% state dollars then requests reimbursement from the grantor for those allowable federal costs related to the 75%. All calculations and supporting reports are included in her reconciliation spreadsheet.

The Analyst posts the reports on MFCD's internal network drive and notifies the Reviewer (Accounting Director or Lead Financial Analyst). They review the reconciliation sheet and supporting reports to ensure that the federal share is accurately calculated. When the Reviewer reviews the draw request, they specifically checks total expenditures on the reconciliation workbook and the monthly expenditure summary report to ensure the draw amounts were determined based on actual expenditure reports. After review, they approve the federal draw down. The approval is documented with her signature on the JV.

Reimbursement requests are submitted on-line through the Payment Management System (PMS). The Office of Financial Management (OFM) will receive the funds and the same day will send a request to the Office via email to complete and submit the A-8 form to adjust the accounting records.

### *SF-425 Preparation*

The Financial Analyst is responsible for maintaining the Grant file and compiling the quarterly information required to support the SF-425 report. The support includes the AFRS Enterprise monthly and quarterly summary reports, the PMS monthly draw down reports, and spreadsheets used to reconcile the expenditures to AFRS and monthly draws. On a quarterly basis, the Analyst prepares the SF-425. After completing the SF-425, the Reviewer reviews the report and supporting documents to ensure the amounts on the SF-425 are properly supported. When reviewing the SF-425 report, the Reviewer specifically ensures the Cash Receipt amounts (Item 10a) and Cash Disbursement amounts (Item 10b) are accurately reported based on reconciliation workbook. They also ensure the calculated balance of cash on hand (item 10C) is accurately determined. Once completed, the Reviewer approves,

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signs and submits the SF-425 report. **Key Control #1: The Accounting Director or Lead Financial Analyst reviews the SF-425 report and its supporting documents prior to submission to CMS to ensure the reports are accurately prepared based on reviewed monthly reconciliation worksheet and expenditure/revenue reports and signs the federal financial reporting indicating approval. (Control Activities/Monitoring)**

### *Summary of Key Controls*

Key Control #1: The Accounting Director or Lead Financial Analyst reviews the SF-425 report and its supporting documents prior to submission to CMS to ensure the reports are accurately prepared based on reviewed monthly reconciliation worksheet and expenditure/revenue reports and signs the federal financial reporting indicating approval. (Control Activities/Monitoring)

**Evaluation of Results:** Did you identify any control deficiencies? No control deficiencies were identified.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

#### **G.2.PRG - Reporting - CMS 64**

**Procedure Step:** L. Reporting - Identification of Key Internal Controls - CMS-64

**Prepared By:** AWW, 12/5/2022

**Reviewed By:** SAG, 2/11/2023

Purpose/Conclusion.*
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance that reports submitted to the Federal awarding agency or pass-through entity include all activity of the reporting period, are supported by underlying accounting or performance records, and are fairly presented in accordance with program requirements.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls.

### **Source:**

Jill Arlow, Federal Financial Reporting Manager

Laura Roberts, Federal Claims Supervisor

Kari Summerour, External Audit Liaison

William Sogge, External Audit Liaison

### **Conclusion:**

Based on our understanding of internal controls over Reporting, we assessed preliminary control risk as low.

However, we noted that the Authority did not file the CMS-64 report timely. Federal law requires states to submit the form CMS-64 quarterly to CMS no later than 30 days after the end of the quarter being reported. In state fiscal year 2022, the Authority filed CMS-64 reports late as follows:

FFY 2022	Quarter	Quarter End	Due Date	Certified Date	Re-Certified Date	Days Late
2021	4	09/30/21	10/30/21	12/08/21		(39)
2022	1	12/31/21	01/30/22	02/16/22		(17)
2022	2	03/31/22	04/30/22	05/16/22	07/13/22	(16)
2022	3	06/30/22	07/30/22	08/24/22		(25)

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This issue will be reported as an exit item (see [EI\\_S1Washington\\_SA22\\_HCA\\_Reporting\\_CMS-64 Late Certification](#)).

### Testing Strategy:

**Note:** Financial report testing populations should include all reports covering expenditures occurring during the audit period. For quarterly reports this means we must include the report covering the period ending June 30 even though it is filed after the audit period. For performance or other special types of reports the testing population should include the reports covering the audit period unless the period covered in the report extends past the end of the audit period. For example, if a performance report covers the federal fiscal year it would generally be due Dec 31. In this case we would test the report due during our audit period. If you have any questions regarding determining the scope for a particular report please consult the Medicaid supervisor or AIC(s). For reports submitted quarterly or more frequently, at least two reports should be tested.

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Determine specific reporting requirements by reviewing the reporting instructions for the report being tested. For additional information, review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement

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- the grant agreement or contract, and
- any available program guidelines or handbooks.

**NOTE:** The Federal Funding Accountability and Transparency Act (FFATA) report is used to capture and report subaward and executive compensation data for first-tier subawards. Entities are expected to comply with FFATA reporting as applicable, but we are not expected to audit this requirement at this time.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

**Document all grant award numbers with expenditures during the audit period and the amount expended for each.**

Gain an understanding of the grantee's internal controls and identify the key controls to ensure:

Financial Reporting - Financial reports include all activity of the reporting period, are supported by appropriate records, and fairly presented;

Performance & Special Reporting - Reports are completed, timely, and include all required elements and those elements are accurate and supported.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

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Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

*Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.*

Guidance/Criteria.:

Record of Work Done.:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

Review scope of work

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We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Reporting requirements. We identified the following: *The CMS-64, Quarterly Statement of Expenditures for the Medical Assistance Program* (OMB No. 0938-1265) – Required to be used in lieu of the SF-425, Federal Financial Report (for all components of the cluster other administrative costs of the state MFCUs), prepared quarterly, and submitted electronically to CMS within 30 days after the end of the quarter. Various provisions of the Act provide for an FMAP that is increased either permanently, or temporarily. Lines and forms on the CMS-64 that reflect these increases present more risk than others. States must report expenditures on the CMS-64 that reflect the date of payment, not the date of service, to obtain the correct FMAP (see 42 CFR 430.30(c)).

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

#### **Certification Dates**

CMS requires the CMS-64 to be submitted within 30 days after the quarter ends. Jill explained this reporting process takes more than 30 days since they must wait for AFRS to close and the reconciliation process takes a lot of time with the final report being hundreds of pages long. Jill informed us that CMS was already aware of this issue and has not enforced this timely filing regulation. The Authority's CMS-64 report filing status for state fiscal year 2022 reports are summarized below:

FFY 2022	Quarter	Quarter End	Due Date	Certified Date	Re-Certified Date	Days Late
2021	4	09/30/21	10/30/21	12/08/21		(39)
2022	1	12/31/21	01/30/22	02/16/22		(17)
2022	2	03/31/22	04/30/22	05/16/22	07/13/22	(16)



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2022	3	06/30/22	07/30/22	08/24/22		(25)
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On September, 14, 2018, we had a call conference with Anh Ta, CMS Seattle Region Financial Analyst to discuss the Authority's late filing issue. Anh was aware of this issue. He also discussed this issue with CMS central office, but CMS cannot put any enforcement actions in place regarding the late filing issue. Anh stated that he was fine with either a finding or an exit item for the reporting level of the late filing issue, but he believed that there would be no CMS enforcement action regarding the late filing issue regardless of the reporting level.

On February 15, 2019, we contacted Felicia DenAdel, SAO Single Audit Specialist, to get her opinion on this issue. Felicia believed that the late filing issue would not rise to a significant deficiency or material non-compliance with the CMS-64 reporting requirements if the reports were being submitted, were materially correct, and the awarding agency was aware of the delay and not taking action. Based on the significant number of days the reports were submitted after the due date, we decided to report this late filing issue as an exit item, see

EI S1Washington SA22 HCA Reporting CMS-64 Late Certification.

### Understanding Meeting

On October 14, 2022 we met with the Authority's Federal Financial Reporting (FFR) staff to gain an understanding of the Reporting: CMS-64 requirement:

- Kari Summerour, External Audit Liaison
- William Sogge, External Audit Liaison
- Jill Arlow, Federal Financial Reporting Manager
- Laura Roberts, Federal Claims Supervisor
- Mary Anderson, Financial Analyst
- Roxanne Smith, Financial Analyst

### Step 1 - Chart of Accounts

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The Authority uses a chart of accounts (COA) to properly categorize and account for the Agency's activities. This information is ultimately used to allocate costs. The agency's COA is developed to reflect specific information that correlates to federal reporting. Cost objectives are designed to identify source of funding, current federal fiscal year, as well as the federal fiscal year the entry relates to. Other coding elements such as program index, project, allocation code, and sub-sub-object, for example, are designed to assist with federal reporting claim items. This information is then incorporated into a mapping tool used by the Federal Financial Reporting unit. Laura will update these codes with Jill's approval.

### **Step 2 - Cost Allocation**

An Automated Cost Allocation Plan (ACAP) is also applied to Medicaid expenditures. It is an on-going process as additions and deletions are made to the Written Cost Allocation Plan, Automated Cost Allocation Plan, and COA. It is built on a monthly basis in the prior month to reflect current data or allocation streams. It is updated on a monthly basis and it is reviewed by Jill.

### **Step 3 - HCA Mapping Tool**

HCA uses a mapping tool that lays out how the coding logic relates to federal reporting. There are two mapping tools: one for assistance and one for administrative costs. The tool was developed as a hierarchy and all mapping is done in accordance with the hierarchy. With this process FFR can accommodate the fact that there are more federal reporting items than coding fields available. The tool is the combined effort of staff in the program area, budget office, and accounting sections. Changes to this tool are the result of discussions by all affected parties. Changes are not made very often, if any change is made, it is done by Laura or a Medicaid Transformation Project (MTP) Financial Analyst with Jill's approval.

### **Step 4 - CMS- Review Workbook**

Per our discussion with FFR staff, the CMS-64 reporting process is summarized as below:

- AFRS data for the quarter is pulled into an HCA database

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- FFR staff confirm that the database and AFRS are in balance (reconciliation)
- FFR staff use the unit's mapping tool to determine where each accounting line in the database should be mapped to the CMS-64 report form (report)
- Once mapping is complete, FFR staff prepare pivot tables to create MBES input sheets (report)
- MBES input sheets are used by FFR staff to manually key into MBES (system)

The CMS-64 claims process begins with pulling statewide accounting data from AFRS from the Department of Social and Health Services (DSHS), the Department of Children, Youth, and Families (DCYF), as well as the Authority, into a database. This is completed by IT Data Management. Agency fiscal staff perform a daily manual reconciliation of ProviderOne to AFRS by verifying the batch data shown in the AFRS batch report matches the ProviderOne batch report. **Key Internal Control #1: Agency fiscal staff perform a daily manual reconciliation of ProviderOne to AFRS by verifying the batch data shown in the AFRS batch report matches the ProviderOne batch report. (Control Activity/Monitoring)** For Key Internal Control #1 we will be relying on the testing for this control that is being completed as part of the statewide financial statement audit under Human Services Key Control #6 AFRS Reconciliation.

Each quarter, FFR staff takes this information and ensures the database data reconciles back to the statewide accounting data (AFRS). **Key Internal Control #2: The Authority uses statewide accounting data from AFRS to create the CMS-64 report. As there are more federal reporting items on the report than coding fields available in AFRS, the Authority uses a mapping tool for additional tracking. The Financial Analyst reconciles the CMS-64 database report (consisting of unmapped data) back to the AFRS Medicaid expenditure report to ensure completeness of the data to be mapped. (Control Activity)** Any missing, duplicative, or erroneous lines are identified and work is done to correct the database until the two systems are in balance. FFR staff perform a review of the actual AFRS distribution of Federal and State funds as compared to the established Federal Medical Assistance Percentage (FMAP) rate. Variances that exceed minor rounding are noted and moved/labeled to Line 0. Follow-up is done after the claim is certified to determine the nature of those

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variances and the action, if any, that is needed.

Unmapped data, which for the quarter is typically around one thousand items or so, must be cleared and manual adjustments made. Manual maps are required for each line item of the CMS-64 report and the data is reconciled to AFRS. Expenditures assigned to line zero are not reported on the CMS-64 report. Manual adjustments are processed for several different items such as Audit Items and Certified Public Expenditures (CPE). An MTP Fiscal Analyst reviews expenditures for the Transformation Waiver, Chau reviews administrative expenditures, and Laura looks at assistance expenditures.

FFR staff starts by pulling certified public expenditures (CPE). CPEs are state expenditures used to support the cost of providing Medicaid-covered services or Medicaid program administrative activity that the state can claim an eligible FMAP. FFR staff manually adjusts the CPEs so the proper amounts are in the total computable. This is done each quarter and manual adjustments from previous quarters can be performed at this time. For CPE, the pay for the federal piece is claimed and the state portion must be input and reported on the claim. This manual adjustment process can be very time consuming. It starts by downloading CPE data percentages for the state and federal funds paid out. The data is manipulated to input correct FMAP rates, total computable, and find the state amount. A pivot table is created to verify total amounts match and used as an input document for a manual adjustment for database line item, program etc. On the program it specifies “M” for manual entry and “A” for financially automatic process.

### **Step 5 - MPES Input Sheets**

When all expenditure transactions for a given reporting quarter have been balanced, mapped, and reviewed, input sheets are prepared for entry into the CMS Medicaid and Children’s Health Insurance Program Budget and Expenditure System (MBES). These input sheets are prepared to represent the several lines (forms) within MBES and the corresponding items. Separate input sheets are prepared for waiver and non-waiver data. Laura, Chau, and an MTP Analyst will each enter their section of the CMS-64 report information into MBES and document their

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reconciliation as each workbook is complete. Total computable amount is entered into MBES and the federal share is automatically determined by the MBES system.

### **Step 6 - Summary Reconciliation**

Once all forms have been entered into MBES, Laura and Chau prepare a reconciliation between MBES summary information and the CMS-64 mapped data report. **Key Internal Control #3: Once all forms have been entered into MBES the Fiscal Analyst performs a reconciliation between the MBES summary information and the CMS-64 mapped data reports to ensure accuracy and completeness of the MBES report. (Control Activity)** The summary sheet from the CMS-64 report is used by line, with variances noted and explained. Pivot tables help identify any irregularities by sorting by assistance, total computable, admin etc. A typical reconciliation item would be to confirm additional federal matching that is not calculated within HCA's data to assure the federal rate is correct and to make comparisons as required. Because all levels of data are rounded, the amounts may vary slightly. The summary reconciliation is prepared for both the services and administrative (include MTP waiver) portions of the CMS-64.

To ensure a segregation of duties between the CMS-64 preparer and reviewer, Jill, the Federal Reporting and Accounting Manager, reviews the CMS-64 report and supporting documents to ensure it is properly prepared. **Key Internal Control #4: There is segregation of duties between the CMS-64 report preparer and the CMS-64 reviewer/certifier. The HCA Federal Financial Reporting Manager reviews the CMS-64 report and its supporting documents to ensure that the CMS-64 is properly prepared before certifying the report. (Control Activity)** According to Jill, she, the reviewer, performs a high level review and makes sure the CMS-64 report summary pages are adequately supported by each subreport and supporting documents such as the reconciliation worksheet. She looks at specific lines, if noted previously and randomly spot checks through MBES to identify any differences compared to previous quarters and she also reads the narratives. She then certifies it. If already certified and if an error is identified, Laura will make the correction after it's been uncertified. Once corrected, the report is recertified. Others at CMS will also review the CMS-64 report once completed and received. This completes the

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reporting process for the quarter and when finished, the process begins again with the next quarter's data. Jill explained that there is no direct documentation, for each step of the process, that details the staff responsible. There are assigned responsibilities, however, the process can be very collaborative if work does not reconcile, staff need assistance, etc. Jill provided a list of who is assigned to which area, clarifying these are the experts for the area, and other staff are cross trained in the areas:

- Laura Roberts – Services, drug rebate, etc., final high-level reconciliation of MBES to HCA
- Chau Duong – Administration and the MTD waiver
- Mary Anderson – CHIP

### **FMAP Rates**

For FFY20 and FFY21 the State base FMAP rate for Medicaid was 50.00 percent and the emergency rate was 56.20 percent. CHIP and some other programs use an enhanced FMAP (E-FMAP) rate of 65.00 percent base, or 69.34 percent for the emergency rate. Generally, most Medicaid payments fall under the FMAP rate, while some programs have federal exceptions. Examples of this are Breast and Cervical Cancer which use E-FMAP, or Services during the COVID-19 public health emergency which uses FMAP plus 6.2 percentage points. More detailed information on exception rates can be found via the Medicaid and CHIP Payment and Access Commission's (MACPAC) website at [Federal Match Rate Exceptions : MACPAC](#), and through FFR's Service (MAP) FMAP chart at [001 CMS-64 Master Mapping Tool - MAP](#).

### *Summary of Key Controls:*

- Key Control #1: Agency fiscal staff perform a daily manual reconciliation of ProviderOne to AFRS by verifying the batch data shown in the AFRS batch report matches the ProviderOne batch report. (Control Activity/Monitoring)
- Key Internal Control #2: The Authority uses statewide accounting data from AFRS to create the CMS-64 report. As there are more federal reporting items on the report than coding fields available in AFRS, the Authority uses a mapping tool for additional tracking. The Financial Analyst reconciles the CMS-64

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database report (consisting of unmapped data) back to the AFRS Medicaid expenditure report to ensure completeness of the data to be mapped. (Control Activity)

- Key Internal Control #3: Once all forms have been entered into MBES the Fiscal Analyst performs a reconciliation between the MBES summary information and the CMS-64 mapped data reports to ensure accuracy and completeness of the MBES report. (Control Activity)
- Key Internal Control #4: There is segregation of duties between the CMS-64 report preparer and the CMS-64 reviewer/certifier. The HCA Federal Financial Reporting Manager reviews the CMS-64 report and its supporting documents to ensure that the CMS-64 is properly prepared before certifying the report. (Control Activity)

**Evaluation of Results:** Did you identify any control deficiencies? No control deficiencies were identified.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

#### **H.2.PR.G - ST1 Utilization Control and Program Integrity - HCA**

***Procedure Step:*** Special Test 1 - Utilization Control/Program Integrity HCA - Identification of Key Internal Controls

***Prepared By:*** KWF, 4/19/2023

***Reviewed By:*** RJC, 4/25/2023

Purpose/Conclusion.
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**Purpose:**

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To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 1 - Utilization Control and Program Integrity.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 1 - Utilization Control and Program Integrity.

### **Source:**

Mike Brown, Division of Program Integrity Assistant Director  
Ming Wu, Program Integrity Deputy Division Director  
Kari Summerour, External Audit and Compliance Manager  
Scott Best, Clinical Nurse Specialist  
Susan Williams, Occupational Nursing Consultant Supervisor  
So (Sojheath) Kong, Occupational Nursing Consultant Supervisor  
Karen Buchanan, Occupational Nursing Consultant Supervisor  
Carey Wallace, Occupational Nursing Consultant  
Kathy Cleeves, Financial Examiner  
Melissa Rustemeyer, Financial Examiner  
Penny Bichler, Medical Assistance Program Specialist  
Glory Dole, Clinical Nurse Specialist  
Trisha Young, Medical Assistance Program Specialist  
Dianne Baum, Section Supervisor

### **Conclusion:**

Though the Health Care Authority does have various methods in place in attempts to safeguard against unnecessary utilization of care and services, it does not appear to be sufficient to meet compliance requirements over Special Test 1 - Utilization Control and Program Integrity for the following reasons:

- The State plan does not properly depict the Authority's methods and procedures for utilization control.
- There exist no controls to ensure that an appropriate MSV process is in place for the MCOs, which are the majority of patient interactions.
- The Authority performs no oversight of DSHS's or other state agencies' program integrity efforts.
- There is no centralized case management tool that tracks the CMT audit cases and their results.
- The Authority does not have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of Medicaid services.



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- The Authority did not have an agreement or communication in place to ensure PACE contractors met False Claims Act requirements.
- The Authority does not have a process in place to identify contractors that exceed the \$5 million threshold, which are paid outside of the P1 system.

Based on our understanding of internal controls over Special Test 1 - Utilization Control and Program Integrity, we found the agency does not have adequate internal controls to prevent material noncompliance. We assess preliminary control risk as high and will report a finding for a material weakness at FI\_S1Washington\_SA22\_HCA-M04\_Medicaid\_Special Test 1 - Utilization Control and Program Integrity. No internal control testing is necessary in this instance except for the key controls surrounding the Federal False Claims Act.

Testing Strategy:

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: The State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, the State must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials (42 CFR parts 455, 456, and 1002).

Suspected fraud must be referred to the State MFCUs (42 CFR part 455.21). See Special Test #6, MFCU.

The SMA must establish and use written criteria for evaluating the appropriateness and quality of Medicaid

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services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. The SMA may conduct this review directly or may contract with an independent entity (42 CFR sections 456.5, 456.22, and 456.23). The SMA must ensure that each managed care organization with which it contracts is evaluated annually on quality, timeliness, and access to the health care services by an external quality review organization (EQRO). The State must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438, Subpart E).

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

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**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

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## **Special Test 1 - Utilization Control and Program Integrity HCA - Identification of Key Internal Controls**

### **Inherent Risk of Noncompliance**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- This area is very broad with high autonomy.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

##### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Utilization Control and Program Integrity requirements. We identified the following:

**Compliance Requirements** - The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services.

The State Medicaid Agency (SMA) must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of Medicaid services. The SMA may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

In addition, the SMA as required per Section 1902(a)(68) - [42 USC 1396(a)(68)] False Claims Education must ensure that providers and contractors receiving or making payments of at least \$5 million annually under a state's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent state laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent state laws and rules.

We then reviewed the state plan (Medicaid State Plan - Numbered Pages) for the methods and procedures to safeguard against unnecessary utilization of care and services. The state plan does not specify the methods and procedures (**Control Weakness 1**); in fact it does not even have

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the box "Directly" or "By undertaking medical and utilization review requirements through a contract with a PRO ..." marked. (see page 68 of H.2.6) [Note: it does specify for inpatient hospital services (page 68), skilled nursing facility services (page 71), and intermediate care facility services (page 72).]

***NOTE:*** *The compliance supplement also includes the following language, which will be separately reviewed under Special Test 6 - Medicaid Fraud Control Unit (MFCU) at ST6 Medicaid Fraud Control Unit (MFCU) HCA: "In addition, the State must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials (42 CFR parts 455, 456, and 1002). Credible allegations of provider fraud must be referred to the State Medicaid Fraud Control Unit (42 CFR part 455.21)."*

**For purposes of our understanding to Special Test 1, it will focus solely on program integrity efforts over their Medicaid control utilization and False Claims Act activities. Further breakdown of our gather information step in relation to this planned scope can be viewed at Planning/Research Analysis.**

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step. Prior to our discussions, the Authority provided us with Division of Program Integrity Chapter 120: Internal Controls documents (Case Management Policies and Procedures) dated April 1, 2021. These documents describe the purpose and policies of the Case Management Team (CMT), which is in charge of making decisions for any PI leads generated including whether to follow up on those leads or refer them to another division or external stakeholder. They also provided procedures regarding their False Claims Act processes (see: Overview of FCA process).

To determine what processes the Authority has in place to ensure proper control utilization of all Medicaid services is in place, we held a myriad of meetings with various parties, as documented below.

**On August 1, 2022**, we met with the following staff from the Division of Program Integrity (DPI) to discuss their involvement in overseeing the program integrity efforts of the Managed Care Organizations (MCOs):

- Mike Brown, Medicaid Program Integrity Assistant Director
- Ming Wu, Program Integrity Deputy Division Director
- So (Sojheath) Kong, Occupational Nursing Consultant Supervisor

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- Susan Williams, Occupational Nursing Consultant Supervisor
- Jessica Stephens, Administrative Assistant
- Kari Summerour, External Audit and Compliance Manager

It was explained that the MCO program integrity oversight involves the Clinical Review Unit (CRU), Audits and Investigations (A&I) Unit, as well as the Case Management Team (CMT). Scott oversees and leads the Clinical Review and Audit section. Both So, who leads the CRU, and Susan, who leads the A&I Unit are under Scott's direction (see org chart at [Org chart for Division of Program Integrity](#)). Ming and Mike clarified that Kathy Cleeves's unit, the Compliance, Operations, & Oversight (COO) unit, conducts the majority of MCO oversight, particularly as it comes to contract provisions. So and Susan's teams deal with health care level transactions, which is a very different level of oversight but does overlap.

The various groups, including those run by So, Susan, and Kathy, work to coordinate efforts over the MCO program integrity efforts by sharing through their manager meetings as well as through CMT for discussion quarterly. They have ongoing communications, but also meet weekly as a platform to collaborate. Each unit may hand-off work to the other depending on the scope and need. Ming mentioned they are using a "finders keepers" type of process, which means if the Division of Program Integrity finds issues they will go ahead and conduct those audits (instead of referring the leads to the MCOs).

### Clinical Review Unit (So's team)

The CRU considers managed care in its data mining and conducts MCO audits

So said that as far as oversight of MCOs' program integrity, one of his team's key activities is conducting data mining and analysis for fraud, waste, and abuse (**Control Activities**). They will always look for risks related to MCOs on those activities. The team will write white papers on the topics they identify and send them to the Case Management Team (CMT) for consideration of how to proceed. This is the primary method, So said.

The CRU also is conducting audits that incorporate oversight and records from both MCOs and contracted providers. The CRU historically focused on inpatient hospitals, then transitioned to other data mining, and, more recently, has taken on managed care. So said that the general expectation is that work is getting transitioned toward managed care. CRU is also transitioning to go beyond inpatient hospitals. So estimated that about 30-50% of CRU's capacity is working on managed care. Any new work will look to see if there is managed care-related risk, though there is still ongoing work focused on fee-for-service.

### Audits and Investigations Unit

Susan indicated her team is continuing to retrieve daily emails from MC Track regarding possible fraud, waste, and abuse, and bring those through intake to the CMT. She said they also participate in quarterly meetings with all the MCOs that are intended to discuss larger issues. Susan specifically monitors the inbox in MCTrack regarding possible fraud, waste, and abuse. Susan then works with CMT, Kathy's team, and the Fraud Coordinator.

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They are working on their first MCO audit, which is focusing on duplicate charges. The audit is looking at MCOs' policies and procedures to determine if they are being followed (**Control Activities**). Susan said that every subject her team looks at covers both fee-for-service and managed care. She estimated that the managed care-focused work represents somewhere in the 50-80% range of overall team effort.

Susan also mentioned medical service verifications (MSVs) for managed care clients, where her team follows up on any exceptions where a client is unaware of a service that is in their name. For more information on this subject, we later held a separate meeting to discuss the topic at greater length. See MSV sections with the dates of August 12 and August 18, 2022 further within this ROWD for more details.

### Case Management Team (CMT)

All oversight efforts (fee-for-service & managed care) funnel through CMT for case review and assignment. This unit involves several members from various units, including representatives from each unit as well as leadership within DPI. CMT reviews issues from a variety of sources to determine whether there has been unnecessary use of resources, improper billing, or fraud (**Control Activities**). These can come from the CRU unit, fraud referrals, and encounter data audits. PI will follow up on these issues and may initiate audits of a particular item across all MCOs.

Case-specific decision making is handled by CMT. CMT helps set the priority for issues that are raised and determine what should be done. For example, does it need to be referred as potential fraud, or should it become an audit? The CMT includes the program integrity management team, the fraud coordinator, and a couple of lead investigators. So also noted that the staff who worked on leads often present to the CMT.

**On August 4, 2022**, we met with the following HCA staff to discuss the Compliance, Operations, & Oversight (COO) unit's involvement in monitoring the MCOs' program integrity activities:

- Kari Summerour, External Audit and Compliance Manager
- Mike Brown, Division of Program Integrity Assistant Director
- Ming Wu, Program Integrity Deputy Division Director
- Kathy Cleeves, Financial Examiner 4
- Melissa Rustemeyer, Lead Financial Examiner

### Compliance, Operations, & Oversight (COO)

Kathy confirmed that the unit she manages under COO is primarily focused on managed care oversight work. Her team reviews monthly program integrity reports with MCOs. Kathy also confirmed that her team is working on encounter data validation audits including site visits and reviewing claims of different MCOs (**Control Activities**). On August 9, 2022, we met with IT Business Analysts to discuss how they ensure the accuracy and completeness of encounter data and on August 10, 2022, we met with the Healthcare Rates & Finance Section to discuss how the encounter data

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and the MCOs' program integrity efforts are used during the rate setting process. As these discussions did not directly address our special test objectives (but more for the purposes of the performance audit), we decided to omit these notes from this control understanding.

Kathy's team also receives an annual audit plan from MCOs. As far as additional activities Kathy's team does, she stated that they provide technical assistance to the MCOs, and are in constant communicate with MCOs on program integrity. Kathy explained another control is that in the monthly deliverables, MCOs provide all the data on their audits, such as the new audits, subject matter, overpayments identified/recovered, cost saving information, and tips.

They also participate in TEAMonitor, which is a broad review of MCO activities, to ensure they comply with contractual requirements, but that is not housed within her unit. For more information on this subject, we later held a separate meeting to discuss the topic at greater length. See TEAMonitor section with the date of September 6, 2022 further within this ROWD for more details.

**On August 12, 2022**, we met with Mike Brown, Ming Wu, and Kari Summerour to discuss its Medicaid Service Verification (MSV) process. Additionally, further control utilization discussion was had as well as discussing how the Authority meets False Claim Act requirements. Then on **August 18, 2022**, we met with the following HCA staff to continue discussing the MSV process in more detail:

- Scott Best, Clinical Nurse Specialist
- Susan Williams, Occupational Nursing Consultant Supervisor
- Ming Wu, Program Integrity Deputy Division Director
- Kari Summerour, External Audit and Compliance Manager

### Medicaid Service Verification (MSVs)

An MSV process, or query, is automatically ran each month in ProviderOne for Fee-For-Service claims. This process does not affect claims through MCOs, however Mike clarified that the MCOs do have a similar MSV process, which is carved out in their contract, and that could be reported back to HCA, though this isn't specifically tracked (**Control Weakness 2**). It was also clarified by Scott that the MSV process included nursing facilities' claims throughout the duration of SFY22, but had not done so in the past.

The MSV query is programmed into ProviderOne and randomly selects approximately 400 Medicaid claims from all eligible claims processed during the last 60 days in ProviderOne and the system generates an MSV letter addressed to the selected service recipient inquiring if they received the services outlined in the letter (**Control Activities**). The letters are sent automatically by ProviderOne, without manual review. Certain claims are excluded from the population if there are confidentiality concerns.



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Of the approximate 400 letters, Mike estimates that less than half are returned with responses each month (around 25% give or take depending on the month). He mentioned that if no response is received, nothing more is done. The responses that are received are tracked in ProviderOne and stored in a secure external drive. Negative responses are tracked in a spreadsheet and are indications that a service recipient either did not receive the service or were required to pay for it (**Control Activities**). HCA Program Integrity staff follows up with the individuals who sent negative responses to ensure they understood the inquiry and to verify the negative responses. If the negative response is verified, it is forwarded for review by the Case Management Team.

When asked if DPI coordinates with DSHS regarding their MSV process or if they monitor their program integrity units to ensure a statewide system of review, Ming mentioned that they do sometimes receive DSHS's MSVs, but this is not something they monitor or claim to be responsible for (**Control Weakness 3**).

### State Plan

Regarding the corrective action plan for the SFY21 audit, HCA noted that they have direction from Centers for Medicaid and Medicare Services (CMS) to maintain the state plan as is, and it would be virtually impossible for them to structure statewide surveillance to meet compliance requirements without dismantling the whole system (**Control Weakness 1**). HCA also noted that other states even use their current structure as a guide for their own.

**On August 18, 2022**, we subsequently met with the following HCA staff to discuss Post-payment Reviews as well as reviews for reviewing the quality and timeliness of Medicaid services as it relates to 42 CFR 456.5, 456.22, and 456.23:

- Mike Brown, Division of Program Integrity Assistant Director
- Ming Wu, Program Integrity Deputy Division Director
- Kari Summerour, External Audit and Compliance Manager

All audits are conducted through CMT. However, CMT would not audit cases for amounts deemed immaterial as the cost of the audit would outweigh any potential benefits. All potential leads are reviewed by CMT to determine if it will be assigned or closed. It was mentioned that outside of referrals, they do regularly scheduled audits and Kathy does some network adequacy work. The CMT audits are not considered to be performed on a sample basis, since they are driven by leads (**Control Weakness 4**). All audits are peer-reviewed, and if discrepancies are found, the lead auditor and Susan will review. We asked if these would typically fall within the description of a post-payment review and it was described that it depends on the audit focus, but this would not always equate to an associated payment for review (**Control Weakness 5**). It was also mentioned that there is no centralized case management tool that tracks the audit cases and their results, however the new FADS project will make more centralized tracking a possibility (**Control Weakness 4**).

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When we asked how they sample for quality and timeliness of services, Mike and Ming agreed that these terms are too broad and undefined to determine if this requirement is met. DPI does not deal in the realm of these types of activities. They were also unsure which team audits for these requirements. They mentioned that possibly TEAMonitor or External Quality Review Organization (EQRO) may have responsibility for this area. HCA contracts with EQRO to provide external quality review that supports quality improvement for enrollees of Washington Apple Health. For more information on these subjects, we later held separate meetings to discuss the topics at greater length. See TEAMonitor section with the date of September 6, 2022 further within this ROWD for more details. Also see the EQRO section with the date of October 6, 2022 further within this ROWD for more details.

**On September 6, 2022,** we met with the following personnel to discuss the controls TEAMonitor uses to ensure compliance with the special test:

- Glory Dole, Clinical Nurse Specialist
- Penny Bichler, Medical Assistance Program Specialist 3
- Trisha Young, Medical Assistance Program Specialist 3f
- Kari Summerour, External Audit and Compliance Manager

### TEAMonitor

TEAMonitor ensures quality/timeliness of care and appropriateness for enrollees by conducting two file reviews on an annual basis. While the scope for these reviews are post-service, they are not necessarily post-payment (**Control Weakness 5**). One of the annual file reviews pertains to services (Care and Authorization) provided and the other is for grievances/denials/appeals (Care Management). 12 files are selected at random for each of these reviews from orderly reports received from MCOs. These files contain large amounts of clinical records annotated with about 12 categories that TEAMonitor needs to see in order to make determinations on quality, timeliness, and appropriateness (**Control Activities**).

The reviews are conducted by clinical staff with background knowledge on the types of, need for, and appropriateness of care. They review against requirements in the CFRs as well as in the contract. Ultimately, they're making the determination as to whether the appropriate decision (appeal, denial, etc) of the beneficiary was granted correctly based on the file information. This review is for elements of utilization management. This allows for the Authority to identify and correct misutilization practices of beneficiaries and providers.

A TEAMonitor reports (Coverage and Authorization and Care Management) are then created based on the reviews and sent to the EQRO. The EQRO then creates their own report based on the information TEAMonitor provides. In addition, a contract element report is created by TEAMonitor every three years. A contract element report was created in SFY22 for services in 2021. It was noted that TEAMonitor does not currently have any written policies and procedures, but they are currently in development, though they do have a TEAMonitor 101 document that staff can utilize for guidance.

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**On September 28, 2022**, we met with the following DPI staff to discuss the Post-payment Reviews of inpatient hospitals as it relates to 42 CFR 456.23:

- Kari Summerour, External Audit and Compliance Manager
- Mike Brown, Division of Program Integrity Assistant Director
- Ming Wu, Program Integrity Deputy Division Director
- Susan Williams, Occupational Nursing Consultant Supervisor
- So Kong, Occupational Nursing Consultant Supervisor

### Inpatient Hospitals

They mentioned that inpatient hospitals receive a retrospective post-payment review on a scheduled basis. These are conducted on paid claims and they cycle through the list of hospitals, based on their determined risk. The review entails looking at a clinical level, such as improper billing or stay over necessary length, provider preventable conditions, re-admissions, coding perspective, etc. This also includes a review of the DRG rate, diagnosis code, and procedure code to determine if it is coded correctly based on date of service.

The team designs rules to select certain claims or cases. They pull a utilization report that is compared against payment data, then select about 80 or so to be reviewed. This approach is a very targeted way to review the cases with a specific risk set of criteria. They mentioned they could do a separate focused audit, if necessary, but this is not very common and this work is very limited.

**On October 6, 2022**, we met with the following staff to discuss the applicability of the External Quality Review Teams' efforts for meeting the objectives of 42 CFR sections 456.5, 456.22 and 456.23 and their review of the quality and timeliness of Medicaid services:

- Penny Bichler, Medical Assistance Program Specialist 3
- Dianne Baum, Section Supervisor
- Karen Buchanan, Occupational Nursing Consultant Supervisor
- Carey Wallace, Occupational Nursing Consultant
- Kari Summerour, External Audit and Compliance Manager

### External Quality Review

It was clarified that neither the team nor the contracted External Quality Review Organization (EQRO), do any program integrity efforts during their review processes and that this is the purview of DPI. Through the produced Annual Technical Report, quality, access, timeliness of Medicaid services, and the results of activities is reported on. They also specified that the review is not specifically considered to be "post-payment" (**Control Weakness 5**).

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## False Claims Act

HCA provided us with their False Claims Act Process for providers. Every year in February, an email is sent to Scott Best, Clinical Nurse Specialist, to run a report that identified, via data mining, which providers were paid at least \$5 million in the most recent FFY (Oct 1 - Sep 30). After running the report, Scott saves it in Excel and Access. Letters requesting providers' policies and procedures and an attestation form are sent around April 1 (**Key Control 1 - Control Activities**). If the provider sent their policies and procedures the previous year, then only an attestation form that their policies and procedures are still current is needed.

When the requested documents are received, they are logged into a tracking spreadsheet. The attestation form needs a printed name, signature, and date. The policies are reviewed via HCA Compliance Checklist for references to the False Claims Act, whistleblower protections, and detection/prevention of fraud, waste, and abuse. If the Authority wishes to, they may conduct additional audits to confirm this process is actually in place. If something is missing, the providers are contacted. If the providers don't respond within 45 days (May 15), the provider is contacted to make sure the request was received. If it was, but they did not respond, a warning letter is sent requesting the information in 30 days. If still not received within the 30 day deadline (June 15), further payments are canceled until documentation is received (**Key Control 2 - Control Activities/Monitoring**). According to Ming Wu, documentation is usually received by the first reminder.

**On April 4, 2023**, we met with the following HCA personnel to discuss the False Claims Act process for contractors:

- William Sogge, Management Analyst 5
- Ming Wu, Program Integrity Deputy Division Director
- Kari Summerour, External Audit and Compliance Manager
- Kathy Cleeves, Financial Examiner 4
- Karen Buchanan, Occupational Nursing Consultant Supervisor
- Penny Bichler, Medical Assistance Program Specialist 3

When we asked the Authority to discuss how they meet the requirements surrounding the False Claims Act for contractors, Kathy responded that compliance is monitored through the TEAMonitor program every 3 years (**Key Control 3 - Monitoring**). They determined compliance in 2021 and the next review will be in 2024. Every review includes training over fraud, waste, and abuse (FWA), which includes the False Claims Act information, including reference to the applicable regulations and policies of the MCO. When we asked specifically about Program of All-Inclusive Care for the Elderly (PACE) contractors, Ming mentioned that HCA had been under the impression that DSHS had responsibility over them, but that they never actually followed up with them on it and didn't have an agreement in place during the SFY22 audit period (**Control Weakness 6**). We followed up with DSHS and they confirmed that they did not handle PACE contractors during the SFY22 audit period. We asked if contractors are required to submit False Claims Act documentation prior to contract approval, and Ming said it's generally not something they do, but that contractors know it

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is required. They don't want to ask for unnecessary information in the event the contractor does not receive \$5 million or more. They mentioned that they could review contractors once it's known that they had actually spent over the \$5 million threshold, however, when we asked what they would do to identify this, Ming stated that they would pull a report of payments in ProviderOne, however we noted that this would not capture contractors paid outside of the ProviderOne system and they could not confirm that they have a set process or time in place to address this (**Control Weakness 7**). Ming and Kathy asserted there would be no other non-MCO or PACE contractors that would be close to the FCA threshold.

### **Summary of Control Understanding and Special Test Requirements**

The compliance supplement specifically details the following requirements, which we have summarized the Authority's efforts to meet:

- The State plan must provide methods and procedures to safeguard against unnecessary utilization of care and services.

The State plan (see page 68 at [Medicaid State Plan - Numbered Pages](#)) does not specify the methods and procedures utilized to safeguard against unnecessary utilization of care and services.

The Health Care Authority does have various methods in place in attempts to safeguard against unnecessary utilization of care and services. Some of these methods include:

- Monitoring the Managed Care Organizations' program integrity efforts by CRU data-mining and MCO audits as well as MCO audits by the A&I Unit
  - Analysis of referrals and leads by the CMT to determine the appropriate action, including possible and subsequent review, audit, or investigation.
  - Conducting various ongoing reviews by the DPI, as identified by necessity or risk
  - Medicaid Service Verifications are performed to determine if claims for Medicaid services were actually received and were detailed accurately.
  - Risk Based audits of inpatient hospitals are performed on an annual basis
  - TEAMonitor and EQR activities are conducted to evaluate the quality, timeliness, and appropriateness of care.
- The State Medicaid Agency (SMA) must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of Medicaid services. The SMA may conduct this review directly or may contract with an independent entity (42 CFR 456.5, 456.22 and 456.23).

The Authority utilizes written criteria for evaluating the appropriateness and quality of Medicaid services through its TEAMonitor and EQR

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activities (42 CFR 456.5). However, as required by 42 CFR 456.22, the Authority does not have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. The TEAMonitor and EQR activities don't include ongoing sampled based review and DPI's audits do not evaluate for quality or timeliness. Additionally, the Authority does not have a set post-payment review process. This process must allow state personnel to develop and review beneficiary utilization profiles, provider service profiles, and exceptions criteria, and then use this information to correct misutilization practices of beneficiaries and providers. Though the Authority has processes to conduct portions of the CFR's expectations, there are not specific processes that ensure they are both post-payment and sample based.

- In addition, the SMA as required per Section 1902(a)(68) - [42 USC 1396(a)(68)] False Claims Education must ensure that providers and contractors receiving or making payments of at least \$5 million annually under a state's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent state laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent state laws and rules.

The Authority has processes in place to ensure that all applicable providers and contractors have False Claims Act policies, they include the detection and prevention of fraud, waste, and abuse, and are included as necessary in employee guidance.

**On November 7, 2022**, we met with Mike, Ming, and Kari to summarize our understanding of internal controls and control weaknesses noted above and to discuss the scope of the audit going forward. They were in agreement with our understanding overall and acknowledged room for improvement. They also noted ambiguity and room for interpretation within the Compliance Supplement over this area. Additionally, we mentioned that although the findings from the prior year will be repeated and we will not test controls or compliance for those requirements, we still plan to test controls and compliance surrounding the False Claims Act requirements, which are new for FY22.

### **Key Controls - False Claims Act**

We identified the following Key Controls:

- **Key Control 1 - Control Activities:** A report identifying providers paid at least \$5 million is generated. Attestation forms and letters requesting documents regarding False Claims Act and whistleblower protections are sent.
- **Key Control 2 - Control Activities/Monitoring:** The status of documents received are logged in a tracking sheet and further payments are canceled if documents are not received by deadline.

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- **Key Control 3 - Monitoring:** To ensure MCOs have the appropriate FCA policies in place, the Authority's TEAMonitor performs reviews every three years, which includes fraud, waste, & abuse training and FCA policies, regulations, and requirements.

### Control Weaknesses

We identified the following control deficiencies:

- **Control Weakness 1:** The State Plan does not specify the methods and procedures to safeguard against unnecessary utilization of care and services.
- **Control Weakness 2:** There exist no controls to ensure that an appropriate MSV process is in place for the MCOs, which are the majority of patient interactions.
- **Control Weakness 3:** The Authority performs no oversight of DSHS's or other state agencies' program integrity efforts.
- **Control Weakness 4:** There is no centralized case management tool that tracks the CMT audit cases and their results.
- **Control Weakness 5:** The Authority did not have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of Medicaid services.
- **Control Weakness 6:** The Authority did not have an agreement or communication in place to ensure PACE contractors met False Claims Act requirements.
- **Control Weakness 7:** The Authority does not have a process in place to identify contractors that exceed the \$5 million threshold, which are paid outside of the ProviderOne system.

### **Evaluation of Results:**

#### Utilization Control and Program Integrity

Though the Health Care Authority does have various control methods in place in attempts to safeguard against unnecessary utilization of care and services, it does not appear to be sufficient to meet compliance requirements over Special Test 1 - Utilization Control and Program Integrity for the reasons documented above. Therefore, they are not key key controls. However, we identified key controls surrounding the False Claims Act requirements. We consulted the Decision Matrix for Single Audit Internal Control Deficiencies and determined that the likelihood of noncompliance is more than remote and the magnitude of potential noncompliance is material. Therefore we assess preliminary control risk as high and will report a finding for a material weakness. No internal control testing over utilization control and program integrity is necessary in this instance.

#### False Claims Act

Because the FCA process in place for providers was found to be sufficient based on our understanding, we will plan to test the key controls surrounding the Federal False Claims Act. We noted that the controls in place over MCOs were not performed during our audit period and

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therefore, limited procedures will be performed to provide assurance on the control structure as well as on compliance. In regards to other contractors, we will assess the effect of the deficiency to the complete population and will reassess controls upon completion of our testing in consideration of the known risks.

### **Preliminary Control Risk Assessment**

#### **Step 4**

##### Utilization Control and Program Integrity

HIGH - Internal control design is not likely to be effective to prevent or detect non-compliance with grant requirements. We will report a material weakness in accordance with 2 CFR §200.516(1).

##### False Claims Act

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### **H.3.PR.G - ST1 Utilization Control and Program Integrity - DSHS MSV & FCA**

***Procedure Step:*** Special Test 1 - Utilization Control/Program Integrity - Identification of Key Internal Controls

***Prepared By:*** KWF, 3/6/2023

***Reviewed By:*** SAG, 3/6/2023

Purpose/Conclusion.*
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#### **Purpose:**PSC Update to Include FCA

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 1 - Utilization Control and Program Integrity - **DSHS**.

To identify the key internal controls and provide a preliminary control risk assessment based upon our



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understanding of the internal controls for Special Test 1 - Utilization Control and Program Integrity - **DSHS**.

### **Source:**

Kristian Rodriguez, ALTSA QA policy program manager

Laura Holloway, ALTSA Audit Liaison

Anthony Blue, DDA Quality Compliance Coordinator Unit Manager

Geoff Nisbet, Audit Liaison and Public Records Unit Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 1 - Utilization Control/Program Integrity Medicaid Service Verification, we assessed preliminary control risk as **low**.

Testing Strategy:

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: The State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services. In addition, the State must have (1) methods of determining criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials (42 CFR parts 455, 456, and

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1002).

Suspected fraud must be referred to the State MFCUs (42 CFR part 455.21). See Special Test #6, MFCU.

The SMA must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for, and the quality and timeliness of, Medicaid services. The SMA may conduct this review directly or may contract with an independent entity (42 CFR sections 456.5, 456.22, and 456.23). The SMA must ensure that each managed care organization with which it contracts is evaluated annually on quality, timeliness, and access to the health care services by an external quality review organization (EQRO). The State must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438, Subpart E).

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

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Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria:

Record of Work Done:

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- During FY22, Provider One paid nearly \$6.2 billion (FY22 ACFR Stratified Summaries - Full Year) in Medicaid medical fee-for-service (HCA) and social service claims (DSHS). Processing funding in that dollar amount is inherently risky.
- Per the Compliance Supplement, this program is considered a "higher risk" program for 2022, pursuant to 2 CFR 200.519.
- The False Claims Act requirements are new to the compliance supplement for the SFY22 audit period, which adds an increased level of risk.

### **Inherent Risk**

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at **HIGH**.

## **Gather Information**

### **Step 2**

#### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Utilization Control and Program Integrity requirements. We identified the following:

Health Care Authority (HCA) is the state's Medicaid agency and responsible for Special Test 1, see HCA Special Test 1 testing at (Special Test 1 - Utilization Control/Program Integrity HCA - Compliance).

We identified relevant guidance for the Utilization Control and Program Integrity requirements at (Overview) in Step 1: Description of audit area.

### **FCA Requirements**

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

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## Medicaid Service Verifications

Laura Holloway, ALTSA Audit Liaison, and Kristian Rodriguez, ALTSA QA Policy Program Manager, provided us with a copy of DDA's and ALTSA's Social Service Electronic Medicaid Service Verification (MSV) process on November 30, 2022, which is located at ([SS MSV Process](#)).

On December 13, 2022, we met with the following DSHS personnel to gain an understanding of internal controls, policies, and procedures surrounding the MSV process:

Laura Holloway, ALTSA Audit Liaison  
Kristian Rodriguez, ALTSA QA Policy Program Manager  
Debbie Johnson, ALTSA Interim Medicaid Unit Manager  
Anthony Blue, DDA Quality Compliance Coordinator Unit Manager  
Geoff Nisbet, DDA Audit Liaison and Public Records Unit Manager  
Teresa Boden, DDA Quality and Compliance Office Chief

The MSV process at ALTSA is managed by Kristian Rodriguez. The MSV process at DDA is managed by Anthony Blue. The MSV process begins at HCA, the state Medicaid Agency. **HCA mails 379 Medicaid Service Verification letters for social services on the 5th of each month (Automated Key Control 1 - Control Activities).** Of the 379 letters, 79 letters are mailed to random DDA clients and 300 letters are mailed to random ALTSA clients (They mail 379 each month to ensure they get a 5% return rate for the year). The verification letter (survey) lists up to four Medicaid services paid for by the State. Completed surveys are returned to HCA and the Authority scans and uploads batches of surveys into ProviderOne (P1). P1 provides access to data on the number of returned surveys, the number of negative responses, and scans of returned surveys under "MSV Responses" in P1.

## ALTSA

According to Kristian, on around the 5th of each month, 300 surveys are mailed out to ALTSA clients by HCA regarding services received during the prior two months. The surveys are voluntary and can be returned at any time. Most are returned within the same month, but some have been received up to 6-7 months later. ALTSA estimates that they generally have a 40% return rate. HCA scans the survey responses into P1, which automatically reads responses and generates a report based on the information received. The report indicates Yes, No, or N/A responses regarding services received. In addition, there are 8 questions on the survey relating to quality/client satisfaction, but these are for mainly for tracking purposes and the team does not follow-up with the client on these responses.

Twice a month, Kristian goes into P1 and reviews social service surveys. If there are No or N/A responses, Kristian sends them to the QA team for initial follow-up. In many cases, the client responds No or N/A due to misunderstanding, but if the client affirms No or N/A in follow-up, the instance is forwarded to the client's local office for further review, where an overpayment and fraud referral is made to the State MFCU, if appropriate. If the QA team is unable to contact the client after 3 attempts, Kristian notifies the Case Manager at the client's local office, who will make additional follow-up attempts, including a welfare check if no response is received after 30 days.

Survey responses, follow-up attempts, and responses from case managers are tracked on a spreadsheet. Statistics derived from this spreadsheet are reported

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annually to CMS.

**Key Control 2 (ALTSA) - The ALTSA QA Policy Manager downloads all MSV *social service* surveys and their responses from ProviderOne each month and adds the information to an excel tracking spreadsheet to track negative responses for follow-up.**

DDA

According to Anthony, the MSV process for DDA is very similar to the ALTSA's except for the following differences:

- DDA estimates that they generally have a 60% return rate for MSVs.
- Anthony goes into P1 and reviews social service surveys daily.
- DDA has a separate tracking spreadsheet from ALTSA in SharePoint, but the information gathered is the same.

**Key Control 2 (DDA) - The DDA QCC Unit Manager downloads all MSV *social service* surveys and their responses from ProviderOne each month and adds the information to a SharePoint tracking spreadsheet to track negative responses for follow-up.**

### False Claims Act

On January 4, 2022, we met with the following ALTSA personnel to discuss the policies, procedures, and controls surrounding the False Claims Act requirements for social service providers:

Jennifer Ullom, Administrative Assistant  
Cheryl Timmons, Program Integrity Manager

Prior to the meeting, we received the procedures that DSHS follows regarding the False Claim Act at ([False Claims Act Requirements](#)) from Jennifer, who received from Cheryl. Per Cheryl, annually between the end of January and the end of February, she runs a report generated by SQL Server Reporting Services (SSRS) SSRS and Aging and Disability Services Administration (ADSA). The report lists social service providers paid at least \$5 million during the previous federal fiscal year. For the SFY22 audit period, the report would cover FFY21 (October 1, 2020 - September 30, 2021). Since the report does not include Area Agency on Aging (AAA) providers, Cheryl requests a similar report for these providers from "fiscal", which is the Management Services Division (MSD), around mid-January. MSD provides the report within 2-4 weeks (**Key Control 3 - Control Activities**).

Generally between March 1 and April 1 annually, providers are sent templated letters requesting certain documentation to be returned, with a due date of 45 days from the send date (**Control Activities**). These letters are sent the same time that HCA sends their letters. However, prior to sending the letters, DSHS provides HCA with the list of providers on their report. If any providers are also on HCA's report, HCA will send the letter and DSHS will defer so as not to send duplicate requests. Providers appearing on the aforementioned report for the first time are sent a letter requesting their policies and procedures including information on the False Claims Act, whistleblower protections, detecting and preventing fraud, waste, and abuse, and any existing employee handbook/policy manual if available. If a provider has sent this information in prior years, the templated letter requests that they send this information only if there have been significant changes to their policies or employee handbook. However, DSHS requests that all providers on the report complete an Attestation of Compliance

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form detailing that they have complied with the requirements listed above.

Cheryl may receive provider responses via mail or email. Once received, she verifies that the policies, handbook, and attestations contain the appropriate information and logs the date it was received on a tracking spreadsheet. If not received by the 45 day deadline, a reminder is sent to the provider to provide the requested information as soon as possible and is logged on the tracking spreadsheet (**Key Control 4 - Control Activities/Monitoring**). When asked if there is a hard deadline to receive this documentation, Cheryl explained that ideally it would be received by the end of the federal fiscal year (September 30), but there is no hard deadline when they would stop payment or disallow services (**Control Weakness**). She added that there has never been a case when they were unable to receive the requested documentation from a provider, however, it has taken up to a year to receive in some cases, but there was constant follow-up with these providers and is not the norm.

On January 18, 2022, met with the following DDA personnel to discuss the policies, procedures, and controls surrounding the False Claims Act requirements for social service providers:

Geoff Nisbet, Audit Liaison and Public Records Unit Manager  
Rick Meyer, External Audit Compliance Manager  
Valerie Kindschy, Waiver Residential Unit Manager  
Megan Kwak, Community Residential Program Manager

Valerie Kindschy informed us that once Cheryl Timmons determines the DDA providers/contractors that reach the \$5 million threshold, she gives DDA the list. From there, the process for reaching out to providers is almost exactly the same as mentioned above for ALTSA. For providers new to the list, letters are sent requesting their policies and procedures as well as their employee handbook, if available. Additionally, an attestation form is sent confirming that the information provided is true and correct. For providers who have sent in this information in prior years, only the attestation that all the information previously submitted is still the same is requested.

Megan Kwak maintains a tracking spreadsheet for DDA, similar to the ALTSA spreadsheet, noting responses received as they come in (**Key Control 4 - Control Activities/Monitoring**). Key Control for DDA? Similar to ALTSA, if responses are not received in 45 days of the initial request, a reminder is sent and they will continue to follow-up until received, but there is no definite date that documentation must be returned and at no point would they stop payments or disallow services for failure to comply (**Control Weakness**). Valerie mentioned that while new providers sometimes struggle to provide the documentation, there has never been a case when they failed to submit it.

### Summary of Key Controls:

#### Key Control 1: Control Activities (Automated) -

HCA mails 379 Medicaid Service Verification letters for *social services* per month, on the 5th of each month.

#### Key Control 2: Control Activities -

ALTSA - The ALTSA QA Policy Manager downloads all MSV *social service* surveys and their responses from ProviderOne each month and adds the

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information to an excel tracking spreadsheet to track negative responses for follow-up.

DDA - The DDA QCC Unit Manager downloads all MSV *social service* surveys and their responses from ProviderOne each month and adds the information to a SharePoint tracking spreadsheet to track negative responses for follow-up.

**Key Control 3: Control Activities** - Annually, a report is generated by the Program Integrity Manager to identify all ALTSA and DDA social service providers that received at least \$5 million during the last FFY. A similar report is generated by the MSD Office Chief to identify all AAA social service providers that received at least \$5 million during the last FFY.

**Key Control 4: Control Activities/Monitoring -**

ALTSA - The Program Integrity Manager reviews documentation from the provider supporting compliance with the False Claims Act and logs the date received in a tracking spreadsheet.

DDA - The Community Residential Program Manager reviews documentation from the provider supporting compliance with the False Claims Act and logs the date received in a tracking spreadsheet.

**Control Weakness:** There is no hard deadline when DSHS would take action to stop payment or discontinue services for a provider for failure to submit required documentation.

**Evaluation of Results:**

We identified the following control deficiency: Control Weakness & Evaluation

1. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. Based on our understanding of the criteria and the condition making up the Control Weakness, we determined the likelihood of noncompliance is **remote** and the magnitude of potential noncompliance is **less than material**.
2. The SMA as required per Section 1902(a)(68) – [42 USC 1396a(a)(68)] False Claims Education must ensure that providers and contractors receiving or making payments of at least \$5 million annually under a state’s Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent state laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent state laws and rules. However, the Department does not have an action plan in place to discontinue services of and payment to a provider that fails to provide the required information. Additionally, the Department has not established a deadline by which the provider must provide the required information before discontinuing services or payment. The Department asserted that while some providers struggle to submit the required information, there has yet to be an instance when one has failed to comply.

**Preliminary Control Risk Assessment**

**Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.



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## I.1.PR.G - ST2 Inpatient Hospital and Long-Term Care Facility Audits

*Procedure Step:* Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - HCA - Internal Controls Identification

*Prepared By:* AMG, 2/16/2023

*Reviewed By:* RJC, 2/16/2023

Purpose/Conclusion.
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - Health Care Authority (HCA).

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - Health Care Authority (HCA).

### **Source:**

Kari Summerour, External Audit and Compliance Manager  
Abigail Cole, Hospital Finance and Rates Manager  
Sarah Cook, Hospital Rates Unit Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 2 - Inpatient Hospital and Long-Term Care

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Facility Audits - HCA, we found the agency does not have adequate internal controls to prevent material noncompliance. Therefore we assess **preliminary control risk as high and will report a finding for a material weakness, see FI\_S1Washington\_SA22\_HCA-M02\_Medicaid\_Special Test 2 - Inpatient Hospital Data Audits**. No internal control testing is necessary in this instance.

Testing Strategy:

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: The SMA pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the State Plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the State Plan (42 CFR section 447.253).

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement

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- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

### Evaluation of Results: Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

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Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance. In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW. However, we did note that a finding was issued in the most recent audit.

### **Gather Information**

#### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - Health Care Authority (HCA) requirements. We identified the following:

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## ***Compliance Supplement***

Compliance Requirements - The SMA pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the state plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the state plan (42 CFR section 447.253).

Audit Objectives - Determine whether the SMA performed inpatient hospital and long-term care facility audits as required and established in the state plan.

### Suggested Audit Procedures

1. Review the state plan and SMA operating procedures and document the types of audits performed (e.g., desk audits, field audits), the methodology for determining when audits are conducted, and the objectives and procedures of the audits.
2. Through examination of documentation, determine if the sampling plan was carried out as planned.
3. Select a sample of audits and ascertain if the audits were in compliance with the SMA's audit procedures.

## ***Medicaid State Plan (Attachment 4.19-A, Part I, page 60 - see WA 21-0029 Approved)***

### 3. Financial Audit Requirements

- Cost report data used for rate setting may be periodically audited.
- Hospital billings and other financial and statistical records will be periodically audited by the agency.

## ***42 CFR section 447.253***

(a) **State assurances.** In order to receive CMS approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to CMS that the requirements set forth in paragraphs (b) through (i) of this section are being met, must submit the related information required by § 447.255 of this subpart, and **must comply with all other requirements of this subpart.**

(g) **Audit requirements.** **The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.**

[WAC 182-550-5410](#)

[WAC 182-550-5700](#)

[I.1 ST2 HCA - Id of IC](#)

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

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On July 7, 2022, we requested that the Authority identify the key controls for Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits and received a response on July 13, 2022 (see [Medicaid Internal Controls - ST 2 - HCA response](#)). Additionally, we asked for a list of inpatient hospitals, see [HCA List of Inpatient Hospitals](#)

On August 10, 2022, we met with the following HCA staff to gain an understanding of the internal controls for Special Test #2:

- Kari Summerour, External Audit and Compliance Manager
- Abigail (Abby) Cole, Hospital Finance and Rates Manager
- Sarah Cook, Hospital Rates Unit Manager

We received the amendment to the Medicaid state plan which was approved by CMS effective October 1, 2021 (see [WA 21-0029 Approved](#)). The Authority began implementing a new process of conducting desk audits in February 2021.

We requested policies and procedures regarding the financial and statistical audits. The Authority stated they are working on updating the operating manual. Additionally, the Authority is working to put all of the new policies and procedures into one location. However, we received the Inpatient Rates Program Manager Manual, see [Inpatient Rates Program Manager Manual FINAL 20220513](#).

Abby started by informing SAO that long term facility rates are not set by HCA and fall under the responsibility of DSHS's Aging and Long-Term Support Administration (AL TSA). She also noted that HCA's Hospital Rate Unit relies on Medicare cost reports provided by inpatient hospitals and added that the cost reports used by HCA are audited independently by Medicare. We asked how the Authority interprets the requirement for periodic audits stated in the State Plan and CFR, they responded "as needed". We followed up with HCA and received the following response from Kari Summerour, External Audit and Compliance Manager, on August 31, 2022:

*"The Division of Program Integrity conducts Inpatient Hospital audits that touches on the financial and billing of the hospitals. It has a more clinical focus, but the way hospitals bill through diagnosis codes, you can't separate the clinical aspect of the review from the financial aspect."*

## Hospital Rates Unit

The process begins when Melissa Craig, Inpatient Program Manager, receives a PDF copy of the hospital cost report. Inpatient hospitals are required to complete and submit cost reports annually within 150 days of their respective fiscal year end to CMS and the Authority. Sarah stated that Melissa is responsible for monitoring deadlines for receipt of hospital cost reports, however, she added there is nothing in the WAC stating they need to track when the reports were submitted and no tracking spreadsheet to ensure the Hospitals have submitted their cost reports. We requested additional information on the tracking of hospital cost reports and received the following response from Kari Summerour, External Audit and Compliance Manager, on August 31, 2022:

*"It is not tracked on a specific sheet, as that would duplicate work. We track it on the same tab we calculate it. If there is no RCC, we did not get the cost report, but the provider is still listed."*

On November 3, 2022, the authority clarified that the tracking spreadsheet is formatted to automatically indicate if the cost report hasn't been received. Additionally, Sarah stated she does not track when the cost reports are received because the spreadsheet automatically does that for staff.

After the cost report is received, the Rates Program Manager (Melissa) renames the file according to HCA's naming convention, records receipt of the report, updates the report information to a SQL server, calculates the new ratio of cost-to-charges (RCC) from the cost report, uploads the report contents into an RCC

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spreadsheet, which is the primary tool used by HCA for rate audits, and then forwards the cost report to the manager for review (**Key Control #1 - Control Activities**). We requested and received a copy of the RCC spreadsheet (see [HCA RCC Rate Audit Tracking Spreadsheet](#)).

Once all of the required information is in the RCC spreadsheet, Sarah explained that she conducts a desk audit and compares the current-year RCC to the prior year to assess whether the change is within tolerance limits (**Key Control #2 - Monitoring and Control Activities**). RCCs are calculated and tracked for every hospital in the state. This review occurs two months after the hospital cost report is received by HCA. For example, for desk audits occurring in June, HCA would have received the cost report in April.

If the RCC has changed by more than 0.1 in the absolute change in ratio or more than 20 percent, then the tolerance limit or threshold is exceeded and the Unit Cost Manager is required to review the cost report to determine the source of the changes and contact the hospital to request clarification and documentation, if necessary, to explain why the rate has changed significantly since the prior cost report. (**Key Control #3 - Control Activities**) Sarah noted that in the last few months of the FY22, no year-to-year changes in RCCs within hospital cost reports have required additional review.

The program manager then follows-up with the hospital if corrective actions or an updated cost report are required. (**Key Control #4 - Control Activities**) In FY22, the Authority issued no corrective action plans or required updated cost reports from inpatient hospitals.

### Division of Program Integrity

We also met with the following staff at Division of Program Integrity (DPI) on September 28, 2022 to gain an understanding of whether the inpatient hospital audits conducted there were applicable to the requirements for Special Test #2:

- Ming Wu, Deputy Assistant Division Director, Program Integrity
- Kathy Cleeves, Supervisor for PI Managed Care Oversight Unit, Program Integrity
- Sojheath Kong, Clinical Review Unit Supervisor, Program Integrity
- Susan Williams, Supervisor of Audit and Investigations, Program Integrity
- Scott Best, Clinical Nurse Specialist
- Kari Summerour, External Audit and Compliance Manager
- Michael Brown, Division Director DPI
- Jessica Stephens, Administrative Assistant 5

DPI reviews inpatient hospital provider claims with a financial and clinical focus on DRG, or diagnosis codes, where improper and overpayments are most likely to occur. They determine specific query criteria they then use to select and review the hospital claims that meet the criteria. DPI stated that they do not utilize inpatient hospital cost reports in their audit process. They only review information specific to the individual claim they identified as possibly improper. If an improper or overpayment is identified, DPI will recalculate the claim amount and seek a refund from the provider. Providers may dispute this determination. DPI will reverse the claim and after refunding the payment, providers may rebill at the corrected amount. All follow-up with billing as a result of the review goes through HCA's Hospital Finance Unit. DPI maintains a distribution list for communicating its review results to the rest of the agency, including the Hospital Rates Unit. In SFY22, DPI reviewed the calendar year 2020 claims and billing of approximately 80 hospitals using the specific claim criteria selected for review for the year. Each fiscal year, DPI repeats this cycle and are currently reviewing calendar year 2021 claims.

HCA does not perform periodic audits of the financial and statistical records of participating providers as required.

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Additionally we reviewed the utilization and hospital "audits" spreadsheet provided by the Authority. The Authority runs high risk tests based off the diagnosis codes and procedure codes for hospitals. These queries are very specific and are not designed to get broad coverage. During SFY22 the Authority conducted a query test on 101 hospitals. Of these tests, 18 hospitals (17.82 percent) had results with no hits. Therefore, the Authority did not conduct any work in this area at 18 percent of inpatient hospitals.

### **Confirming Results:**

On November 2, 2022 we met with the following staff to discuss our results from the audit this far:

#### **HCA:**

Kari Summerour, External Audit and Compliance Manager  
William Sogge, Management Analyst 5, External Audit Liaison  
Michael Brown, Assistant Director, Division of Program Integrity  
Ming Wu, Deputy Division Director, Division of Program Integrity  
Abby Cole, Section Manager, Hospital Financial & Drug Rebate  
Michelle Corral, Hospital Finance Unit Manager  
Sojheath, Kong, Occupational Nursing Consultant Supervisor  
Jessica Stephens, Administrative Assistant 5

#### **SAO:**

Aaliyah Gillett, Assistant State Auditor, Auditor in Charge  
Ronni Copeland, Assistant Audit Manager, Audit Supervisor  
Cavan Busch, Program Manager for Single Audit

During this meeting we explained to the Authority that we did not see a methodology, policies, or procedures in place to determine when and how the audits for financial and statistical records of the inpatient hospitals would be performed. Michael Brown confirmed that they did not have these in place. Additionally, we could not determine the types of audits being performed based on the state plan or meetings with the Authority. The Authority responded that they considered themselves in compliance because they are conducting high risk query "audits" that look at some of the claims records from the inpatient hospitals. They also asked what is considered financial records. We explained that these records could include the financial statements/information used to set the rates, but they should consult the federal government to help guide them. Abby Cole, mentioned that the cost reports they use to set the rates are Medicare cost reports and that they were impossible for the Authority to audit. She also mentioned that these cost reports are audited by third party contractors. However we determined the Authority has no assurance HCA is receiving the same cost report information that CMS is receiving. During the FY20 audit, this information was communicated and we determined the following:

#### ***From FY2020 Medicaid:***

*Because HCA was relying on CMS's reconciliation of the cost reports to meet this requirement, Cavan Busch, Assistant Audit Manager over the Medicaid audit, spoke with the Federal Single Audit contact for Washington State, Tammie Brown, on November 23, 2020 to discuss this issue. Tammie stated that the review of*



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*CMS 2552 reports performed by CMS contractors cannot be relied on by HCA to meet this requirement. She further stated that HCA itself needs to be meeting the state plan requirements of 1) periodically auditing the Cost Report data used for rate setting and 2) periodically auditing the hospital billings and other financial and statistical records.*

### **Summary of Key Controls:**

**Key Control #1:** The Rates Program Manager (Melissa Craig) sends the Ratio of Costs-to-Charges (RCC) report to the Unit Cost Manager (Sarah Cook) for review to ensure the rates have been calculated correctly **(Control Activities)**.

**Key Control #2:** The Unit Cost Manager (Sarah Cook) conducts a desk audit and compares changes in the current-year RCC to the prior year to ensure that any changes are within tolerance limits **(Monitoring and Control Activities)**.

**Key Control #3:** The Unit Cost Manager (Sarah Cook) reviews evidence from inpatient hospital(s) with RCC changes exceeding tolerance limits to determine the cause. If the cause is not supported, the Unit Cost Manager will issue a corrective action plan or request an updated cost report to ensure that rate changes are reasonable and supported. **(Monitoring and Control Activities)**.

**Key Control #4:** For hospitals with corrective action plans or updated cost report requirements, the Rates Program Manager (Melissa Craig) follows-up and monitors the facility to ensure the facility completes all required corrective activities **(Monitoring and Control Activities)**.

**Key Control Weakness #1:** The Authority does not have documented methodology, policies, or procedures to ensure the cost reports are accurate and supported. **(Information and Communication)**

**Key Control Weakness #2:** The Authority does not have documented methodologies, policies, or procedures to ensure the inpatient hospitals financial and statistical records are periodically audited. **(Information and Communication)**

### **Evaluation of Results:**

We identified the following control and compliance deficiency: The Health Care Authority does not perform periodic audits of the financial and statistical records of participating providers as required. In addition, the Authority does not audit the Cost Report data provided to ensure they are correct, accurate, and properly supported. When the Authority performs the desk audits, it does not audit the numbers provided to ensure they are correct/accurate. The numbers are only compared to the prior year's report to determine the percentage changes. There is also no examination of other financial and statistical records of participating hospitals. According to 42 CFR section 447.253(g), the Medicaid agency, must provide for periodic audits of the financial and statistical records of participating providers. The Authority relies on the audits performed by Medicare and CMS which does not satisfy the requirement set forth in the CFR. Additionally, the Authority does not have a documented methodology to determine when the audits will be conducted and which records will be reviewed to determine if the cost reports are accurate and supported. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **more than remote** and the magnitude of potential noncompliance is **material**. We concluded

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that the Authority does not have adequate internal controls in place to prevent material noncompliance for the Special Test #2 requirement. Therefore we assess **preliminary control risk as high and will report a finding for a material weakness**, see FI\_S1Washington\_SA22\_HCA-M02\_Medicaid\_Special Test 2 - Inpatient Hospital Data Audits.I.1 ST2 HCA - Id of IC

### **Preliminary Control Risk Assessment**

#### **Step 4**

HIGH - Internal control design is not likely to be effective to prevent or detect non-compliance with grant requirements. We will report a **material weakness** in accordance with 2 CFR §200.516(1).

### **I.2.PRG - ST2 Inpatient Hospital and Long-Term Care Facility Audits - DSHS**

***Procedure Step:*** Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - DSHS - Internal Controls Identification

***Prepared By:*** AMG, 9/22/2022

***Reviewed By:*** RJC, 1/24/2023

Purpose/Conclusion.

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - DSHS.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - DSHS.

### **Source:**

Jamie Franzen, Cost Reimbursement Analyst 4, MSD

Tiffany Hills, Nursing Facility Rates Manager

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### **Conclusion:**

Based on our understanding of internal controls over Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits -DSHS, we assessed preliminary control risk as low.

Testing Strategy:
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### **Step 1: Assess Inherent Risk (IR)**

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: The SMA pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the State Plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the State Plan (42 CFR section 447.253).

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement

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- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

### Evaluation of Results: Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

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Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria:

Record of Work Done:

### **Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - DSHS - Internal Controls Identification**

#### **Inherent Risk of Noncompliance**

##### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

#### **Gather Information**

##### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special

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Test 2 - Inpatient Hospital and Long-Term Care Facility Audits - DSHS requirements. We identified the following:

## Compliance Supplement

The State Medicaid Agency (SMA) pays for inpatient hospital services and long-term care facility services through the use of rates that are economic and efficient and are in accordance with the state plan. To the extent the state pays reconciled costs, the SMA must provide for the filing of uniform cost reports for each participating provider in order to establish payment rates. The SMA must provide for the periodic audits of financial and statistical records of participating providers. The specific audit requirements will be established by the state plan (42 CFR section 447.253).

## Medicaid State Plan - Attachment 4.19-D, Part 1 (page 249)

### Nursing Facilities and Swing Bed Hospitals Section I. Introduction

This State Plan Amendment (SPA) to Attachment 4.19-D, Part I, describes the overall payment methodology for nursing facility services provided to Medicaid Recipients: (1) by privately-operated nursing facilities, both non-profit and for-profit; (2) by nursing facilities serving veterans of military service operated by the State of Washington Department of Veterans Affairs; and (3) by nursing facilities operated by public hospital districts in the state. Both privately operated and veteran's nursing facilities share the same methodology. Facilities operated by public hospital districts share the methodology described below also, except for proportionate share payments described in Section XVII below, which apply only to them.

The payment rate methodology for nursing facilities operated by the State's Division of Developmental Disabilities, which is described in Attachment 4.19-D, Part II.

Chapter 388-96 of the Washington Administrative Code (WAC) chapter 74.46, chapter 34.05, and chapter 70.38 of the Revised Code of Washington (RCW), and any other state or federal laws or regulations, codified or uncoded, as they exist as of July 1, 2017, as may be applicable, are incorporated by reference in Attachment 4.19-D, Part I, as if fully set forth.

The methods and standards used to set payment rates are specified in Part I in a comprehensive manner only. For a more detailed account of the methodology for setting nursing facility payment rates for the three indicated classes of facilities, consult chapter 388-96 WAC and 74.46 RCW.

The methods and standards employed by the State to set rates comply with 42 CFR 447, Subpart C, as superseded by federal legislative changes in the Balanced Budget Act of 1997.

## RCW 74.46.022

The department shall establish, by rule, the procedures, principles, and conditions for the nursing facility Medicaid payment system addressed by the following principles:

- (1) The department must receive complete, annual reporting of all costs and the financial condition of each contractor, prepared and presented in a standardized manner. The department shall establish, by rule, due dates, requirements for cost report completion, actions required for improperly completed

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or late cost reports, fines for any statutory or regulatory noncompliance, retention requirements, and public disclosure requirements.

(2) The department shall examine all cost reports to determine whether the information is correct, complete, and reported in compliance with this chapter, department rules and instructions, and generally accepted accounting principles.

(3) Each contractor must establish and maintain, as a service to the resident, a bookkeeping system incorporated into the business records for all resident funds entrusted to the contractor and received by the contractor for the resident. The department shall adopt rules to ensure that resident personal funds handled by the contractor are maintained by each contractor in a manner that is, at a minimum, consistent with federal requirements.

(4) The department shall have the authority to audit resident trust funds and receivables, at its discretion.

(5) Contractors shall provide the department access to the nursing facility, all financial and statistical records, and all working papers that are in support of the cost report, receivables, and resident trust funds.

(6) The department shall establish a settlement process in order to reconcile Medicaid resident days to billed days and Medicaid payments for the preceding calendar year. The settlement process shall ensure that any savings in the direct care or therapy care component rates be shifted only between direct care and therapy care component rates, and shall not be shifted into any other rate components.

(7) The department shall define and identify allowable and unallowable costs.

(8) A contractor shall bill the department for care provided to Medicaid recipients, and the department shall pay a contractor for service rendered under the facility contract and appropriately billed. Billing and payment procedures shall be specified by rule.

(9) The department shall establish the conditions for participation in the nursing facility Medicaid payment system.

(10) The department shall establish procedures and a rate setting methodology for a change of ownership.

(11) The department shall establish, consistent with federal requirements for nursing facilities participating in the Medicaid program, an appeals or exception procedure that allows individual nursing home providers an opportunity to receive prompt administrative review of payment rates with respect to such issues as the department deems appropriate.

(12) The department shall have authority to adopt, amend, and rescind such administrative rules and definitions as it deems necessary to carry out the policies and purposes of this chapter.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step. As part of our preliminary planning work performed at [Overview](#), we requested, received, reviewed, and documented all of the Department's written policies and procedures related to the compliance area. On July 28, 2022, we met with the following Cost Reimbursement and Rates Setting Unit Staff via Teams to gain an understanding of internal controls at the Department that ensured they are compliant with Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits:

- Jamie Franzen, Nursing Facility Cost Report Lead
- Tiffany Hills, Nursing Facility Rates Manager

Each facility must submit to the Office of Rates Management (ORM) an annual cost report by March 31st of each year for the 12-month calendar year (January - December) of the preceding year. The cost report data is utilized to implement rates in future periods for cost settlement. Facilities normally hire consultants to complete the cost report on their behalf. The new payment rates have to be announced by July 1, which allows for a three-month window to complete all cost

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report reviews.

The Lead worker is primarily responsible for tracking the progress of the reviews on a spreadsheet to ensure that all cost report reviews are completed before the deadline and up to a 15 day grace period. If the nursing facility cannot provide the cost report by the due date, the Department (Tiffany is the only one with this authority) may grant two extensions of up to thirty days each if the provider's request letter clearly indicates that circumstances were not foreseeable and were unavoidable by advance planning. We asked if any blanket waivers or extensions had been granted due to the effects of public health emergency and we were told that there were none and that all providers were expected to meet the annual filing date. If the provider does not meet the due date, civil fines and penalties will be assessed at \$100 per facility, per day. To ensure that all Cost Report Submissions are all timely submitted, extensions are granted, or fees are assessed, the Nursing Facility Rates Manager will hold weekly meetings during the review process to identify issues such as missing cost reports and cost report issues (**Key Control 1 - Control Activities**). By having these meetings weekly, the Team is able to ensure that all cost reports are being worked and will be completed by the deadline. Additionally these meetings are used to discuss issues with a cost report that may be on other cost reports, since consultants will normally complete multiple facilities' cost reports.

All final cost reports must be certified, signed by authorized signers, and notarized. The certification page is now received electronically in PDF format along with the cost report. All nursing facilities' cost reports are prepared in a standardized manner and form which was developed by the ORM. There is also a manual for Facilities and Consultants to use to aid in completing the cost report called the Nursing Facility Cost Report Instruction Manual (see: 2021 Cost Report Manual for Facilities). This informs the Facility or Consultant of items that need to be submitted with the cost report, how to complete the schedules, and informs them of the extensions and fines for late submissions.

There are six Cost Reimbursement Analysts who are responsible for reviewing the cost reports. Files are all securely sent by the facilities or consultant to the Cost Reimbursement Team with password protections. They are then downloaded onto a shared folder. Analysts ensure that each submitted file includes the notarized certification page. After the initial screening, the analysts import the cost reports into the Nursing Facility Information System (NFIS) from the electronic files that are submitted by the facilities or consultants. Since there may be up to 30 files received, these are rolled up into one PDF file and uploaded into NFIS in preparation for the cost report examinations. Math edits are setup and run to safeguard against any missing or inaccurately submitted data. For corrections of major math errors, cost reports are returned to the providers. The Math Edit task will be complete after all the error message "flags" are resolved.

Once the math edits validate the files, the analysts are assigned a set of cost reports for examination, which are also listed in the master tracking spreadsheet maintained by Jamie (Tiffany also has access to this). The analysts examine the cost reports based on a set of standard procedures. There is a Nursing Home Rates Cost Report Exam Guide developed by the Department to address the critical segments of reported costs (see: Cost Report Desk Manual - Examination Guide). The exam planning involves developing an overall strategy for the conduct and scope of the exam. The nature, extent, and timing of planning vary with the size and complexity of the entity, experience with the entity, and knowledge of the entity's business. The Department developed procedure guidance and a detailed instruction manual along with standardized forms to ensure all nursing facility cost forms are completed according to established standards and procedures and also developed procedural guidance and a detailed instruction manual along with the standardized examination tool (Reason Code Work Paper) to ensure staff are reviewing the nursing facility cost reports in accordance with standards and procedures (**Key Control 2 - Information and Communication**). The Analysts review all pages of the cost report in accordance with the exam guide to ensure all pieces and support are included and accurate. If anything is not available or was excluded, the Analyst will work with the facility to get additional documentation or clarification. Cost Reimbursement Analysts will sign off on each reason code after review to document that they have completed the initial review in accordance with standards and procedures (**Key Control 3 - Control**



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## Activities).

The Cost Report Exam Guide provides detailed instructions to analysts when they examine different reason codes by stating the purpose, theory and what to look for in the cost reports. If incomplete or incorrect information is found, the analysts will make adjustments to the reported information. All examination procedures and explanations for adjustments are documented. All adjustments are provided to the facility, including dollar amount and explanations for the adjustments. Based on the adjusted cost on the cost reports, the facility's Medicaid rates are established and also settlement amounts are determined. The Department utilizes 18 Reason Codes for their examinations of the cost report schedules, as follows (the first four are required to be completed by all facilities and should be completed first by the analyst).

- Reason Code 37 - Census Reconciliation
- Reason Code 18 - Allowable Reconciliation
- Reason Code 19 - Square Footage
- Reason Code 20 - Facility Building Age Calculation
- Reason Code 12 - Undocumented or Unallowable Costs
- Reason Code 8 - Administrator in Training (AIT)
- Reason Code 21
  - Part A - Expanded Community Service (ECS) and Community Home Projects (CHP)
  - Part B - Vent/Trach Payments
- Reason Code 22 - Number of Licensed Beds
- Reason Code 36 - Labor and Industries Rebate
- Reason Code 39 - Allowable Bad Debt
- Reason Code 55 - Purchased Services
- Reason Code 4 - Schedule G2 HO and Schedule G2
- Reason Code 28 - Average Cost for Private Pay
- Reason Code 6 - Hold Room Revenue
- Reason Code 11 - Adjustment for Allowable Therapies Expense
- Reason Code 97 - Comparison of Year to Year per Patient Day
- Reason Code 99 - Reclassify Entries
- Reason Code 92 - Safety Net Assessment Exemption for Continuing Care Retirement Community (CCRC-Like)

Each Analyst will have a caseload of exams to review which they individually track and document the updates on their own personal tracking sheet. These changes automatically update the master tracker sheet with up-to-date current progress. The Nursing Facility Rates Manager uses this to track and ensure that each cost report was submitted in its entirety and includes all schedules, that each reason code was examined and that each cost report examination received a review by another analyst. To ensure that all Nursing Facility Cost Reports are properly prepared and contain only allowable items, another Cost Report Analyst that did not perform the initial examination will perform a secondary peer review and sign off on each reason code (**Key Control 4 - Control Activities**). The peer reviewer checks for accuracy, will point out any necessary corrections, and will assure all pieces are available. If an error is identified, the reviewer will notify the original analyst to make the corrections. They will also include notes and the associated WAC if an adjustment is need. When each reason code is

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completed, it is initialed and dated in the upper portion of the reason code, and if it is not applicable, it is also notated. Analysts will verify all adjustments that have an "R" for "written adjustment" and saves to SQL.

The written adjustments are utilized during the final settlement process to determine nursing facility daily rates for payments. The final settlement process compares the actual expenditures to the rate set for each year in July. Prior to the new rate implementation, the facility will receive a letter notifying them of their upcoming rate change. We were informed that this settlement process takes place at least two years after the rate year is closed. The reason is to ensure that all appeals are closed and a final number can be agreed upon. The final settlement process will take into account any adjustments that were made during the exam process.

We inquired if there were any notable changes to the cost report, exam guide, or review process since the prior audit period, especially in consideration to changes in response to the COVID-19 pandemic. Tiffany stated that there were no substantial changes and that the process had not been altered. She did mention that any COVID money on schedule F would be moved to schedule R. Schedule R is new and will require 2020 Covid-19 funding to be reported by funding type. Additional schedule O no longer includes the stabilizer gain/loss and roll forward rates, the Covid add-ons have been included.

### **Summary of Key Internal Controls**

- **Key Control 1 - Control Activities:** To ensure that all Cost Report Submissions are submitted timely, extensions are granted, or fees are assessed, the Nursing Facility Rates Manager will hold weekly meetings to identify issues such as missing cost reports and cost report issues.
- **Key Control 2 - Information and Communication:** The Department developed procedure guidance and a detailed instruction manual along with standardized forms to ensure all nursing facility cost forms are completed according to established standards and procedures and also developed procedural guidance and a detailed instruction manual along with the standardized examination tool (Reason Code Work Paper) to ensure staff are reviewing the nursing facility cost reports in accordance with standards and procedures.
- **Key Control 3 - Control Activities:** Cost Reimbursement Analysts will sign off on each reason code after review to document that they have completed the initial review in accordance with standards and procedures.
- **Key Control 4 - Control Activities:** To ensure that all Nursing Facility Cost Reports are properly prepared and contain only allowable items, another Cost Report Analyst that did not perform the initial examination will perform a secondary peer review and sign off on each reason code.

### **Evaluation of Results:**

We did not any control deficiencies over Special Test 2 - Inpatient Hospital and Long-Term Care Facility Audits at the Department of Social and Health Services.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

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## J.1.PRQ - ST3 ADP Risk Analysis and System Security Review

**Procedure Step:** Special Test 3 - ADP Risk Analysis and System Security Review - Identification of Key Internal Controls  
**Prepared By:** AFH, 10/20/2022  
**Reviewed By:** KJW, 10/25/2022

Purpose/Conclusion.

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 3 - ADP Risk Analysis and System Security Review.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 3 - ADP Risk Analysis and System Security Review.

**Source:**

Cindy Raves, Internal Auditor and Kari Summerour, HCA External Audit Liaison

**Conclusion:**

Based on our understanding of internal controls over Special Test 3 - ADP Risk Analysis and System Security Review, we assessed preliminary control risk as low.

As noted below in the ROWD Step 3, we did not find any significant issues

Testing Strategy.

## **Step 1: Assess Inherent Risk (IR)**

### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

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### Step 2: Gather Information

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure the SMA has performed the required ADP risk analyses and system security reviews.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than**

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**material/material>.**

**2. Document the rationale for a LOW or HIGH risk assessment.]**

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.ʹ

Record of Work Done.ʹ

**This record contains information considered confidential under RCW 42.56.420 of the Public Records Act. As such, distribution of this record is limited.**

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

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In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance as LOW.

## **Gather Information**

### **Step 2 - Review scope of work**

We reviewed the 2022 Compliance Supplement regarding Special Test 3 for scoping:

### **"ADP Risk Analysis and System Security Review**

**Compliance Requirements** SMAs must establish and maintain a program for conducting periodic risk analyses to ensure that appropriate and cost effective safeguards are incorporated into new and existing systems. SMAs must perform risk analyses whenever significant system changes occur. SMAs shall review the ADP system security installations involved in the administration of HHS programs on a biennial basis. At a minimum, the reviews shall include an evaluation of physical and data security operating procedures, and personnel practices. The SMA shall maintain reports on its biennial ADP system security reviews, together with pertinent supporting documentation, for HHS onsite reviews (45 CFR 95.621).

**Audit Objectives** Determine whether the SMA has performed the required ADP risk analyses and system security reviews.

#### **Suggested Audit Procedures:**

- a. Review the SMA's policies and procedures, and document the frequency, timing, and scope of ADP security reviews. This should include any Service Organization Control (SOC) 1 type 2 reviews following statement on Standards for Attestation Engagements (AT) Section 801, Reporting on Controls at a Service Organization that may have been performed on outside processors (service organizations).
- b. Evaluate the appropriateness and extent of reliance on such reviews based on the qualifications of the personnel performing the risk analyses and security reviews and their organizational independence from the ADP systems.
- c. Review the work performed during the most recent risk analysis and security review to determine if findings were identified and what actions the SMA took to address the findings."

## **Understanding of Internal Controls**

### **Step 3 - Gain and Document an Understanding of Internal Controls**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

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### **ADP Security Review and Risk Assessment**

The ProviderOne system is the State of Washington's Medicaid Management Information System and is managed by both the Health Care Authority (HCA) and the vendor, CNSI. As required by the Washington State Office of the Chief Information Officer (Standard No. 141.10), all state agencies must perform IT Risk Assessments on systems processing Category 3 (confidential) data or higher once every three years. **HCA completes a risk assessment annually in order to meet HIPAA requirements (Control #1 - Risk Assessment).**

This risk assessment requirement applies to ProviderOne since it contains a significant amount of HIPAA data. HCA also identifies risks that arise during the normal course of business. These risks are discussed with CNSI during ongoing meetings between the two entities to determine what changes need to be made to the system. Larger system changes are also discussed during these meetings. All of the processes, roles and responsibilities, and expectations for these interactions are documented in the [ProviderOne Operations Guide](#) for the State of Washington ProviderOne Project Operations and Maintenance. **The Operations Guide along with policies regarding ongoing risk assessments constitute HCA's "program" for conducting periodic risk analyses to ensure appropriate, cost effective safeguards are incorporated into ProviderOne (Control #2 - Risk Analyses Program).**

As far as ADP system security reviews, **HCA has language in its contract with CNSI requiring the contractor to undergo a biennial Statement on Standards for Attestation Engagement (SSAE) No. 16 Type II audit (Control #3 - Monitoring).** This type of audit produces a SOC report and describes a service organization's system and the suitability of the design and operating effectiveness of controls. The first of these audits was completed during the first quarter of calendar year 2014.

HCA also has a security review performed every three years as required by the OCIO. These reviews look at the entire agencies IT security controls, not just a particular system. The IT Systems division within SAO recently completed this engagement in September 2022.

On 09/14/2022 we asked Cindy Raves, HCA Internal Auditor, if there were any other external ProviderOne performed within the last two years for ProviderOne. She replied there were none completed during that timeframe.

### **Evaluation of Results:**

In regards to the audits and reviews, we did not find any significant issues. SAO found through their testing that overall the HCA IT Security Program addressed the OCIO requirements; however, many of the policies are in a backlog for formal approval at this time.

### **Preliminary Control Risk Assessment**

#### **Step 4 - Evaluation of Results:**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements.

### **K.2.PR.G - ST4 Provider Eligibility (Screening and Enrollment) - HCA**

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**Procedure Step:** Special Test 4 - Provider Eligibility (Screening and Enrollment) - Identification of Key Internal Controls  
**Prepared By:** BAB, 10/12/2022  
**Reviewed By:** RJC, 10/17/2022

## Purpose/Conclusion.

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 4 - Provider Eligibility (Screening and Enrollment).

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 4 - Provider Eligibility (Screening and Enrollment).

### **Source:**

George Wagner – Section Manager, Provider Enrollment  
Cindy Raves – Internal Audit Liaison  
Kari Summerour – External Audit and Compliance Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 4 - Provider Eligibility, we found the agency does not have adequate internal controls to prevent material noncompliance. Therefore we assess preliminary control risk as high and will report a finding for a material weakness at FI\_S1Washington\_SA22\_HCA-M03\_Medicaid/CHIP\_Special Test 4\_Provider Eligibility. No internal control testing is necessary in this instance.

## Testing Strategy.

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify,



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determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: In order to receive Medicaid payments, providers must: (1) be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and Section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)); (2) screened and enrolled in accordance with 42 CFR part 455, subpart E (sections 455.400 through 455.470); and make certain disclosures to the State (42 CFR part 455, subpart B, sections 455.100 through 455.107). Medicaid managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR part 438, subpart H.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness*

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*likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and***

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***coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria:

Record of Work Done:

## **Special Test 4 - HCA Provider Eligibility - Identification of Key Internal Controls**

### **Inherent Risk of Noncompliance**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the provider eligibility compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The Compliance requirement is new to the agency and the requirement has changed recently
- The Authority utilizes a system that has been recently implemented to meet the requirements over this area

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

Additionally, we noted that in prior audits, the Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure federal provider eligibility requirements for the CHIP and Medicaid programs were met, including the revalidation of certain providers every five years and the screening and fingerprint-based criminal background checks.

Unresolved findings for this special test can be located at [\[Overview\]](#). All unresolved findings will be follow up on at [\[Finding Follow-up\]](#).

### **Gather Information**

#### **Step 2**

##### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program

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guidelines to determine Provider Eligibility requirements. Per review of both the compliance supplements for the CHIP and Medicaid programs, we identified the following:

In order to receive Medicaid or CHIP payments, providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and Section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)) or CHIP program (42 CFR 457.900); (2) screened and enrolled in accordance with 42 CFR part 455, Subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (Medicaid: 42 CFR part 455, subpart B, sections 455.100 through 455.106) (CHIP: 42 CFR 457.900(a), cross referencing 455.107). Medicaid and CHIP managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid and CHIP fee-for-service providers in accordance with 42 CFR Part 438, Subpart H.

Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the Medicaid and CHIP programs (42 CFR 457.990, 42 CFR 455 Subpart E). Lists may be found at [https://oig.hhs.gov/exclusions/?utm\\_source=oigNewsletter&utm\\_medium=oig-nl-nav&utm\\_campaign=leie-nl](https://oig.hhs.gov/exclusions/?utm_source=oigNewsletter&utm_medium=oig-nl-nav&utm_campaign=leie-nl).

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step. On September 7, 2022, Stephanie Garza, Kelvin Fitzgerald, Elijah Stidham, and Benjamin Bostrom met with the following HCA staff to discuss provider eligibility and provider revalidation:

- George Wagner – Section Manager, Provider Enrollment
- Cindy Raves – Internal Audit Liaison
- Kari Summerour – External Audit and Compliance Manager

George mentioned that although HCA's corrective actions for the prior year findings are in progress, they are not yet complete. He also mentioned that in November 2021, they received the results of their Payment Error Rate Measurement (PERM) audit, which he stated found very similarly reported issues as the SAO had, such as ineligibly enrolled providers and revalidations being done untimely. He added it also included control deficiencies regarding staff errors made when conducting provider eligibility functions, which directly contribute to eligibility decisions made **(Risk)**.

The Provider Enrollment (PE) Unit is responsible for ensuring compliance with provider eligibility, including initial enrollments, reenrollments, and revalidations. The PE Unit has 32 staff (an increase of 11 staff from the previous audit period) **(Risk)**, consisting of line staff, leads, program heads,

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supervisor, and George. George confirmed that both CHIP and Medicaid providers utilize the same processes with no differentiation. The process is conducted just once and if a provider is determined eligible, they are approved to provide services for both Medicaid and CHIP clients alike. He also explained that revalidations are very similar to enrollments. The same requirements listed in the enrollment manuals will apply to revalidations with the only exception being that the Authority chooses to not collect application fees for revalidations.

George then began by providing us background information into the different types of providers that apply for eligibility. There are three different types of providers that get evaluated for provider eligibility: billing providers, service providers, and non-billing providers.

- Billing Providers - These are also known as furnishing providers and they are for licensed health care professionals enrolling with HCA as either a solo practice or licensed health care-groups and facilities. There are approximately 15,000 billing providers in ProviderOne.
- Service provider - These are for licensed health care professionals who are performing provider practicing under a group or facility. These providers are typically employees of a billing provider that already has an established core provider agreement (CPA). These providers are small and have just enough information to identify an individual (SSN, name, licensure). There are approximately 120,000 service providers in ProviderOne.
- Non-billing providers - This type of provider was set up upon request by those who wanted to participate as a managed care entity or Behavioral Health Organization (BHO) and be included in ProviderOne (P1), but not part of fee-for-service (FFS). Non-billing providers have a similar agreement to the CPA that allows them to enroll under the non-billing agreement. There are approximately 3,000 to 4,000 non-billing providers in ProviderOne.

At initial enrollment, providers sign up through HCA's website and ProviderOne (P1) portal. George stated they currently receive, on average, about 1,500 applications a month for providers of the CHIP and Medicaid programs, while their previous year average was between 800 and 1,000 new applications a month (**Risk**). HCA provides different sets of instructions via their website and offers different manuals depending on the provider type. The required documents that the provider must submit vary based on their provider type. Billing providers require documentation in the form of a W9, a debarment form, and a Core Provider Agreement (CPA). Service providers do not need these same forms but use Automated Provider Screening (APS) in a similar manner, having different application fields screened. These checked fields include licensure, sanctions, and an identity check for a high degree of confidence in accuracy. Staff then screen additional fields, disclosure information, and verifies that all listed names of the service providers are also in good standing. All providers must have screening processes conducted as a part of initial enrollment or revalidation. Screening is used to determine whether a provider is eligible to participate under the Medicaid and CHIP state plans. Servicing providers are screened as individuals and both billing and nonbilling providers are screened as an organization. Additionally, Managed Care Organizations (MCOs) are required by contract and 42 CFR 438.608(b) to screen their providers according to federal and state rules.

When a new provider determines that they want to enroll in ProviderOne, they begin by completing an application form. An application wizard will

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walk providers through the application process and inform them of what fields are mandatory and which fields are optional. Once the application is filled out, it gets automatically sent to George's team for review. His team reviews the application for completeness and begins screening the provider for good standing and risk. Occasionally, a provider application will be submitted as a hard-copy and not electronically. George informed us that these applications are still accepted. Once hard-copy applications are received, one person from George's team will enter the information provided into ProviderOne. Once entered, a second staff member will do the review of the application, and there will always be two different individuals doing application review for provider eligibility.

The Health Care Authority charges an application fee for new providers. This fee is set yearly by the Center for Medicare and Medicaid Services (CMS) and is around the ballpark of \$500-\$600. The application fee does not apply to servicing only providers, sole proprietorships, or groups comprised of sole proprietors. Also, if the provider is enrolled in Medicare, then they don't collect an application fee, as this has already been paid during that process. For those providers who are required to pay an application fee, the application will not be processed or advanced until the fee is collected by the finance section. It is the current practice that application fees are not collected at revalidation, however George brought to our attention that this directly contradicts the guidance within the MPEC (see page 66-78 at [MPEC](#)) (**Control Weakness**). Per review of the 1135 waiver (see highlighted sections at [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#) and approval letter at [WA 1135 Flexibilities Approval Letter final signed](#)), we noted that due to COVID-19, the collection of application fees was not required for those received after March 25, 2020. However, beginning October 1, 2020, the collection of application fees was reinstated. The decision to override the waiver on these areas was communicated via Directive from the Authority's executive management team.

The first step in enrolling or revalidating a provider is to determine the provider's screening risk level. A provider can be designated as one of three risk levels: limited, moderate, or high. All providers are screened, at minimum, at the lowest risk level and if a provider is designated as moderate or high risk, additional screening measures are required. Each risk level requires progressively greater scrutiny of the provider before it can be enrolled or revalidated. These risk-screening activities are uniformly held across all of the different provider types that providers can enroll under for eligibility. The following are the required screening procedures for each of the risk levels:

### Limited risk:

- Verify that the provider meets applicable federal regulations or state requirements for provider type before making an enrollment or revalidation determination.
- Conduct license verifications, including for licenses in states other than where the provider is enrolling
- Conduct database checks to ensure providers continue to meet the enrollment criteria for their provider type

### Moderate risk:

- Perform the limited risk screening requirements
- Conduct pre-enrollment and post-enrollment site visits

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### High risk:

- Perform the moderate risk screening requirements
- Conduct a fingerprint-based criminal background check

HCA does not yet have an established process in place to conduct fingerprint checks of applicable high-risk providers (**Control Weakness**). HCA has designated a Program/Project Manager to lead this work and is currently working on implementation and anticipates completion by December 31, 2022. There is currently a waiver in place (effective March 1, 2020 through the end of the emergency declaration) for the fingerprinting requirement (see: [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#) and [WA 1135 Flexibilities Approval Letter final signed](#)), although he has reason to believe that the waiver will end in January 2023. Since no fingerprinting is currently being done, there is no difference between moderate and high risk. They are currently looking for a vendor to conduct fingerprinting background checks for enrollments and re-enrollments. George mentioned that there are a small volume of newly enrolling providers who are required to be fingerprinted since the vast majority of these are enrolled with Medicare and CMS allows States to rely on their provider screening results.

George confirmed they perform site visits for only moderate and high-risk providers. However, he explained that most providers were enrolled with Medicare, and as Medicare enrollment of providers require an on-site visit, the Provider Enrollment team utilizes the results of the Medicare visits through review of the Medicare system, Provider Enrollment, Chain, and Ownership System (PECOS). Due to this, George's team only visits the moderate and high-risk providers that are not also Medicare enrollees. George further explained that the majority of the moderate and high-risk category was related to durable medical good providers, and they are required to be enrolled in Medicare. All other risk monitoring requirements have been reinstated as of October 1, 2020, including on-site visits. The decision to override the waiver on these areas was communicated via Directive from the Authority's executive management team. Notices to reinstate the applicable efforts during enrollments or revalidations made after October 1, 2020 were sent out during this same time.

According to federal regulation, a provider's categorical risk level must be adjusted from limited or moderate to high when any of the following situations occur:

- A payment suspension is imposed on a provider based on credible allegation of fraud, waste, or abuse. The provider's risk level remains high for ten years after the date of the payment suspension was issued.
- A provider is found to have an existing state Medicaid plan overpayment at enrollment or revalidation, if it:
  - is more than 30 days old
  - has not been repaid at the time the application was filed
  - is not currently being appealed
  - is not part of an approved extended repayment schedule for the entire outstanding overpayment
- The provider has been excluded by the Office of Inspector General (OIG) or another state's Medicaid program in the previous ten years.

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- A Medicaid agency or CMS had lifted a temporary moratorium for the particular provider type in the previous six months.
- The provider is included on the Do Not Enroll List (DEX Edits)

To identify potentially high risk providers, program enrollment staff utilize specialists throughout the Authority to identify providers fitting any of the criteria listed above. For payment suspension, Sally Riley, Medical Assistance Program Specialist, from the Fraud Investigation Unit will send a list of providers with a payment suspension based on credible allegation of fraud, waste or abuse. For overpayments, Daniel Hughes, Operations Research Specialist, from Program Integrity will send a list of providers with overpayments of \$1,500 or greater that was identified by an algorithm. For Moratoriums, Medical Program Specialist, Pooji Tran and Kristina Hawley, from the Quality Management Team (QMT) will send a list of providers when temporary prohibitions are made and lifted by the state Medicaid agency or CMS. For payment suspension, overpayment and moratoriums, the list includes the provider information and the start-date in which the payment suspension, overpayment, or moratorium went into effect. The Provider Enrollment staff do the final review of the lists above to ensure that providers selected for the High Risk Category meet the right criteria before they change the provider's risk in the ProviderOne domain (**KC #1 - Monitoring**). Provider Enrollment staff will log the risk entry into the QMT log for the LEIE/OIG Exclusion and DEX (aka Do Not Enroll) providers. The PE staff will then also log the provider into the High Risk Providers' Queue on the SharePoint site for the next steps within the screening process for high-risk providers. Providers that are not included in the three mentioned lists above are processed as limited risk by HCA. K.2 - ST4 HCA - Id of IC

Once the risk level is properly assessed, the appropriate screening steps can then be performed. Prior to November 2018, the screening process mainly consisted of manual searches of state and national databases to verify the existence, qualifications, and licensing of a provider. George informed us that HCA partially implemented an Automated Provider Screening (APS) process to conduct all the necessary data matches in ProviderOne in November 2018. After the full implementation of the Automated Provider Screening, manual work consists only of reviewing those providers that do not pass the automated screening, which is more efficient than one-at-a-time manual review. This new solution integrates between the LexisNexis, the Provider Credentialing Service (PCS), and ProviderOne into HCA's APS solution. The Provider Screening Solution provides the ability for the provider enrollment unit to screen enrollment information and store screening results for the user to review. The screening results are stored in PCS and will be available for state staff to review and make appropriate decisions regarding whether to approve, deny or investigate further on the enrollment/modification applications. The APS system is used for both initial eligibility and revalidations, as well as ongoing screenings. These automated checks cover required checks for licensing, criminal background checks, and federal databases. If the APS has issues with a verification item, the provider information is logged and Provider Enrollment staff manually check the verifications. George provided a letter from their vendor, Client Network Service, Inc. (CNSI), which outlines the origination of various federal database information obtained directly by LexisNexis during the automated screening processes of APS (see: 4.15.2018 LN PIS Data Sources CNSI WA). We noted the following federal databases are checked at regular intervals, as well as at enrollment and revalidation:

- Death Master file is obtained weekly from the Social Security Administration
- List of Excluded Individuals and Entities is acquired monthly from the U.S. Department of Health and Human Services, Office of the Inspector General



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- Excluded Parties List System is obtained from the System for Awards Management website monthly
- National Plan and Provider Enumeration System (NPPES) data is updated weekly from NPPES

Previously, there was no direct integration between the ProviderOne APS system and the various MCO credentialing systems. MCO's were required under contract to ensure their provider networks are credentialed and ensure they are enrolled with HCA. George mentioned that there was a big push to get these MCO network providers enrolled within the P1 system by June 30th, 2022, which was the reason they experienced a drastic increase in new applications received in SFY22 (**Risk**). Those MCO network providers enrolled with HCA are now screened under the APS.

For the screening for licensure, there is an interface in place between Department of Health (DOH) and HCA which automatically updates ProviderOne provider licensure information in ProviderOne on a daily basis. Typically, when the federal database check determines a provider has an expired license, the ProviderOne system automatically terminates providers by deactivating the taxonomy, which will cause claims to deny for as long as the license is not active. However, because of the blanket 1135 waivers the Authority received (see: COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers and WA 1135 Flexibilities Approval Letter final signed), this function was shutoff to avoid excessive burden on healthcare professionals assisting with patients and to avoid roadblocks to providing necessary services. This has not yet been turned back on, but George did clarify that while this licensure verification automation has been turned off, HCA staff have continued to manually check licensure at enrollment, revalidation, and related updates in accordance with the licensure requirements under 42 CFR 455.412. Also, the interface between DOH and HCA which automatically updates P1 with licensure information from DOH has continued to be active.

However, due to the automatic function being turned off, HCA may not know for some time if a provider's license expired, so it is possible to find some active providers with an expired license (**Control Weakness**). George informed us that if there was an issue that caused a provider to lose their license, DOH quality management would know very quickly and action would be taken to deactivate the provider. We did not contact DOH to confirm this information since we already consider this issue a control weakness. K.2 - ST4 HCA - Id of IC Upon review of the waiver documents, we further inquired on the allowability of forgoing the continuous licensure checks. George stated that he agrees with the SAO, the blanket 1135 waiver specifically refers to out of state providers, and the State DOH waiver was for a limited time span in 2020. The WA 1135 licensure requirement waiver under #4 was applicable in April 2020, and is not specific to out of state, but after more than a year he agreed that the provisional requirement for any providers enrolled under this waiver would no longer apply (**Control Weakness**). He stated that they don't want to turn the licensure validation automation back on only to find that the interface isn't working with providers receiving denied claims, but it is something HCA is working on. Over the past year, 14 additional staff have been hired and they are currently trying to get everyone trained before implementing changes (**Risk**).

1.

Once applications are reviewed and considered in good standing, they will be approved. Only after this approval does the provider go live within ProviderOne. This happens automatically and a welcome letter is given to the provider. A second letter is also sent to the provider with information

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needed to access the ProviderOne portal. The effective date is marked as the approval date and claims submitted after that date can begin being submitted into ProviderOne immediately. This overall enrollment process takes approximately 45 to 60 days with a posted goal of 30 day approval on the HCA website. George explained that it is common for HCA to back date enrollments when requested by providers to allow for the processing of claims, limit gaps of service, and meet business needs, as described in WAC 182-502-0005(6). CMS allows backdating, and discusses the practice on pages 66-67 of the MPEC (see: [MPEC](#)). Additionally, the Chief Medical Office has issued authorization to extend past the 365 day limit in order to meet critical agency needs as referenced in the process request provided by George at [FW Draft of new effective date process for the MCO network enrollment project](#). CMS focus is ensuring payments are not made to providers prior to the date of screening. Provider Enrollment has been asked by agency management to waive the requirement for "Effective Date Change Request" forms when the provider identifies a desired effective date on their application, therefore this desired start date is identified under the "enrollment effective date" field under the "Provider General" page. The main purpose of waiving this requirement was to enroll MCO network providers timely without payment disruption.

Once the provider is enrolled, the APS also runs monthly automated checks of all active providers and flags providers that may not be in compliance. The APS system creates "edits" during the automation indicating possible exclusions and sanctions; these edits need to be worked manually by staff. The monthly APS edits process consists of two parts:

1. Monthly automated process involving ProviderOne systems review of LexisNexis (LN) responses for ALL enrolled HCA providers and their disclosures utilizing the federal databases, any non-positive LN responses are posted to an "edit" queue in ProviderOne.
2. HCA staff are assigned to work this edit queue, validate with the source database to see if edit posted is a false positive, and document the check directly in the ProviderOne edit queue. If the source database also indicates a sanction concern, the provider is referred to the HCA Quality Management Team for 2nd level review.

It takes about 60 hours per month to manually work these edits lists and there was more than a 90% rate of false positives in SFY22. The assignment of these monthly edits for staff to work is a somewhat manual process and is performed by the supervisor or lead worker. Both spot check work done by staff, which includes the edits. When we met with George, he confirmed the timeline/progression of the APS process as summarized at [APS Progression Timeline](#). George stated that HCA started using the APS edits intermittently starting October 2018, but did not have all the kinks worked until October, 2020. Since October 2020, HCA has worked the APS edits monthly to ensure compliance with 455.436. Prior to October 2020, HCA conducted monthly LEIE exclusion checks for several years using a separate method including LEIE downloadable databases in order to comply with 42 CFR 455.436. The Program Integrity unit ran the LEIE downloadable database, which was provided from Ming Wu, Deputy Administrator Program Integrity. After October 2020, this process was supplemented by the new APS process and the downloadable database continued for a couple more months as a backup precaution to allow time to ensure APS's credibility. The APS system works by taking existing ProviderOne data and sending it to LexisNexis before running it against an exclusion database to generate possible hits, which flags potentially excluded providers.

Once APS was fully implemented, HCA ran into systems issues with this edit process which creates a large number of false positive sanction matches

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and made working these by HCA staff time prohibitive. George explained to us that his team worked on these edits, but at some point during the summer of 2020, LexisNexis made changes to how their data was stored. This was the primary cause of the large number of false positives being generated within the system. When staff work an edit, they add comments in ProviderOne (such as indicating a false positive or no match). If the edit isn't worked by staff, and the management team didn't notice this, no comments will be in P1, and the edit will show up again the next month for staff to work. Because of this, HCA has stopped working the monthly edits until the systems issues are resolved (**Control Weakness**). George confirmed with us that the edit was only ran once during the audit period and that no other checks were done. He told us that the results were returning 90%+ false positives and that the time investment to manually filter all the false positive was too high. Program Integrity stopped running the LEIE downloadable database once APS was fully implemented and didn't reimplement their process when George's team ran into systems issues with this edit process. The last month edits were worked by HCA staff was July 2021. The P1 systems folks are working with the P1 vendor, CNSI, to fix the issues, and HCA is also looking at other options for compliance with this requirement.

In addition to the new provider applications, HCA is required to revalidate all providers every five years, regardless of provider type. George mentioned that the Authority processes approximately 300-400 revalidations each month. The revalidation process consists of HCA rescreening already enrolled providers to verify continued existence and up to date qualifications and licenses. Per the 1135 Waiver (see: [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#)), the Authority has received approval for the postponement of all revalidation actions through the end of October 2020, when a management decision was made to reinstate most all (excludes background checks) eligibility processes covered under the waiver. Normally, service providers already effectively get screened and revalidated every month through the APS automated process. All providers receive the screening conducted through APS during revalidation as well as monthly, however, during the audit period, the monthly screening process was turned off and edits were not being worked by HCA staff. [K.2 ST4-HCA - Id of IC](#)The biggest focus for revalidation is on those providers with a Core Provider Agreement (CPA). Billing providers must sign a Core Provider Agreement and provide certain disclosures, whereas, servicing providers practicing under a group or facility must have a CPA and disclosures on file with HCA under their billing provider. During revalidation of servicing providers, staff check to verify the servicing provider's biller has a CPA on file and is current with HCA. For Providers with a CPA, a new agreement must be submitted every five years. Providers are asked to enter ProviderOne, look at and update any information, and then send in new documentation. Staff will then screen the provider using the exact tools used during the enrollment process. There is a process that providers can take to extend the deadline by communicating with HCA. New applications to ProviderOne can be submitted and payments can be backdated through 2023, but providers are asked to re-apply if removed from the system.

For revalidations, providers are automatically sent the revalidation notification every 5 years. This notification is controlled by a provider validations screening indicator in ProviderOne and is intended to be sent 90 days prior to the revalidation due date however this is not occurring. The notification is sent one day after the revalidation due date. At this time, ProviderOne begins to assemble a revalidation packet by producing a new CPA and prompting a revalidation letter to be sent to the billing provider requesting action. If no response is received within 30 days of the first revalidation notice, ProviderOne automatically sends out a second letter to the provider indicating they will be deactivated if no response is received. The provider

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then has up to 60 days to provide the requested information necessary to complete the revalidation process. George confirmed that the Authority was made aware by the results of both PERM and SAO audits of control and compliance issues over the revalidation process by stating that HCA's revalidation process is insufficient to meet compliance requirements (**Control Weakness**). It was found that Authority's automated system is actually designed to notify providers of their revalidations one day after the revalidation due date. Due to this design, it's highly unlikely that providers' revalidations would be completed timely. Provider Enrollment is working with P1 systems to create a ProviderOne systems Change Request to change the following:

1. Change the notification schedule from the current 60 months since enrollment or last revalidation completion date to 55 months. This will allow HCA and the provider time to complete the revalidation within the 60-month requirement, and if the provider does not respond, the provider will be deactivated by the system prior to the 60-month requirement.
2. Currently there is a compliance issue when providers receive a revalidation notice, respond but the revalidation is not properly processed by HCA staff (**Control Weakness**). HCA is working with the P1 systems team to change the P1 system to fix this problem.

When the provider responds and completes the revalidation requirements, and HCA Program Eligibility (PE) staff have worked the revalidation including required screening activities and the checklist, HCA PE staff will send a revalidation completion notice to the provider, update the provider's eligibility in ProviderOne to allow payments (if ended), and update the provider validations screening indicator to ensure the next revalidation notice is sent in 5 years.

A provider who enters into or renews a CPA-based agreement agrees via manager signature to present at the time of entrance, renewal, or at the discretion of HCA to provide disclosures that include the following per the core provider agreement. These required disclosures are as follows:

- Ownership and control information as required by 42 CFR § 455.104;
- Information related to business transactions as required by 42 CFR § 455.105;
- Information on persons convicted of crimes as required by 42 CFR § 455.106; and
- Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

CPA providers must also notify HCA of any material and/or substantial changes in information contained on the Medicaid Provider Disclosure Statement given to the HCA by the Provider via writing within 30 days of the triggering event. This includes but is not limited to ownership, licensure, federal tax identification number, additions, deletions, or replacements in group membership and any change in address or telephone number. The Authority utilizes standardized Core Provider Agreements and Medicaid Provider Disclosure Statements, which are signed by each billing provider, to ensure the agreement with the provider complies with the disclosure requirements (**KC#2 - Control Activities**). George provided the CPA template disclosure form, which can be seen at [09-015-core-provider-agreement](#).

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For the servicing non-billing providers, they work under a billing provider and are covered by their provider agreement. As part of this coverage, the billing provider is responsible for making this disclosure on behalf of the non-billing provider. Servicing providers must be tied to an active billing provider with a valid CPA to remain active. In order to identify any invalid providers, the PE unit will work the weekly auto-generated "Servicing Providers with No Billing Provider Report" which identifies servicing providers which are not tied to a billing provider and then the PE staff will manually deactivate them if no additional information is provided to link them to an active billing provider with an up-to-date CPA (**KC#3 - Control Activities**). The report is exported as a spreadsheet by the PE management team and loaded into a SharePoint queue. Staff are assigned to work this queue on a weekly basis. George mentioned that this report has been producing mostly false positives that PE staff must manually check to determine the appropriate eligibility action. When working the report, the business status of servicing providers on this list are manually end-dated by staff for 60 days later. Claims will deny if the NPI's of these end-dated servicing providers are used on claims. George mentioned that because the prior year audit found exceptions where servicing providers were not properly linked to a billing provider with an active CPA, the Authority is in review of the cause for these issues to determine if they were purely a manual staff error or if there could be a larger potential system issue (**Risk**).

In order to ensure all applicable screening and enrollment/revalidation steps have been completed prior to enrollment/revalidation, Provider Enrollment (PE) staff use checklists for each processed enrollment and each processed revalidation. The PE staff member signs and dates the checklist to indicate the provider is eligible to render services and receive payments (**KC#4 - Control Activities/Monitoring**). The checklist has several sections applicable to the provider in order for the PE staff member to verify copies of licenses were gathered, any applicable additional screening steps were completed (site visit), provider verifications were made, and that all agreements and disclosures were obtained and signed by the provider. If APS returns a negative response, staff are instructed to check the source database (if available) to ensure there isn't a false positive in APS. The staff checklist has a specific area to document these kinds of source validations. If the check also fails at the source, staff are instructed to route the application/revalidation to the HCA Quality Management Team, who conducts a second level review of the provider, which could include additional review by the Medical Dental Advisory Committee, and the agencies Chief Medical Officer.

Automated edits are in place to ensure payments are not authorized if the eligibility review process is not completed (**KC#5 - Information and Communication**). There are actually three different claim edits depending on what field the provider NPI is submitted on the claim.

- 01240 – Referring provider is missing or not active for the dates of service
- 01425 – Billing provider is not in active status
- 01445 – Attending or servicing provider is not active for date of service.

George stated that it is a federal rule that providers must be known in order to be on claims and encounters. Therefore, for new enrollments, providers cannot be paid, nor can their NPI be used on any claim, until HCA PE staff validate that screening activities are completed, and approve

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the application in ProviderOne. Only after the application is approved by HCA PE staff does the provider record become active in ProviderOne. Claims submitted in ProviderOne which includes a NPI not active (enrolled) with HCA are denied by ProviderOne. Providers tend to add multiple locations to one NPI, but there is a single base location where each provider will be paid. For revalidations, when a deactivation letter is sent, ProviderOne also sets the provider's eligibility with HCA to end and be deactivated 90 days from the date of the first revalidation notice sent to the provider. P1 changes the business status to "Terminate/Revalidation Incomplete". Any fee-for-service claim submitted by this provider with dates of service after their deactivation date will be denied, as the provider is not active in the same manner as any other claim for a provider not active (**KC#5 – Information and Communication**).

### **Summary of Key Controls:**

We identified the following key controls over provider eligibility at the Health Care Authority:

- **Key Control #1 - Monitoring:** The Provider Enrollment staff do the final review of the high-risk provider lists to ensure that providers selected for the High Risk Category meet the right criteria before they change the provider's risk in the ProviderOne domain.
- **Key Control #2 - Control Activities:** The Authority utilizes standardized Core Provider Agreements and Medicaid Provider Disclosure Statements, which are signed by each billing provider, to ensure the agreement with the provider complies with the disclosure requirements.
- **Key Control #3 - Control Activities:** In order to identify any invalid providers, the PE unit works the weekly auto-generated "Servicing Providers with No Billing Provider Report" which identifies servicing providers which are not tied to a billing provider and then the PE staff will manually deactivate them if no additional information is provided to link them to an active billing provider with an up to date CPA.
- **Key Control #4 - Control Activities/Monitoring:** Provider enrollment staff ensure all applicable screening and enrollment/revalidation steps have been completed prior to enrollment/revalidation by completing a provider checklist and signing it to indicate the provider is eligible to render services and receive payments.
- **Key Control #5 - Information and Communication (Automated):** If an enrollment/revalidation packet is not completed and submitted timely by the provider, ProviderOne edits are set to automatically deactivate the provider so that payments cannot be processed.

### **Evaluation of Results:**

We identified the following control deficiencies over provider eligibility at the Health Care Authority:

- The P1 function that automatically terminates providers between enrollments when their license is not active was shutoff and has not yet been turned back on.
- HCA has stopped working the monthly edits until the issues with the systems are resolved. These were last worked in July 2021 and alternative methods to review these edits, such as the LEIE downloadable database, have also ceased throughout the duration of the audit period. Without working these edits, HCA does not know if a provider is potentially ineligible. K.2 ST4 HCA - Id of IC
- The Authority is not collecting application fees for applicable providers at revalidation, as required

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- The Authority has not yet established a process to ensure that fingerprinting requirements are met (federal waiver is currently in place, expected to end in January 2023, therefore no exception to be taken) K.2 ST4 HCA-Id of IC
- The Authority's revalidation process is insufficient to meet compliance requirements. Revalidation notices are sent to providers the day after the revalidation due date instead of 90 days before the revalidation due date. Currently there is a compliance issue when providers receive a revalidation notice, respond but the revalidation is not properly processed by HCA staff. Due to inadequate system design, deactivation of unvalidated providers will not be processed until 30 days after their eligibility end date.

Additionally, we identified the following risks that may have an impact towards meeting compliance requirements:

- PERM audit results found control deficiencies regarding staff errors made when conducting provider eligibility functions which directly contribute to eligibility decisions made. During the audit period, 14 new staff were hired. The Authority has also increased the average number of applications per month by 500-700 more than the prior year, due to the MCO requirements being implemented. Based on these factors, the risk is increased for staffing errors.
- A potential control deficiency, per HCA, may exist in ensuring servicing only providers are properly linked to at least one billing provider with an active CPA on file

We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment and determined the likelihood of noncompliance is more than remote and the magnitude of potential noncompliance is material. Based on our understanding of internal controls over Special Test 4 - Provider Eligibility, we found the agency does not have adequate internal controls to prevent material noncompliance. Therefore we assess preliminary control risk as high and will report a finding for a material weakness at FI\_S1Washington\_SA22\_HCA-M03\_Medicaid/CHIP\_Special Test 4\_Provider Eligibility. No internal control testing is necessary in this instance.

### **Preliminary Control Risk Assessment**

#### **Step 4**

HIGH - Internal control design is not likely to be effective to prevent or detect non-compliance with grant requirements. We will report a **material weakness** in accordance with 2 CFR §200.516(1).

### **K.3.PR.G - ST4 Provider Eligibility (Screening and Enrollment) - DSHS**

*Procedure Step:* Special Test 4 - Provider Eligibility (Initial Enrollment and Revalidation) - Identification of Key Internal Controls

*Prepared By:* SAG, 5/9/2023

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**Reviewed By:**

RJC, 5/29/2023

Purpose/Conclusion.

**Purpose:**

To gain an understanding of the internal controls DSHS has established that provide reasonable assurance of compliance with the Special Test 4 - Provider Eligibility - Initial Enrollment Eligibility and Revalidation.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 4 - Provider Eligibility - Initial Enrollment Eligibility and Revalidation.

**Source:**

Rick Meyer, External Audit Compliance Manager  
Cheryl Timmons, HCS Program Integrity Manager  
April Hassett, ALTSA Contract Manager (MSD)  
Melissa Diebert, Contract Specialist (MSD)  
Dustin Quinn-Campbell, Payment Policy and Program Manager (HCS)  
Kristian Rodriguez, ALTSA QA Policy Program Manager  
Sonya Declat, ALTSA Consumer Directed Employer Manager  
Debbie Johnson, ALTSA Interim Medicaid Unit Manager  
Julie Manning, ALTSA Contract Specialist 2 (MSD)  
Laura Holloway, ALTSA QA Administrator  
Geoff Nisbet, DDA Audit Liaison

**Conclusion: PSC - Conclusion**

Based on our understanding of internal controls over Special Test 4 - Provider Eligibility - Initial Enrollment Eligibility and Revalidation, we assessed preliminary control risk as **low**. We identified the following immaterial control weaknesses to be reported as an exit item at

EI\_S1Washington\_SA22\_DSHS\_Medicaid\_Special Test 4 - Provider Eligibility:

- The Department has controls in place to ensure Providers, including Nursing Facilities, are revalidated at least every five years. However, during the audit period, management did not have a documented procedure or control in place to ensure they terminated Nursing facility providers that have not re-enrolled by the five year mark.



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- An error in the control subsystem allowed payments to be made in rare cases.

Testing Strategy:

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

***Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: In order to receive Medicaid payments, providers must: (1) be licensed in accordance with Federal, State, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and Section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)); (2) screened and enrolled in accordance with 42 CFR part 455, subpart E (sections 455.400 through 455.470); and make certain disclosures to the State (42 CFR part 455, subpart B, sections 455.100 through 455.107). Medicaid managed care network providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR part 438, subpart H.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

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### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or

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2. The auditee's internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.7

Record of Work Done.7

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the provider eligibility compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The program is considered a "higher risk" program for 2022 in the Compliance Supplement, pursuant to 2 CFR section 200.519(c)(2).

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

Additionally, we noted that in prior audits, the Department did not have adequate internal controls over and did not comply with requirements to ensure certain Medicaid providers were revalidated every five years or that screening and fingerprint-based criminal background check requirements were met.

### **Gather Information**

#### **Step 2**

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## Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Provider Eligibility requirements. We identified the following:

In order to receive Medicaid payments, providers must: (1) be licensed in accordance with federal, state, and local laws and regulations to participate in the Medicaid program (42 CFR sections 431.107 and 447.10; and section 1902(a)(9) of the Social Security Act (42 USC 1396a(a)(9)); (2) screened and enrolled in accordance with 42 CFR part 455, subpart E (sections 455.400 through 455.470); and make certain disclosures to the state (42 CFR part 455, subpart B, sections 455.100 through 455.106). Medicaid managed care providers are subject to the same disclosure, screening, enrollment, and termination requirements that apply to Medicaid fee-for-service providers in accordance with 42 CFR part 438, subpart H. States must also follow guidance issued in the Medicaid Provider Enrollment Compendium (MPEC) to enroll providers into their Medicaid programs. Providers who have been barred from participation by the OIG exclusion list are not eligible to be enrolled in the Medicaid program (See 42 CFR 455.436).

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We received the internal controls response (SFY22 Medicaid ST4 Provider Eligibility Internal Controls Request ALTSA Response) from Laura Holloway, ALTSA QA Administrator on November 30, 2022. Note that the Management Services Division (MSD) is a division of ALTSA that implements the internal controls over provider eligibility for both ALTSA and DDA.

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- On December 13, 2022, we met with the following personnel to gain an understanding of internal controls, policies, and procedures surrounding provider eligibility:
- Sonya Declet, ALTSA Consumer Directed Employer Manager
- April Hassett, ALTSA Contract Manager (MSD)
- Laura Holloway, ALTSA Audit Liaison
- Debbie Johnson, ALTSA Interim Medicaid Unit Manager
- Cheryl Timmons, ALTSA Program Integrity Manager
- Melissa Diebert, ALTSA Management Analyst 4 (MSD)

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On January 25, 2023, we had an additional understanding meeting with the following personnel to continue the discussion:

- Laura Holloway, ALTSA Audit Liaison
- Cheryl Timmons, ALTSA Program Integrity Manager
- Melissa Diebert, ALTSA Management Analyst 4 (MSD)
- Julie Manning, ALTSA Contract Specialist 2 (MSD)
- Kristian Rodriguez, QA Policy Program Manager

## Initial Provider Eligibility

### Contract Process Overview

Cheryl explained that in order for a provider to get paid for Medicaid, they must first enter into a contract with DSHS to provide services to DSHS clients. Contracts are executed at DSHS Headquarters (**HQ**), local DSHS offices, or Area Agencies on Aging (**AAA**), depending on the type of services provided. ALTSA contracts with AAAs to develop, maintain, and ensure a quality statewide Medicaid provider network to serve clients who are eligible for Medicaid Long Term Care services and Supported Living. Individual Provider contracts are executed by DDA or ALTSA regional offices or by AAAs located throughout Washington State. The HQ contract unit executes Nursing Facility contracts as well as Assisted Living, Adult Family Home, Deaf/Hard-of-Hearing, and some Individual Providers as well. The contract term, procedures, and screening requirements also vary based on provider type. Individual Provider and other Medicaid Service Provider contracts, such as Adult Family Home, Assisted Living Home, and Home Care Agencies, are written for a term of four years, although some are only written for a term of one or two years. Supported Living is negotiated with DDA but these contracts should be renewed every two years. Nursing Facility contracts have no end date (per the Assistant Attorney General) as CMS expects these contracts to be open-ended, but they are revalidated every five years.

Initial federal database checks - Social Security Administration's Death Master File (**DMF**), the List of Excluded Individuals/Entities (**LEIE**), Department of Enterprise Services (**DES**), and the Excluded Parties List System (**EPLS**) - are completed via a ProviderOne (**P1**) interface (**Automated Key Control 1**). Automated Key Controls However, the National Plan and Provider Enumeration System (**NPPES**) checks are generally not performed except for Nursing Facilities, because NPI is not required for non-health care service providers. Additionally, as DSHS is only responsible for social service providers who are not required to have a medical license, the medical license screening requirement does not apply. Licensure For Nursing Facility contracts with DSHS, the HQ Contract Unit manually checks the validity of an NPI on the NPPES website. The P1 interface usually provides the results of the federal database checks within 10-15 minutes to the HQ Contract Unit. If there was an issue in the search, a manual check to the appropriate website(s) will generally be performed by the next business day.

Cheryl mentioned that there no providers identified as high risk during the audit period based on the CFR requirements.

### Individual Provider:

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Potential Individual Providers (**IP**) submit an application packet, which includes a Contractor Intake Form ( [Contractor Intake Form](#)), a copy of the IP's valid driver's license or identification card, a copy of the IP's Social Security Card, and a Background Check authorization form to the appropriate AAA contract staff, who then run a State Name and DOB background check. IPs do not complete the Medicaid Provider Disclosure Statement (**MPDS**), which addresses certain disclosures such as ownership, controlling interests, and affiliations. When we inquired about how the Department obtains these required disclosures from IPs, both Rick Meyer and Laura Holloway asserted that the Department views IPs as individuals and that they believe the disclosures referenced in 42 CFR 455.100-107 are meant for businesses. They therefore do not obtain these disclosures from IPs. We confirmed this, through review from CMS guidance (see: [CMS - Toolkits to Address Frequent Findings: 42 CFR 455.105](#) ), where we could confirm that the requirements at 42 CFR Subpart B sections 455.101 through 455.106 are not intended for individuals that are "direct-care providers responsible for their own business & there are no behind the scenes individuals". Disclosures for IPs?

Once the background check has been passed and the contracting application packet is accepted by the office, a Contract Specialist creates a contract file in the Agency Contracts Database (**ACD**) and prints out the contract form. The Contract Specialist reviews the intake documents to verify the application identification and authorization to work in the United States. If the IP has no ID or is not eligible to work in the United States, the Contract Specialist sets the ACD index status of the contract file to inactive and flags it. If the provider is otherwise eligible, the Contract Specialist begins the approval process.

The ACD has an interface to the Health Care Authority's (**HCA**) Automated Provider Screening System (**APS**), which automatically screens the provider through the DMF, LEIE, DES, and EPLS in real time. APS is triggered when the contract specialist clicks the "Approve button" in ACD. (**Automated Key Control 1**). An automated email notification is generated and sent to the approving contract specialist when a contractor has passed debarment and exclusion checks by APS and the contract is approved. If a contractor has not passed initial screening checks by APS, the contract is sent back to pending status and an automated email is generated and sent to both the Contract Specialist and the HQ Contract Unit. HQ Contract Unit staff then conduct manual validation checks on the contractors that come back with errors and troubleshoot any discrepancies found in the data and make necessary corrections or notifies field service office staff that research for corrections that are needed. The contract remains in pending or draft status. If all manual checks are okay, HQ Contract Unit staff manually approve the contract and notify the field service office that the contract has been approved. If it's determined that the issue was a legitimate hit, the contract is placed in an inactive status and flagged.

A contracting specialist refers to the "Staff" section in ACD to ensure the federal database checks were completed for the provider applicant. After confirming the federal database checks are completed, the contract specialist submits the contracting packet including ACD contract document, intake document and supporting documents to a contracting specialist manager with signing authority. Laura informed us that the contracting specialist manager at AAA reviews the contracting packet to ensure the individual provider's qualifications are properly checked before signing the individual provider contract (**Key Control 1 - Control Activities**). The contract effective date is the date DSHS signs the contract, and no services

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from the provider are authorized until the contract is signed.

On October 1, 2021, DSHS began transitioning IPs to Consumer Direct Care Washington (CDWA) via the Consumer Directed Employer program. This began transitioning employment-related activities to CDWA and allowed DSHS to focus more on case management activities. October 1 was the pilot phase of the transition, which moved 158 IPs to CDWA in the following WA counties: Lewis, Mason, and Thurston. Phase 1 began on February 1, 2022 and moved roughly 15,000 IPs to CDWA. The final phase (2) began April 1, 2022 and moved roughly 29,000 IPs to CDWA, ending on May 31, 2022. If a provider was revalidated before their particular CDWA phase-in time, DSHS would have screened them, but if they were a new provider or already phased in before that time, then CDWA would screen them in as an employee. However, DSHS would have been required to conduct monthly screening regardless of when the phase-in occurred, although this screening ended after the audit period on December 31, 2022. The first annual monitoring of CDWA is currently planned to be completed May - July 2023, with a final report on it done by September 2023, although there is a possibility of that time frame changing for subsequent years. CDWA

### Revalidation:

To ensure the Department revalidates IPs in accordance with federal criteria, the Department drafts IP contracts that expire after no more than four years and utilizes a system edit (System Edit 31035) in P1 that does not allow providers to receive payments once their contract expires **(Automated Key Control 3)**. Automated KC - Edit 31035 The system edit in coordination with the four year contract length effectively prevents any IP from receiving pay for providing services without first being revalidated, which must necessarily occur before the federally required time period of five years. In order to be revalidated, a provider must effectively reapply to be an individual provider. The process for revalidations is the same as initial validation.

### Nursing Facility:

The contract process for potential Nursing Facilities is similar to the Individual Provider's described above. A corporation or business has a more involved screening process and is required to submit Medicaid Provider Disclosure Statement (**MPDS**), which can be viewed at (Nursing Facility Revalidation Process 2021), identifying ownership, financial, managerial, and controlling interests, along with the Contractor Intake Form. The MPDS is a standardized form the Department relies on to obtain disclosures required by 42 CFR 455.104. Once the DSHS HQ Contract Unit receives the MPDS and supporting documents from the facility, it updates ACD with information disclosed and the date the information was received. The NPI is verified via the NPPES website. DSHS HQ Contract Staff then screen all individuals listed on the disclosure form and verify they are approved to work in Washington. The facility and disclosed individuals with ownership interest are automatically included in the list of providers for the federal database checks - Social Security Administration's Death Master File (**DMF**), the List of Excluded Individuals/Entities (**LEIE**), the Excluded Parties List System (**EPLS**), and the National Plan and Provider Enumeration System (**NPPES**). If a contractor has not passed initial screening checks by APS, the contract is set back to pending status and an automated email is generated and sent to both the Contract Specialist and the HQ Contract Unit. If the Contract Unit verified that a screening hit was legitimate, the Medicaid Integrity Administrator is notified, and ACD index is set to inactive.

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Once set to inactive in ACD, the provider couldn't be contracted without future investigation.

After confirming the federal database checks are completed and all required documents are ready for review, the Contract Specialist submits the contracting packet, including the ACD contract file, Contractor Intake Form, MPDS, and supporting documents to the Contract Manager, who reviews to ensure all disclosures required by 42 CFR 455 subpart B have been met prior to signing the contract (**Key Control 1** - Control Activities)

All medical providers have core provider agreements with HCA and all screening for medical services are completed through P1. HCA verifies the licenses are in place before they approve the contractor. The Registered Nurse Delegator and Private Duty Nursing Program Managers check the Nurses' licenses.

### Revalidation:

Melissa Diebert provided us with a copy of the Nursing Facility Revalidation Process ([Nursing Facility Revalidation Process 2021](#)). To ensure the Department revalidates nursing facilities every five years in accordance with 42 CFR 455.414, the Nursing Facilities Contracts Specialist (Julie Manning) uses a spreadsheet on which all contracted nursing facilities are listed. The spreadsheet identifies each facility and lists the date of the facility's last Medicaid Provider Disclosure Statement (MPDS) received in the MODIS system.

Julie Manning monitors each nursing facility on the list (quarterly) and sends each facility a notification email 57 months after the date of its last MPDS submittal (three months prior to the facility's five year mark)(**Key Control 2 - Control Activities**). The email (see [Nursing Facility Revalidation Process 2021](#)) contains the provider intake form and the MPDS required by 42 CFR 455 subpart B. It also notifies the facility that the revalidation information is required and that failure to comply may lead to the termination of that facility's contract. Once the facility has provided the revalidation info, which must include the Medicaid provider disclosure statement required by 42 CFR 455, subpart B, Julie updates the facility's information in MODIS and the contract is good for another five years (**Key Control 2- Monitoring**). If a response is not received within 2 weeks, Julie sends a reminder email. If not received within 30 days of the reminder, Julie notifies Angela Nottage, NPI Unit Manager, who then notifies Rates Unit to stop payment. If the provider does not respond, the contract will be terminated. The Department does not have a formal policy or a procedure that outlines how they would go about terminating a facility's contract should they fail to provide the revalidation information. This was identified in the prior year as well. (**Control Weakness 1: 42 CFR 455.416 requires SME to Terminate the enrollment of any provider who did not submit timely and accurate information and cooperate with screening methods. The Department does not have procedure/control in place to ensure they terminate providers that have not re-enrolled by the five year mark**).

### **Monthly Federal Database Checks**

42 CFR Section 455.436(c)(2) requires the Department to check the LEIE and EPLS no less frequently than monthly. HCA performs the monthly federal database checks for all 1099 providers, including nursing facilities, and individual providers. The ProviderOne APS runs a monthly



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automated check of all enrolled providers and flags providers that may not be in compliance (**Automated Key Control 2**). These flagged providers are then checked by Contract Staff manually (**Key Control 3 - Information and Communication**). The APS system creates "edits" during the automation indicating possible exclusions and sanctions; these edits need to be worked manually by staff. Cheryl explained the "edits" are run between the 7th and the 10th each month. Cheryl then runs reports on the 15th or 16th of the month, documents the results and notifies HCA and each supervisor.

We met with April, Melissa, and Cheryl on January 25th, 2023 to discuss how the Department ensures the LEIE and EPLS checks are being completed as required.

HCA Operation Research Specialists Daniel Hughes and Kasey Kraft run the checks on a monthly basis and send the results to contract unit and cc's Cheryl. The email comes to a common email account that is run by five people. Whoever is manning the inbox that day will take the results and put them in the validations folder (pertains to the exclusions and validations). If there is a hit, whoever is manning the box will forward to Melissa. Melissa will check the LEIE website to see if the provider is actually excluded. If so, she will notify Cheryl, who will see if the Department made any payments to that provider and terminate the provider, if necessary.

Cheryl explained the Individual ProviderOne checks the ELPS for IPs are completed through APS and that the ELPS checks are also run through PPL (a vendor) at the beginning and ending of the month. The results are sent to Jennifer Smith, Individual ProviderOne Program Manager, and Lori Shepard, Social and Health Program Consultant 4. If there is a hit, Jennifer and/or Lori email the Contracts Unit. If the hit is positive, the Contracts Unit would contact the field office, the contract would be terminated, and the index in ACD set to inactive so the field office could not contract with the provider again, without first speaking to HQ Contract Unit.

Melissa performs the Monthly SAM checks for Nursing Facilities at the end of each month. We met with Melissa and walked through what she does to meet the monthly SAM check requirement. Melissa checks all 1099 providers (not IPs) against the SAM exclusions list on a monthly basis. To do so:

- Melissa accesses the SAM website, downloads the most recent exclusion list, and saves the list in a data reporting file.
- Melissa uses a SQL Server Reporting Services (SSRS) report, to identify any potential matches. The SSRS does this by using sequel to compare contractor data from the ACD against the SAM exclusion list.
  - Melissa enters the contract date parameters into the SSRS
  - SSRS returns a list of potential hits in an Excel spreadsheet
  - Melissa filters the spreadsheet to show the 1099 providers, then verifies the potential hit/match has a valid contract in ACD. If the provider has a valid contract, Melissa will then search for the provider using the SAM website.

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- If Melissa finds the provider is excluded she will click on "view details" link that provides the details about the excluding agency and directs the reader to the corresponding exclusion in the LEIE/OIG.
- Melissa will verify that the provider information in ACD matches the provider information in the "SAM details" then notify Cheryl Timmons.

The results are maintained in a shared drive under contracts and includes a snapshot of the data source and the spreadsheet generated from the data source.

### **Risk Assessment-Level Adjustments for Providers**

It is of paramount importance to understand that a provider's risk category begins from a predetermined level, based on the inherent risk of the *service-type* the provider is to provide and **NOT** by assessing the person/entity's circumstances (background, payment history, etc.). In this way, the Department must assess a provider's payment history and exclusion-list status and subsequently *adjust* the provider's risk category from the predetermined level if warranted. 42 CFR Section 455.450, requires the Department to screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." Section (e) of that code requires the Department to adjust the categorical risk levels to "high" when any of the following conditions occur:

- The SMA imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.
- An overpayment that meets the criteria to adjust a provider to "high" risk is \$1,500 or greater and all of the following (Per MPEC at [MPEC](#)):
  - Is more than 30 days old
  - Has not been repaid at the time the application was filed
  - Is not currently being appealed
  - Is not part of a SMA-approved extended re-payment schedule for the entire outstanding overpayment
- The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

The Department assesses the applicant's risk category at initial enrollment to the applicable risk category based on the pre-determined risk level of their particular service type unless there are risk indicators which warrant a higher risk level. ALISA determined these risk categories in collaboration with CMS and documented them in a "Provider List for Risk Matrices" ([ALISA Provider List 7-15-19](#)). Higher level risk indicators and the process for assessing that risk can be seen at ([H22-049 Highrisk Providers](#) and [DSHS Contract Revalidation High Risk Indicator Process\\_v2\\_final](#)).

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The Department has the following risk adjustment process in place:

1. Office of Financial Recovery, (Rebecca Davidson) creates a monthly report of all DSHS providers with \$1,500 or more overpayment balance.
2. April Hassett, Contracts Manager (MSD), runs a monthly report from the ACD of what contracts are ending in three (3) months.
3. Rick Meyer, External Audit Compliance Manager, then compares the OFR Report to the ACD Report and sends the potential results to Cheryl Timmons, HCS Program Integrity Manager, who does research on the potential matches.

Cheryl provided the Contract Revalidation High Risk Indicator Process at ([DSHS Contract Revalidation High Risk Indicator Process\\_v2\\_final](#)). We noted that if there is a SAM/EPLS, LEIE/OIG Exclusion, DES finding, payment suspension or overpayment, Contracts Staff must complete all database checks upon finding a High Risk Provider. Staff use the Checklist for High Risk Indicator Process (see [DSHS Contract Revalidation High Risk Indicator Process\\_v2\\_final](#)) to ensure logging providers at the time of revalidation are completed. On the checklist, Staff select the reason for the high risk indicator and add the High Risk Indicators to the Contractor's record in the ACD even if the contract was completed or terminated. The provider is then logged into the "High Risk Providers" queue on the ALTSA SharePoint. The HCS Program Integrity Manager, Eligibility and Payments Systems Unit Manager, and Contracts Staff review to ensure high-risk providers selected for High Risk Category meet criteria before adding a High Risk Indicator to the provider's record in ACD (**Key Control #4 - Control Activities**).

We reviewed the Corrective Action Plan (CAP) (see 2020-052 on pages 13 - 14 at [Corrective Action Plans](#)) and noted the following related to fingerprint-based criminal background checks for high-risk providers:

- By September 2021, a work group will be established to develop policies and procedures for completing fingerprint-based criminal background checks for the high-risk providers.
- By November 2021, the Department will convene a fingerprint-based criminal background check stakeholder work group to provide an overview of rules and requirements, with a goal to formally adopt policies and procedures by April 2022.
- By July 2022, a training plan for the finger-print based criminal background check will be established for providers and staff.

The Department completed policies and procedures regarding fingerprinting for high-risk providers ([DSHS High Risk Provider Fingerprinting Notification of Providers policy 09292022\\_Final](#)), but implemented them after the audit period on September 30, 2022. Additionally, the training document from their Management Bulletin ([H22-049 Highrisk Providers](#)) was established on October 17, 2022. We reviewed this documentation and verified that the policies and procedures would likely assist the Department in complying with fingerprinting requirements, if followed. Based on this, we will consider the CAP completed subsequent to the audit period. [K.3.9 - Fingerprinting Policy](#)

**Control Weakness 2:** The Department has a documented procedure in place to ensure providers categorized as "high" risk underwent the

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required fingerprint background check, when applicable. However, this procedure went into effect September 30, 2022, after the SFY22 audit period.

Note: Due to the PHE ([COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#)), there is a waiver in place for fingerprint criminal background checks, therefore we will not take exception but will follow-up during the next audit as the US Dept of Health and Human Services is currently expecting the PHE to end May 11, 2023 per their [website](#). [Waiver for PHE](#)

### **System Edit 31035**

Regarding how the Department ensures that the individual provider contracts are revalidated within the prescribed time frame, the Department sets individual provider contract terms at four years on purpose. System edit 31035 in the ProviderOne system (P1) does not allow the individual provider to receive payment if there is not a valid contract in ACD (**Automated Key Control 3**). Therefore, the provider must renew/revalidate their contract a year prior to the prescribed five year time line in order to continue receiving payment. We spoke with DSHS HCS Payment Policy and Program Manager, Dustin Quinn-Campbell to learn more about the system edit.

According to Dustin, ProviderOne system edit 31035 prevents the Department from using federal funds to pay providers that have not been revalidated within the prescribed time frame by instructing P1 to ensure a provider has one or more taxonomy codes on their profile before ever receiving a claim from the provider.

When a provider contracts with DSHS to provide Medicaid services, the provider's contract states which services the provider is authorized to provide and their associated service codes. After the Department executes the provider's contract, ACD uploads the contract information to the provider's profile in Provider One (P1) via an automatic interface. This contract information includes two key elements: the contract beginning and end date and the provider's authorized service codes.

Provider One uses the service codes to populate the Authorized Service Lines in the provider's P1 profile. The Authorized Services Lines represent the one or more procedures/services for which the Department has contractually authorized the provider to provide (*e.g. in-home care, travel reimbursements, training, etc.*). The contract beginning and end date are the dates between which the Department has authorized the provider to receive pay for providing those services. The contract end date can be made shorter if the contract was canceled prior to the existing end date, however, the end date cannot not be extended in the system.

If the provider's service line is associated in an existing taxonomy and if the provider's authorization to provide that service (i.e. the contract) is not expired, P1 will conclude the provider's taxonomy is present for that service line. P1 will then list that service under the provider's "Authorization Header", which enables P1 to receive claims from the provider for rendering that service.

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Edit 31035 works by changing the taxonomy status of the provider's service line to "error" on the first date for which the provider is no longer authorized to provide the service (i.e. expired/revoked contract) and posts the message "unable to derive taxonomy".

Example:

Contract ends 01/31/2022.

Taxonomy ends 01/31/2022.

Service line exists from 01/01/2022 – 02/28/2022.

Edit 31035 posts on all dates 02/01/2022- 02/28/2022.

In this example, the individual provider would be able to submit claims for dates of service 01/01/2022 – 01/31/2022. However, they would not be able to submit electronic claims for dates 02/01/2022 or greater, nor would they be paid for those dates if they somehow got a claim submitted via paper. Dustin noted that if they determine the provider retroactively ineligible, they apply the date of ineligibility and all claims as of that date would result in the error status.

Dustin then explained how edit 31035 also prevents providers from ever submitting claims to P1. As we have hitherto described, the IP's profile exists in P1, but the IPs themselves do not access P1 to submit their claims. IPs submit their claims through a separate system called Individual Provider One (IP1). The "Authorization Header", which dictates the services for which the IPs may claim payment, exists in IP1, but it is not a modifiable field. IP1 receives an IPs Authorization Header from P1 in a nightly feed. Dustin explained that IP1 will not even display any services that are in error status.

Dustin informed us that while the system edit was still in effect during SFY22 as noted above, there was an error in the system that caused payments to be able to be paid to IPs with terminated contracts under very specific circumstances. On January 31st, 2023, we met with Dustin, Cheryl, and Laura to discuss this in further detail.

According to Dustin, System Edit 31035 would not stop payment to an IP under a very rare scenario. In 2019, it was discovered that if the following events occurred simultaneously, a payment would be made to an IP with a terminated contract:

- An IP contract was terminated sooner than the original contract end date
- The Primary Case Manager for the IPs payment authorization left service without immediate replacement
- An IP made a payment request in IP1

Dustin noted that if only one or two of these events occurred, the payment would not be made, so all three events would have to occur for the payment to be made in error, making the likelihood of occurrence very rare. The error was due to the payroll subsystem's requirement that all

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transactions be attributable to an active Primary Case Manager. However, when a case remained under the worker ID of a terminated Primary Case Manager, the payroll subsystem would fail to reflect the terminated status of the IP's contract and allow a requested payment to occur (**Control Weakness 3**).

When this error was discovered, the overpayments resolution team mitigated the error by filing recoupment paperwork in order to recoup payment from the IPs. Recoupment efforts were completed in August 2022, however, they did not keep track of which recoups were due to the subsystem error (due to the project having been a higher level focus on collection efforts), so they would be unable to quantify the effect of this error. Ultimately, the issue was resolved in May 2022 when the Department ceased the payroll subsystem, which was run by Public Partnerships Limited (PPL). Until then, PPL acted as an intermediary for claims, remitting payment to the IPs and billing the Department. The Department transitioned IPs to CDWA for payment and other employer-related responsibilities around the same time.

### **ALTSA Quality Assurance**

In prior audit periods, the Department relied on Area Agencies on Aging (AAAs) to contract with IPs to ensure they are able to develop and maintain a quality Medicaid provider network statewide. The Department had a QA process to ensure IP contracts are properly processed at the AAA offices. However, by the end of the SFY22 audit period, these contracts were transitioned to CDWA. In light of this, the Department chose to discontinue the QA process as CDWA would have responsibility over these contracts.

### **Summary of Key Controls and Weaknesses**

**Control Weakness 1:** The Department did not have a documented procedure or control in place to ensure they terminate Nursing facility providers that have not re-enrolled by the five year mark.

**Control Weakness 2:** The Department did not have a procedure, documented or informal, in place to ensure providers categorized as "high" risk underwent the required fingerprint background check, when applicable. (Note: due to the PHE, there is a waiver for fingerprint background checks therefore we will pass further review during this audit but will follow up during the next audit.)

**Control Weakness 3:** There was an error in the IP1 subsystem that allowed IPs with terminated contracts to be paid. (Note: this was discovered and mitigated by recoupment efforts, and the issue was resolved in May 2022 by ceasing the process and transitioning to CDWA.)

**Automated Key Control 1:** The ACD has an interface to the Health Care Authority's (**HCA**) Automated Provider Screening System (**APS**), which automatically screens the provider through the DMF, LEIE, DES, and EPLS in real time. APS is triggered when the Contract Specialist clicks the "Approve" button in ACD. If initial screening is not passed, the Contract Unit performs a manual check before approving the contract.

**Automated Key Control 2:** The ProviderOne APS runs a monthly automated check of all enrolled providers and flags providers that may not be in compliance.

**Automated Key Control 3:** System edit 31035 in the ProviderOne system (P1) does not allow the individual provider to receive payment if there is

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not a valid contract in ACD.

**Key Control 1:** A contract specialist manager with signing authority reviews initial and revalidation contract applications for errors, including the contract length and to ensure the Provider was screened in accordance with federal criteria before signing the individual provider contract, and for nursing facilities that the Medicaid provider disclosure statement required by 42 CFR 455, subpart B, was included.

**Key Control 2:** The Nursing Facilities Contract Specialist uses a spreadsheet to monitor each contracted nursing facility to ensure it is revalidated within five years.

**Key Control 3:** The ProviderOne APS runs a monthly automated check of all enrolled providers and flags providers that may not be in compliance (Automated Key Control). These flagged providers are then checked by Contract Staff manually.

**Key Control 4:** HCS Program Integrity Manager, Eligibility and Payments Systems Unit Manager, and Contracts Staff review to ensure high-risk providers selected for High Risk Category meet criteria before adding a High Risk Indicator to the provider's record in ACD.

### Evaluation of Results:

We identified the following control deficiencies:

#### Initial Provider Eligibility and Revalidation Evaluation of Results

- **Control Weakness 1:** Federal criteria, outlined in 42 CFR section 455.414, requires the Department to revalidate the enrollment of all providers regardless of provider type at least every five years. The Department has controls in place to ensure Providers, including Nursing Facilities, are revalidated at least every five years. However, during the audit period, management did not have a documented procedure or control in place to ensure they terminate Nursing facility providers that have not re-enrolled by the five year mark. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. Based on our understanding of the criteria and the condition making up Control Weakness 1, we determined the likelihood of noncompliance is **remote** and the magnitude of potential noncompliance is **less than material**.
- **Control Weakness 2:** According to 42 CFR 455.434, the State Medicaid agency must require fingerprint background checks for high-risk providers or persons with 5% or more ownership interest in the provider. The Department did not have procedures in place to conduct fingerprinting until after the SFY22 audit period in September 2022. However, due to the PHE waiver in effect, the Department was not required to perform these fingerprint background checks during the audit period. Additionally, the Department did not have high-risk providers during the audit period. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. Based on our understanding of the criteria and the condition making up Control Weakness 2, we determined the likelihood of noncompliance is **remote** and the magnitude of potential noncompliance is **less than material**.
- **Control Weakness 3:** In order to receive Medicaid payments, providers must be screened and enrolled in accordance with 42 CFR Part 455, Subpart E (sections 455.400 through 455.470). The Department had controls in place to ensure payments were not made

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to inactive providers, but an error in the control subsystem allowed payments to be made in rare cases. The Department mitigated this by recoupment efforts, which completed in August 2022, but did not track which recouped payments were due to the subsystem error. Therefore, we cannot quantify the effect of the error. Additionally, the error was further mitigated in May 2022 by ceasing the payment subsystem with the error, so that no more payments would occur. We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. Based on our understanding of the criteria and the condition making up Control Weakness 3, we determined the likelihood of noncompliance is **remote** and the magnitude of potential noncompliance is **less than material**.

Based on the immateriality of the weaknesses notes, and in consideration of the effects of each weakness on the compliance area as a whole, we determined the likelihood of noncompliance is **remote** and the magnitude of potential noncompliance is **less than material**. The recommendations will be provided to the Department in the form of an exit item (see: EI\_S1Washington\_SA22\_DSHS\_Medicaid\_Special Test 4 - Provider Eligibility).

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### **Preliminary Control Risk Assessment**

#### **Step 4**

#### Initial Provider Eligibility and Revalidation

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### **L.3.PRГ - ST5 Provider Health and Safety Standards - DOH HCR**

***Procedure Step:*** Special Test 5 - Provider Health and Safety Standards -Hospital Complaint Response Process - Internal Control

Identification

***Prepared By:*** SNK, 12/23/2022

***Reviewed By:*** SAG, 5/2/2023

Purpose/Conclusion.*
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards- **Hospital Complaint Process**.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 5 - Provider Health and Safety Standards - **Hospital Complaint Process**.

### **Source:**

Jeff Arbuckle-External Audit Manager  
Rodel Carlos-Performance and Case Management Administrator  
Sara Moriarty-Operations and Case Management Manager  
Brian York- Complaint Intake and Compliance Supervisor  
Christine Winkelman-Operations Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - Hospital Complaint Response, we assessed preliminary control risk as low.

Testing Strategy:
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### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the

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Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

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**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as **“LOW”** when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Record of Work Done:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- Multiple departments in Washington state are responsible for administering the requirement.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - Hospital Complaint Response Process requirements. Part 4 of the compliance supplement lists the audit objective - determine whether the State ensures that hospitals, nursing facilities, and ICF/IID that serve Medicaid patients meet the prescribed health and safety standards.

*\*Note: Nursing facility and ICF/IID complaints are reported to and managed by the Department of Social & Health Services (**DSHS**) and were reviewed in the following sections: , ST5 Provider Health and Safety Standards CRU, ST5 Provider Health and Safety Standards NH.*

The Washington State Department of Health (**DOH** or **Department**) is responsible for ensuring that providers and health facilities are compliant with Medicaid requirements in order to render health care services furnished under

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Medicaid. The Office of Health Systems Oversight, within the Department, is responsible for the management of Hospital complaints received and incidents reported. Chapter 5 of the State Operations Manual (**SOM**), published and revised as needed by the Centers for Medicare and Medicaid Services (**CMS**), contains regulations and provides guidance for complaint procedures. Based on the SOM Chapter 5, for FY22, there were four priority definitions for hospital complaints:

1. Immediate Jeopardy (**IJ**) - State Agency (**SA**) must initiate an on-site survey within 2 business days of receipt for non-deemed and within 2 business days of receipt of Regional Office (**RO**) authorization for deemed.
1. Non-IJ High - SA must initiate an on-site survey within 45 calendar days of prioritization for non-deemed and within 45 calendar days of receipt of RO authorization for deemed.
2. Non-IJ Medium - SA must investigate no later than when the next on-site survey occurs for non-deemed and complaint is referred to the applicable accrediting organization(s).
2. Non-IJ Low - SA must track/trend for potential focus during the next on-site survey for non-deemed and complaint is referred to the applicable accrediting organization(s).

In addition to the Federal time lines for complaint response, WAC 246-14-040 states that "the basic time period for initial assessment is twenty-one days."

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step. Based on the information

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provided we identified the following risks for the program based on our understanding of the control environment and risk assessment internal control structures:

- The current health care enforcement and licensing system (ILRS) is nearing the end of its useful life. The vendor no longer provides feature upgrades and product support, and the system currently cannot meet all internal and public access needs for information and will need to be replaced. (Technology Risk)

While this risk is related to one of the key systems for the program, it merely states that the system will need to be replaced in the future. We do not foresee this risk impacting specific testing.

### Complaint Intake - Office of Investigative and Legal Services (OILS)

On September 29, 2022 we met with the following staff at DOH to discuss the complaint intake process:

- Christine Winkleman-Operations Manager (OILS)
- Brian York-Complaint Intake and Compliance Supervisor (OILS)

OILS is responsible for complaint intake at the Department; a complaint can be received by e-mail, online, by phone, written or verbally. Upon receiving a new complaint, the assigned staff will first look in ILRS to determine if DOH has jurisdiction. *Note: the Department informed us that there are some hospitals that maintain a "deemed" status, which means they are surveyed by an Accreditation Organization (AO) instead of by the Department. For deemed facilities which warrant a federal survey, DOH must request and receive approval from CMS to conduct a complaint investigation.*

Next, the staff will review past complaints to ensure the complaint has not already been received and entered into ILRS. The complaint is also reviewed for imminent danger using this criteria. If the review results in the complaint meeting the imminent danger criteria, the file will be expedited for processing as well as forwarded to an expedited case management team (**ECMT**) for review. If the complaint does not meet the imminent danger criteria, the staff member who completed the review notifies another staff member to input the complaint into ILRS. The staff member will input all information in ILRS pertaining to the complaint, once the complaint has been input

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ILRS will notify the next staff member in the queue to complete review of the file by creating an action item.

Tracking of complaints consists of "action items" in ILRS. Action items are assignments created by staff who are working on the complaint and are what push the complaint to the next staff person to complete their role. Once an action item has been entered, ILRS will prompt the next step of the process to be completed by the correct assigned staff. L.3 ST5-DOH-Id of IC After the file has been input into ILRS, another staff member will verify that all necessary information is available in ILRS and assign the "Present for Assessment" action item which will send the complaint to the assigned case manager's ILRS queue. *\*Necessary information includes credential number, respondent name, complainant name, case nature, case alleged issues and date received*

Several OILS intake staff are involved in the process of inputting the complaint into ILRS as well as review of complaint to ensure it is accurate, includes all required information, properly tracking and addressed. **(Key Control #1-Control Activities & Monitoring)**

On a weekly basis the OILS Operations Manager reviews a spreadsheet to monitor how many complaints are out of time line, due that day and within time line to ensure the initial assessment of complaints is completed within the required time frame. **(Key Control #2-Monitoring)**

### Case Management - Office of Health Systems Oversight (OHSO)

On September 29, 2022 we met with the following staff at DOH to discuss their process once a complaint comes to their office.

- Rodel Carlos-Operations Manager
- Sara Moriarty-Operations and Case Management Manager

Complaints come in to OHSO many different ways including; from OILS, an accrediting organization, internally

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as a result of an on-site investigation already being conducted on behalf of the State, and directly from CMS. Depending on how the complaint came to OHSO determines their response process. All complaints referred to OHSO are assigned to a case management team who reviews cases to ensure they are properly triaged and complaints that meet the federal threshold are properly authorized and investigated in accordance with State and Federal time frames (**Key Control #3 - Control Activities**). A case manager, is the first to receive and review hospital complaints. They review the complaint for immediate jeopardy and deemed status. *Note: The Department of Health is responsible for intake and management of federal-level complaints for both deemed and non-deemed facilities. If a hospital is deemed, the Department must receive Regional Office (RO) authorization prior to initiating an on-site survey. Authorization is obtained by submission and return of form CMS-2802 through ASPEN Complaints Tracking System (ACTS).*

If the case manager determines a complaint may meet the IJ criteria, they promptly confirm their assessment with the hospital investigation unit manager. If IJ is confirmed, the hospital investigation unit manager will assign and coordinate with the investigation team to initiate an on-site survey within two business days. For Non-IJ complaints, case management meetings are held weekly, where the case managers assess all complaints that came in for the week and determine whether they warrant a Federal, State/Federal, or State only investigation then prioritize them by severity. If the complaint is determined to potentially result in a federal condition finding, the case manager inputs the complaint information and decision into ACTS. For state-only deficiencies, the follow-up procedures are documented in ILRS. When an IJ or EMTALA case is referred by CMS or an AO, the complaint is immediately processed for investigation, and therefore, will not be discussed at the weekly case management meeting. (**Key Control #4-Activities Allowed/Monitoring**)

### **Summary of Key Controls Identified:**

*Office of Investigation and Legal Services (OILS) (Complaint Intake Staff)*

**Key Control #1**-Several OILS intake staff are involved in the process of inputting the complaint into ILRS as well as review of complaint to ensure it is accurate, includes all required information, properly tracking and addressed.



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### **(Control Activities & Monitoring)**

**Key Control #2** - The OILS Complaint Intake and Compliance Supervisor monitors how many complaints are out of time line, due that day, and within time line on a weekly basis to ensure the initial assessment of complaints is completed within the required time frame. **(Monitoring)**

*Office of Health Systems Oversight (OHSO) (Complaint Investigation Staff)*

**Key Control #3** - All cases are reviewed by a case management team to ensure they are properly triaged and complaints that meet the federal threshold are properly authorized and investigated in accordance with State and Federal time frames. **(Control Activities)**

**Key Control #4** - Program staff hold weekly meetings with CMS to discuss and ensure complaints that meet the federal threshold are properly authorized and investigated in accordance with Federal time frames. **(Monitoring)**

**Evaluation of Results:** No control deficiencies were identified.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

#### **L.4.PR.G - ST5 Provider Health and Safety Standards ICF/IID**

**Procedure Step:** Special Test 5 - Provider Health and Safety Standards - ICF/IID - Internal Control Identification

**Prepared By:** JDP, 3/1/2023

**Reviewed By:** RJC, 3/7/2023

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Purpose/Conclusion.\*

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards - **ICF/IID**.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 5 - Provider Health and Safety Standards - **ICF/IID**.

**Source:**

Rebecca Kane, Reg 3 Reg Administrator  
Jody Just, Reg 3 Field Services Administrator  
Justin Smith, Reg 3 ICF/IID Field Manager  
Melissa Davis, Admin. Assistant  
Arika Braiser, LTC Surveyor  
Olivia St. Claire, LTC Surveyor

**Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - ICF/IID, we assessed preliminary control risk as low.

Testing Strategy.\*

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

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Compliance Requirements: Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood

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of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.

2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

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In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - ICF/IID Survey requirements. We identified the following:

*Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.*

***Audit Objective*** - Determine whether the state ensures that hospitals, nursing facilities, and ICF/IID that serve Medicaid Patients meet the prescribed health and safety standards.

We reviewed 42 CFR Part 442, Subpart C - Certification of ICFs/IID

Section 442.109 Certification period for ICFs/IID

(a) A survey agency may certify a facility that fully meets applicable requirements. The State Survey Agency must conduct a survey of each ICF/IID not later than 15 months after the last day of the previous survey.

(b) The statewide average interval between surveys must be 12 months or less, computed in accordance with paragraph (c) of this section.

(c) The statewide average interval is computed at the end of each Federal Fiscal year by comparing the last day of the most recent survey for each participating facility to the last day of each facility's previous survey.

We reviewed the State Operations Manual (SOM) Chapter 2 Section 2141 - Recertification - ICFs/IID

- The regulations at Section 442.15 provides that provider agreements for ICF/IID's would remain in effect as long as the facility remains in compliance with the Conditions of Participation (COP's). Regulations at 442.109 through 442.11.
- Beginning on May 16, 2012, ICF/IID's are no longer subject to time-limited agreements. However, they are to be surveyed for re-certification an average of every 12 months and at least once every 15 months.
- If during a survey the survey agency finds a facility does not meet the standards for participation the facility may remain certified if the survey agency makes two determinations - The facility may maintain its certification if the survey agency finds Immediate Jeopardy doesn't exist, and if the facility provides an acceptable plan of correction.
- An ICF/IID may be decertified under procedures outlined in Section 3012 of the State Operations Manual. More specifically, a facility may be decertified if an immediate jeopardy finding remains unabated after 23 days or if it fails to regain compliance with conditions of participation after 90 days.

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We reviewed Residential Care Services (RCS) Chapter 16 - Intermediate Care Facilities for Individuals with Intellectual Disabilities and found the following relevant information:

*Chapter 16C2 - ICF/IID Plan of Correction (POC) states in part:*

Following the survey process and upon receipt of the Statement of Deficiency (SOD), the facility must develop a Plan of Correction (PoC) to address all stated deficiencies outlined in the SOD within 10 calendar days of receipt of the SOD. Regulations allow certification of ICF/IID facilities with deficiencies at the standard level "only if the facility has submitted an acceptable PoC for achieving compliance within a reasonable period of time acceptable to the Secretary." Failure to submit a PoC could result in termination of the facility agreement.

Decisions on acceptance of the PoC by the survey team must occur within 5 working days of receipt by RCS.

The facility has no longer than 60 calendar days to implement the PoC and correct the deficiency. The correction date for a specific deficiency may be less depending on the circumstances of the deficiency.

*Chapter 16C6 - Required Timelines for Condition of Participation (CoP) and Immediate Jeopardy (IJ) states in part:*

2. Tenth Working Day - On the tenth working day, (day one begins following the day the team exits from the facility); the survey team sends the Statement of Deficiencies (SOD) CMS Form 2567 containing the deficiencies to the facility and HCA and/or CMS. The survey team informs the facility in writing that there is a determination of noncompliance and that it is recommending termination to be effective within 90 calendar days from the date of the survey. The recommended termination date is included in the letter.

The survey team informs the facility that the termination process provides an opportunity to make corrections and achieve compliance. This opportunity allows the facility ten calendar days to complete and return a PoC on the CMS Form 2567. The Field Manager gives notice in the letter with the SOD that they will revisit within 45 calendar days of the survey if they receive a credible allegation of compliance.

Under the 42 CFR Part 442, as well as the Centers for Medicare & Medicaid Services' State Operations Manual (SOM), Appendix J, and Appendix Q, States are held responsible for certifying Intermediate Care Facilities for Individuals with Intellectual Disabilities in order for the facility to provide Medicaid services. An ICF/IID is an institution that meets Federal conditions of participation (CoPs) with its primary purpose being the provision of health or rehabilitation services to individuals with intellectual disabilities or related conditions and is receiving care and services under the Medicaid program. The ICF/IID conditions of participation recognizes the developmental, social and behavioral needs of individuals with intellectual disabilities who live in residential settings by requiring that each individual receives active treatment to be eligible for Medicaid funding.

Washington State Department of Social and Health Services (DSHS) oversees 4 ICF/IID facilities. The Department is required to perform an annual certification survey of each ICF/IID. The primary focus of the certification survey is on the "outcome" of the facility's implementation of ICF/IID active treatment services. During SFY21 L.4 ID of IC (R) this requirement was waived because CMS has suspended survey activities due to

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Covid and the State does not need to meet the requirement; this requirement is still waived as of SFY22.

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We met with ALTSA ICF/IID staff, field manager, and surveyors. Their team is responsible for surveying ICF/IID facilities for compliance with federal health and safety standards. Surveys are performed to ensure that every aspect of a facility is in compliance with federal requirements for certification as a registered ICF/IID center. The Department has the discretion to perform unannounced survey visits at any time and for a variety of reasons, however typically, the surveys occur between 11 and 15 months apart due to scheduling of staff and status of the facility's corrective action since the last survey. Very rarely do facilities receive surveys just 9 or 10 months apart, unless serious conditions of participation are not being met that could lead to revocation of the facility's Medicaid certification by CMS.

While the State Operations Manual (SOM) requires a full survey of these facilities be completed every 15.9 months, there are three types of actual surveys that can be performed for an ICF/IID:

1. **Fundamental Survey** - conducted to determine the quality of services and supports received by individuals, as measured by outcomes for individuals and essential components of a system which must be present for the outcomes of active treatment to occur. These surveys typically test compliance with 55 federal standards.
2. **Extended Survey** - conducted when standard level deficiencies are found during the fundamental survey and the survey team has determined or suspects that one or more Conditions of Participation examined during the fundamental survey (42 CFR 483.420, 42 CFR 483.440, 42 CFR 483.450, and 42 CFR 483.460) are "not met". These surveys can test compliance with up to 400 standards.
3. **Full Survey** - conducted at an initial survey and at the discretion of the survey agency, based on the agency's identification of concerns related to the provider's capacity to furnish adequate services. The decision may be based on criteria, including but not limited to, the following:
  - a. Condition-level deficiency on the previous year's recertification survey
  - b. Existence of time-limited agreement of less than twelve months due to programmatic deficiencies, or
  - c. Evidence related to diminished capacity to provide services based on other sources, such as complaints, inspection of care findings or State licensure deficiencies that are relevant to Federal requirements.

During the meeting, it was stated that during SFY 2022 there were 4 ICF/IID facilities with current federal certifications.

We asked staff to briefly take us through the survey process. They mentioned that prior to the survey visit, the team of surveyors selected to

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assist with the evaluation, hold a meeting, along with the field supervisor, to go over the planned scope of the survey based on one of the three formats listed above. They agree on an entrance date, as well as a planned timeline for completing required work, then hold an exit interview with facility management to explain any citations or deficiencies that will be documented and communicated in writing.

They explained that the process begins with the Field Manager notifying available surveyors of any upcoming survey due dates for any given facility. Facilities approaching the 15 month survey deadline are traditionally given the highest priority of completion. Both Field Manager and the Administrative Assistant conduct a meeting with the proposed surveyors to be assigned to the evaluation to determine the date(s) staff are available to complete the work, and develop an estimated timeline for completion. The Administrative Assistant prepares planning paperwork for the lead surveyor to begin planning for the survey approximately 2 weeks out from the scheduled entrance. All the recertification surveys are unannounced, however post surveys are scheduled since the provider must allege they have addressed all prior reported deficiencies in order for RCS to evaluate facility compliance.

Working with the Lead Surveyor, the Administrative Assistant then creates a survey "shell" file within an electronic database called ASPEN (Automated Survey Processing Environment Software) and notifies the field supervisor once an entrance document is generated. The lead surveyor will then fill out the planning forms including a review of the facility's prior history, the date of the last survey, and the status of any deficiencies that were previously identified. Staff stated that one step in planning for the survey is for the Lead Surveyor to obtain a full client and staff listing from the facility and select client samples for record review while on-site. L.4 ID of IC (R) Clients are selected based on risk criteria (Mild, Moderate, Severe, or Profound) which include the client condition, prior incidents/complaints reported, and history of noncompliance with standards and requirements identified through previous surveys.

The surveyors will then prepare an entrance document and meet with the facility directors to go over the scope of the survey and begin their work. The size of each ICF/IID facility monitored by RCS can vary between 6 and 120+ clients at any given time. State-owned and operated facilities generally house more clients than the one privately-owned facility that the Department monitors (Privately Owned Rocky Bay was closed January 2021). We asked approximately how long the survey process can take for facilities of varying sizes. Staff responded that the typical recertification survey takes about seven days.

We discussed with staff further to gain a better understanding of the entire facility survey process on 10/27/2022. (*\*\*Note: We also understood that ICF/IID surveyors are also responsible for investigating complaints received from ICF/IID facilities for improper provider actions, including fraud, client abuse, neglect or exploitation, or noncompliance with laws/regulations. The complaints are triaged by the Complaint Resolution Unit at RCS and assigned to surveyors based on their availability and workload. Our understanding of these complaint investigations will be documented elsewhere, in the CRU section located at (See. Overview)*)

The Department utilizes a Survey Review Checklist to ensure that areas of the SOM are included in the survey, the checklist outlines all areas that need to be completed for the recertification survey and follows the SOM procedure (See. Team Leader Full Survey Checklist) **(Key Control #1 - Control Activities)**



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### Pre-Survey Tasks:

Staff explained that the team meets regularly to discuss upcoming surveys and it is at those meetings that the survey is scheduled and a Team Leader is selected. There are many factors that go into determining when a facility is surveyed, including:

- Availability of surveyor(s) during the proposed timeframe
- Amount of time that has passed since the previous certification survey was completed
- The number of recent complaints received for the facility, and the severity level of the allegations
- Whether the facility is approaching the 15 month survey deadline

Staff stated that the ICF/IID unit would ideally prefer to survey each facility within 10-12 months. However, due to the fact that ICF/IID surveyors are performing complaint investigations received by the Complaint Resolution Unit, their time is more valuable than in prior years, despite no change in staffing levels. Staff also stated that facilities have been taking longer to achieve compliance, which delays post-surveys and follow-up visits that are required to be completed before the next recertification survey can be initiated. RCS must also coordinate with the Fire Marshal if a certification survey is to be performed, as there are fire safety codes requiring a full inspection annually. Once on site, the fire marshal will conduct their annual survey Life Safety Code (LSC) inspection to ensure fire protection requirements are met. DSHS coordinates their survey with the Fire Marshals so not to give indication to the provider that a certification survey is approaching (in other words, if the Fire Marshal arrives before DSHS does, the provider will know an inspection is about to take place and may rush to correct any issues that they may be cited for during the survey process). The Administrative Assistant will then contact the Administrative Assistant for Nursing Homes to contact the Fire Marshal to coordinate their visit with the survey. Scheduling a survey involves meeting with all survey members prior to the entrance, as well as coordinating lodging and survey dates to ensure the visit goes smoothly and the Department completes its work in a timely manner.

Two weeks prior to a scheduled survey the administrative assistant (AA3) provides the lead surveyor a packet with the necessary forms to get the planning started for the survey. The AA3 then goes into ASPEN and creates the shell for the survey file which lets CMS know that the survey is getting ready to be completed. When the shell is created, an entrance letter is generated that will be provided to the Facility Administrator during the entrance conference. The lead surveyor will then fill out the forms and also review the history of the facility, the date of the last survey, and any citations that were issued. Surveys are typically scheduled at an interval of 9 to 10 months, if the facility is problematic; or 12 to 14 months if they are smaller in size or if no issues were found during the previous visit. As stated earlier, the schedules may be modified depending upon staff availability and priority of imminent jeopardy or other complaints that require the Department's immediate attention. This ensures that if there are any problem areas from prior surveys, they can review those during the current survey.

### On-Site Procedures:

On the day of the survey, the team will meet at the agreed upon meeting place and go to the facility from there. Field Managers are on-site or, if not on-site, in communication with surveyors to ensure that the surveys are completed accurately and completely. **(Control Activities)** Surveys

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are to be unannounced, to avoid giving the facility advance notice of the survey. Once they arrive at the facility, they meet with senior management and conduct the entrance meeting at that time. The entrance meeting will alert senior management of the following:

- Purpose of the visit
- Number of days the survey is anticipated to take
- Introduction of team leader and other surveyors
- Arrangements for work space for surveyors

The surveyors use hard copy forms to document their survey since there is no electronic system in place for completing the survey. The required steps include:

- Documenting recently filed complaints or citations for the facility, and results of any follow-up actions taken
- Obtaining the client roster and selecting a survey sample
- Medication observation and distribution
- Human Resources background evaluation of administrative and nursing staff
- Fire drill history report
- Kitchen/food service observation
- Environmental inspection report
- Record review of supporting documents kept at the ICF/IID facility
- RCS Surveyor Notes (optional)

The clock for the survey 15.9 month deadline starts on the last day the surveyors are on-site from the previous survey (i.e. exit date) and stops on the first day on-site of the current survey (entrance date).

### Survey Task 1

Once surveyors have their assignments and a work space, they can begin surveying their assigned areas and their sample of residents. The team leader will assign survey areas to specific surveyors depending on their workload and familiarity level with that area. The primary focus of the survey is residents' treatment. The surveyors will ask a series of questions and observe the day to day activities of the residents. They also observe the resident's surroundings to ensure that residents are safe in the environment they live in. In addition to evaluating the "outcome" of the facility's implementation of ICF/IID active treatment services and ensuring consistent implementation of a program of specialized and generic training, treatment, health, and related services, they also walk around the facility to perform environmental checks of the facility's community areas such as the gym and swimming pool areas.

The facilities send their census on a monthly basis to the Department. Staff stated that when selecting a sample, there are guidelines that lay out how to select samples but the main components include:

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- The size of the facility (# of residents or houses)
- Diagnostic functionality level of each resident:
  - Mild
  - Moderate
  - Severe
  - Profound
- Services offered at the facility

Arika and Gerald explained that when selecting their sample, the surveyors also try to include a resident from each housing unit of the facility to ensure that the sample is representative of the facility as a whole. The purpose of the sample is not to produce a “statistically valid” sample but rather a sample that is tailored to the developmental strengths and needs presented of individuals at the facility. There is, however, a sampling guide developed by ALTSA to assist surveyors with selecting their survey samples.

### Survey Task 2

The next step after selecting the client sample is to perform a review of the facility's systems in place to prevent abuse, neglect and mistreatment of clients and to resolve any complaints. It is during this step that the surveyors start requesting documentation from the facility about any complaints that were referred to them from the Department's Complaint Resolution Unit. Surveyors will also request incident reports that go back 3 months, documentation of any hospitalizations and a list of clients who require restraints as part of their treatment plan.

### ***Statement of Deficiencies and Plan of Corrections***

Once the survey is completed, the survey team gathers to discuss the results of their surveys. During this "consensus" meeting, they will discuss any deficiencies that were identified and reach an agreement regarding the deficiencies the facility will be cited for. This includes determining whether a deficiency exists, and what specific citation ("tag") was violated. If the team members cannot agree on a citation, the team leader will then take the supporting documentation to the Field Manager to make the final decision. At this time, the team will also determine whether the facility has violated any of the federal conditions of participation (CoPs) and if so, they bring it to the attention of management to identify what remedies will be imposed on the facility.

After the final decisions have been made, the team leader will have an exit meeting with the facility's senior management and discuss the general citations that have been found. If management disagrees with any of the citations, the team leader will give them an opportunity to provide evidence that the citation is not warranted. If no other issues, the team can wrap up and leave the facility.

The team lead will then input the results of the survey into the Facility Management System (FMS) and notify the AA3 to generate the Statement of Deficiency (SoD) on CMS Form 3070H (See. [CMS-3070H-508](#)). To ensure that initial or annual recertification surveys have all requirements and conditions reviewed completely, the team leader ensures all surveyors who performed the survey sign and date a certification on Form 3070H to indicate they completed the survey and reviewed all areas. **(Key Control #2 - Control Activities)**. The SoD notes all the citations along with

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the details supporting the citations for the facility to review. The SoD letter is reviewed by the Field Manager and once this is done, the Field Manager notifies the AA3 of the completed SoD. She then mails the SoD letter to the facility via Certified Mail. For convenience, she also emails the Director of each facility with an electronic copy of the SoD for faster delivery. Since the SoD has to be mailed to the facility within 10 working days of the last day of the survey, the survey team has a limited amount of time to get the SoD completed and reviewed by management prior to mailing it.

Loida Baniqued, HQ Office Chief signs a statement from the Department addressed to the facility/provider. This SoD form is mailed with the Form CMS-2567 (See. [CMS2567](#)) (required by CMS for communicating deficiencies at the facility) via certified mail. The SoD is a summary statement (on DSHS letterhead) that is mailed to the provider communicating the deficiencies and requirements for corrective action and the CMS-2567 is the standard CMS template to report deficiencies found during certification surveys. If the Department is approaching the 10 work day deadline for issuing the SoD but has not yet done so, the AA3 will also email or fax the letter and SoD to ensure that the facility receives it timely. The letter contains the details of when the survey took place, how the Department arrived at the citations they are being issued, and what the next steps are for the facility after receiving the SoD. Those steps include a plan of correction (**PoC**) that the facility must prepare in writing to address the citations as well as how they plan to remedy them. The plan of correction is written in the second column of the SoD and specific corrections must be included for each deficiency in the letter. The letter also lets facility directors know what to do and who to contact if they have questions or if they would like to dispute any of the citations.

After the facility receives the SoD, they have 10 calendar days to submit an acceptable plan of correction to DSHS Residential Care Services (RCS). This ensures that the facility makes the necessary corrections that will eliminate the citations from continuing. CMS outlines the minimum required elements of an acceptable PoC in the SOM, Chapter 7 (Standard Survey Procedures) which RCS enforces when reviewing submitted PoC's for acceptance. The PoC also allows the facility to allege what action(s) will be taken to address deficiencies reported by RCS. Upon reviewing the PoC, RCS is to conduct a post-survey to determine if the corrections were actually implemented and are sufficient to address the weaknesses identified during the survey.

Staff commented that facilities often have questions about federal regulations and corrective actions recommended by DSHS. Since 2016, RCS ICF/IID Surveyors have participated in Quarterly Conference Calls with ICF/IID facility Administrators, Directors, and in some cases Nursing Staff, to solicit questions or concerns from the facilities in meeting ICF/IID program requirements.

### ***Tracking Process***

We met with Melissa Davis, Administrative Assistant for ICF/IID surveys, to view the spreadsheets and databases used by the Department to track its completed and ongoing surveys to ensure compliance with federal timeliness requirements.

Melissa gave us an overview of the tracking process to ensure that surveys are meeting the required survey frequencies. The current frequencies that are mandated by the Centers for Medicaid and Medicare Services (CMS) Mission and Priority Document (MPD) are 15.9 for annual certification surveys and a 12.9 month statewide average. Under the current ICF/IID survey protocol, the Administrative Assistant uses the 365 Day Average

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Report to track the survey frequencies as well as the statewide average frequency to ensure they meet the mandated frequencies. This spreadsheet is updated each time a facility survey is completed. The Field Manager meets with the Administrative Assistant and reviews the 365 day average report to determine if survey schedules need to be modified in order to meet the federal requirement on a quarterly basis (**Key Control #3 - Control Activities**). When the survey is complete and the survey team has conducted an exit meeting with facility management, the lead surveyor will then give Melissa the survey packet (i.e. "work papers") so that she can begin inputting the information into SharePoint and ASPEN.

There is also a Survey and Citations spreadsheet maintained in RCS' SharePoint site, which is used for tracking all complaints, and scheduled surveys for each ICF/IID. This spreadsheet also includes due dates for surveys that have yet to be scheduled. To ensure due dates are met for Statement of Deficiencies (SoD), Plans of Correction (PoC), the Administrative Assistant tracks survey information and their due dates and notifies the surveyors and Field Manager of any approaching deadlines (**Key Control #4 - Control Activities/Monitoring**). As she receives communication with the facilities, she will stamp the documentation with the dates received. When the PoC is received, Melissa scans a copy of it and emails it to the lead surveyor and the Field Manager so that they can review it and determine whether it is an acceptable action plan. *If it is deemed acceptable, a letter is then mailed out to the facility to let them know that it has been approved.* We asked Melissa how she is made aware of whether a PoC is acceptable to the survey team. She stated that often times she is present during the discussion as she schedules the meeting for the surveyors to convene. She says she also receives an email or written notification from the Field Manager when a plan is accepted or denied, and the reasons why.

Melissa stated that because her tracking spreadsheet is located on SharePoint for the team to access at their convenience, it is often reviewed to determine which surveys assigned to specific staff need to be completed in the short-term. The survey team communicates regularly to ensure that if a survey is coming due, there will be staff available to complete it before the drop dead (15.9 month) date.

Surveyors must complete the training described on the RCS Staff Orientation Checklist (see: [Staff Orientation Checklist](#)) before they are qualified to conduct surveys beyond a training capacity. Field Managers sign off that these trainings have been completed to ensure Surveyors are properly certified under CMS requirements before completing surveys. Managers use this training to ensure surveyors are aware of timeliness requirements in conjunction with Melissa's spreadsheet.

### **Key Internal Controls Identified:**

**Key Control #1 :** The Department utilizes a Survey Review Checklist to ensure that areas of the SOM are included in the survey, the checklist outlines all areas that need to be completed to complete the recertification survey and follows the SOM procedure (**Control Activities**)

**Key Control #2:** To ensure that initial or annual recertification surveys have all requirements and conditions reviewed completely, the team leader ensures all surveyors who performed the survey sign and date a certification on Form 3070H to indicate they completed the survey and

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reviewed all areas. **(Control Activities)**.

**Key Control #3:** The Field Manager meets with the Administrative Assistant and reviews the 365 day average report to determine if survey schedules need to be modified in order to meet the federal requirement on a quarterly basis (12.9 and 15.9 month timeline) **(Control Activities)**.

**Key Control #4:** To ensure due dates are met for Statement of Deficiencies (SoD), Plans of Correction (PoC), the Administrative Assistant tracks survey information and their due dates and notifies the surveyors and Field Manager of any approaching deadlines **(Control Activities/Monitoring)**.

### **Evaluation of Results:**

No control deficiencies were identified.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### **L.5.PR.G - ST5 Provider Health and Safety Standards CRU**

**Procedure Step:** Special Test 5 - Provider Health and Safety Standards - Complaint Resolution Unit - Internal Control Identification

**Prepared By:** CL, 11/18/2022

**Reviewed By:** RJC, 12/14/2022

Purpose/Conclusion.
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards - Complaint Resolution Unit:

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for

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Special Test 5 - Provider Health and Safety Standards - Complaint Resolution Unit.

**Source:**

Laura Holloway, ALTSA Quality Assurance Manager  
Shiela Bower, CRU Manager  
Jody Pilarski, Business Operations Chief  
Jered Gunn, Business Intelligence Analyst

**Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - Complaint Resolution Unit, we assessed preliminary control risk as low.

Testing Strategy:
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## Step 1: Assess Inherent Risk (IR)

### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

## Step 2: Gather Information

Compliance Requirements: Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement

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- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

### Evaluation of Results: Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)



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Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - DSHS ALTSA Complaint Resolution Unit (CRU) requirements. We identified the

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following:

### Background

The Centers for Medicare and Medicaid Services (CMS) is the oversight authority to ensure Residential Care Services is following federal requirements. Their first objective and priority for the complaint/incident management system is protective oversight. This is accomplished by effective prioritization of complaints so that those with the greatest potential for harm, or allegations where harm has already occurred, are investigated immediately. The second objective is prevention and refers to cases that do not pose an immediate threat, but could L.5 CRU Id of IC have a negative impact on the health care services provided and could potentially escalate to a more serious complaint. The third objective is to promote efficiency and quality within the health care delivery system.

To meet these objectives, the State Operations Manual (SOM) uses the following descriptors to categorize complaints:

1. **Immediate Jeopardy** - *"A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."*
2. **Non-Immediate Jeopardy - High** - *Intakes are assigned a "high" priority if the alleged noncompliance with one or more requirements may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well being that a rapid response by the State Agency (SA) is indicated.*
3. **Non-Immediate Jeopardy - Medium** - *Intakes are assigned a "medium" priority if the alleged noncompliance with one or more requirements caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status or function.*
4. **Non-Immediate Jeopardy - Low** - *Intakes are assigned a "low" priority if the alleged noncompliance with one or more requirements may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage.*

CRU follows CMS guidelines for prioritization and response but they use a different terminology for prioritization. The table below shows the breakdown of complaint terminology from CMS to CRU:

CMS Category	CRU prioritization
Immediate Jeopardy (IJ)	2 Working Day
Non-Immediate Jeopardy High (Non-IJ High)	10 Working Day
Non-Immediate Jeopardy Medium	20 Working Day

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(Non-IJ Medium)	
Non-Immediate Jeopardy Low (Non-IJ Low)	45 Working Day

Internally, CRU can also prioritize a complaint as a Quality Review (QR). A QR is a reported allegation where the home appears to have taken appropriate action in response to the situation and measures have been instituted by the home to prevent reoccurrences. In this case, all parties have also been notified, including professional licensing boards (if applicable). Allegations may also be categorized as a QR if another report that is more urgent in nature has already prompted an investigation of the situation by the Department. In some cases, field managers may choose to re-prioritize a complaint to 90 days, which RCS defines as a "complaint investigation may be delayed if the allegation is general in nature, anonymous, and survey is scheduled within 90 working days". In general, this is a priority assignment made by the field manager, not the CRU. Due to the Public Health Emergency, the Department is able to suspend activities for 20 Day and 45 Day complaints to prioritize 2 day and 10 day complaints (See page 5 of: [QSO-22-19-NH 0](#)) [L.5.8](#)CMS may change this requirement at a later date. We will only test compliance for 2 day and 10 day complaints.

Prioritization of the complaint by CRU is one of the most important steps of the entire process and sets the expected timeline and tone of response for the remainder of RCS' complaint response. Response for nursing home and ICF/IID is covered under CMS' SOM Chapter 5 - Complaint Procedures, 5070 - Priority Assignment for Nursing Homes, Deemed and Non-Deemed Non-Long Term Care Provider/Suppliers, and EMTALA states in part:

*An assessment of each complaint or incident intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge of Federal requirements and his/her knowledge of current clinical standards of practice. In situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to start the on-site investigation within two working days of receipt of the complaint or incident report in the case of a deemed provider or supplier, within two working days of RO authorization for investigation. For all non-immediate jeopardy situations, the complaint/incident is prioritized within two working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information.*

CRU is required under Washington state law to initiate a response within 24 hours after knowledge of the complaint:

RCW 74.34.063, Response to report - Timing - Reports to law enforcement agencies - Notification to licensing authority, states in part:

*(1) - Response to reports - Timing: "The department shall initiate a response to a report, no later than twenty-four hours after knowledge of the report, of suspected abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult"*

CRU operates from 8:00am to 5:00pm and is closed on state holidays. They utilize "working days" for all timeframe calculations.

### Prior Audit Findings

We noted that in the FY2021 audit there was a finding issued for not ensuring timely investigation of complaints of client abuse and neglect at Medicaid residential facilities.

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## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We requested policies/procedures and laws related to the compliance requirement and received the following:

SOM Chapter 5

Complaint Resolution Unit SOP Chapter 4

RCW 74.34

Complaint Resolution Unit SOP Chapter 20 Complaint Investigations (002)

### **Onsite Meeting**

On November 9, 2022 we met with the following staff from DSHS to update our understanding of the CRU:

- Laura Holloway, Internal Audit Liaison
- Sheila Bower, CRU Manager
- Loida Baniqued, Business Operations Office Chief
- Jennifer Ullom, Administrative Assistant

The Department's tracking system, TIVA, was replaced by a new system called STARS in October of 2021. The systems are fundamentally identical, but STARS is a little more user friendly and has the capacity to record enforcement activities and ties in with Perceptive Content, which is the Department's workflow and records storage tool. The department worked with the software vendor to make the new system as much like TIVA as possible, including giving output reports similar names. Staff were given training on STARS to ensure a smooth transition. Add this last sentence to the Sampling Methodology

### **Date**

Once CRU has knowledge of a report, meaning it has been received by staff, and not the time it was reported if outside working hours, the unit has 24 hours to initiate a response and two working days to get the information to the field. During the COVID-19 emergency, the unit received no waivers or exceptions on timely response and continued to work as designed. In addition to the 2, 10, 20, and 45 day investigation response requirements, there is also a 90 day window used by field staff for reports determined to be lowest priority. The unit noted that there has been a

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significant growth in reports handled by the unit from 38,000 to 51,000 over a 2 year period and that the unit has handled the increased workload without disruption. CRU has asked for an additional five staff to help with the increased workload - three intake specialists, one supervisor, and one additional RN or Triage Nurse. At times, because Sheila is an RN, she has performed dual roles as the unit manager and triage nurse. On November 14, 2022 Loida Baniqued indicated that the Department had not been able to add these positions.

We asked Laura and Sheila to show us how the Unit monitors complaints to ensure they are addressed within 24 hours of receiving the complaint. Once the report goes into TIVA, a Program Specialist 3 creates the intake for a nursing home or ICF/IID which is then reviewed by a Triage Nurse to make further referrals. To ensure all complaints are monitored on a weekly basis, the CRU Manager/Supervisor will review TIVA/STARS 2106 report, typically every Tuesday morning, to ensure that complaints which require a response within 24 hours and those that require a two working day response time are handled within the mandated timeline, this report is ran daily but formally documented on tuesday **(Control Activities/Monitoring)**. Sheila monitors these timelines by running a daily TIVA/STARS 2106 (Intake) report using TIVA Report Generator and exports the results into an Excel spreadsheet. She walked us through her review, which includes preparing a report by specifying in TIVA/STARS the Begin and End Date range for complaints received. Sheila stated although she runs this report daily, she will typically make the Begin Date on Monday of the given week to ensure that no complaints are overlooked. She then sorts the complaints by Knowledge Date and Time and also utilizes a field with an automated formula calculation titled, "Knowledge to Response Time". This field includes a time interval (measured in hours and minutes) which is auto-populated by TIVA based on the Knowledge Date & Time of the Intake. It then compares this time to the Response Initiated time, which is recorded once the Intake ID is generated in TIVA by a Program Specialist. Sheila scans for any complaints over 24 hours, and if such instances are found, she discusses them with staff to determine appropriate actions.**(Control Activities/Monitoring)**

We asked Sheila about the different avenues that citizens, providers, law enforcement or state employees have to report complaints of adult abuse, neglect, exploitation or substandard care. Sheila explained that complaints can be submitted through:

- Online submission (TIVA online portal for all provider types; also a public link available through RCS' website)
- **INI** Interactive Voice Response System INI Hotline (phone message, or "live call" if received between 8AM and 4:30 PM Monday-Friday) (Note: If a voice mail message is left, the Knowledge Date is recorded as of the moment the Program Specialist downloads the voice message file)
- Fax transmission
- Email (the emails are routed in Outlook to a Shared Inbox, and the Program Specialist 4s review each complaint and assigns them to a PS3 based on their current workload)
- Mail (people submit documentation to RCS outlining the alleged violations and supporting evidence)
- In-person - the CRU accepts first-hand reports, though they are quite rare and are usually made by DSHS employees (not private citizens)

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A PS4 is responsible for assigning live calls to available PS3's and managing the workload of all PS3's as necessary. The supervisors will communicate with the PS4 about complaints that were received and it is then up to PS4 to assign the complaints to the PS3 staff based on their current workloads. She also explained that she will occasionally review complaint submissions via online reports and will also review the transcriptions to ensure accuracy and completeness of information being provided to the PS3's. Field Managers have the authority to change priority levels for reports based on what they learn when investigating reports. Nurse review is not required for this change, but many of the Field Managers are nurses. There are also internal QA and CMS reviews of prioritizations to ensure correctness.

The PS4 will monitor and track the timeliness of responses to complaints by reviewing complaints submitted into each of the staff's inboxes and reviewing each open complaint to identify the submission date and time (**Key Control #1 Monitoring**). The PS4 maintains a spreadsheet which has the days and times that has the timelines so that they can look at a complaint's received date and determine when the deadline to get it prioritized and/or investigated is. On the same sheet, there are columns that will show the deadline for initiating responses for each priority level. Using a color-coding system, they can flag complaints that are close to being due within each staff's assigned inbox. They are also responsible for reviewing and tracking complaints that are received but no intake is created.

CRU has a memorandum of understanding with the Medicaid Fraud Control Unit (MFCU) for handling referrals. For serious allegations of abuse, fraud or misappropriation that would require law enforcement involvement and/or action by the Attorney General's Office, there are 10 codes that require automatic referrals and the unit may also make referrals at their discretion. MFCU has also asked that any CRU complaints that are for nursing homes and ICF/IID facilities and contain the following alleged violations be forwarded to them:

- Resident/Patient/Client Abuse
- Resident/Patient/Client Neglect
- Injury of Unknown Origin
- Restraints/Seclusions-Death
- Restraints/Seclusions-General
- Death-General
- Fraud/False Billing
- Falsification of Records/reports
- Unqualified Personnel
- Fatality/Transfusion Fatality

The intake specialist will go into the Referral Tab of the TIVA/STARS system and complete the distribution information such as the Agency Type, Agency Name, Referral Method, and Document type. This will then automatically transmit the referral to the appropriate agency. If the referral has not been transmitted, the intake worker will receive a pop-up alert stating that the intake cannot be linked to the field until all referrals are sent (**Control Activity**).

Upon inputting a newly received complaint into the TIVA/STARS system, the Date Received field is automatically populated with the current date

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and time. Once all information on the Intake has been transcribed, the PS3 verifies that all steps have been completed prior to submitting for Intake Review (Triage Nurse Review). We inquired as to when Triage Nurse reviews take place, and the PS3 responded that all intakes for Nursing Homes and ICF/IID facilities are reviewed by one of three Triage Nurses on-staff for appropriateness and completeness prior to finalization. To ensure that all intakes for Nursing Homes and ICF/IID facilities are appropriate and complete, one of three Triage Nurses on-staff will review the intake prior to finalization **(Key Control #2 Control Activities)**. Complaints that have a clinical component, such as medication handling or administration concerns, are automatically reviewed by a nurse as they possess specialized knowledge required to determine the severity of the allegation(s). Staff commented that a crucial part of the Nurse Review step is determining the Priority level of the allegation for when it is assigned for investigation. If the triage nurse disagrees with, or has questions about the intake, the PS4 has instructed the nurses to work directly with supervisory staff. If there is agreement, the Triage Nurse will mark the Intake as Reviewed, in which the TIVA/STARS system records the approval date & time, and the Intake is routed to the appropriate Field Manager and Administrative Assistant for investigation. See additional steps at (See. [Special Test 5 - Provider Health and Safety Standards - CRU - Internal Control Identification](#) ) If there are complaints that have exceeded the required response time, during management's review of the weekly reports, management will discuss the issues with the appropriate staff. An automated alert message will appear in TIVA/STARS if the response time input into the system for an intake exceeds 24 hours from the time the complaint was initially received. This requires the Program Specialist to notify the Unit Manager to review and approve the intake for late processing. TIVA also requires that reports are assigned to and reviewed by a Triage Nurse before they can be linked to a Nursing Home or ICF/IID for intake processing. **(Key Control #3 Control Activities/Monitoring)**

This alert message is shown to the Program Specialist processing the intake, and under the "Decision" screen, there is an Explanation text box for the Unit Manager to complete, stating why the Intake was not processed within 24 hours of the knowledge date. The intake cannot be processed without documenting a response in this field, and must be completed by the Unit Manager.

### **Summary of Key Controls Identified:**[L.5 CRU Id of IC](#)

**Key Control #1:** To ensure all complaints are monitored on a weekly basis, the CRU Manager/Supervisor will review TIVA/STARS 2106 report to ensure that complaints which require a response within 24 hours and those that require a two working day response time are handled within the mandated timeline, this report is ran daily but formally documented on Tuesday **(Control Activities/Monitoring)**

**Key Control #2:** To ensure that all intakes for Nursing Homes and ICF/IID facilities are appropriate and complete, one of three Triage Nurses on-staff will review the intake prior to finalization **(Control Activities)**

**Key Control #3:** An automated alert message will appear in TIVA if the response time input into the system for an intake exceeds 24 hours from the time the complaint was initially received. This requires the Program Specialist to notify the Unit Manager to review and approve the intake for late processing. TIVA also requires that reports are assigned to and reviewed by a Triage Nurse before they can be linked to a Nursing Home or ICF/IID for intake processing. **(Control Activities/Monitoring)**

**Evaluation of Results:** No control deficiencies were identified.

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## **Preliminary Control Risk Assessment**

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## **L.5.PR.G - ST5 Provider Health and Safety Standards CRU**

*Procedure Step:* Special Test 5 - Provider Health and Safety Standards - CRU - Internal Control Identification

*Prepared By:* CL, 12/12/2022

*Reviewed By:* RJC, 12/14/2022

Purpose/Conclusion.

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards - Complaint Investigation.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 5 - Provider Health and Safety Standards - Complaint Investigations.

### **Source:**

Laura Holloway, ALTSA Quality Assurance Manager  
Shiela Bower, CRU Manager  
Loida Baniqued, Business Operations Chief  
Jered Gunn, Business Intelligence Analyst

### **Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - Complaint Investigations, we assessed preliminary control risk as low.



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Testing Strategy:

Guidance/Criteria:

Record of Work Done:

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

## **Gather Information**

### **Step 2**

(See First CRU Understanding Special Test 5 - Provider Health and Safety Standards - Complaint Resolution Unit - Internal Control Identification)L.5  
Compliant Investigation Id of IC

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

## **Complaint Investigations**

We met with the following staff with DSHS to get more information about the complaint investigation process on November 14, 2022:

- Laura Holloway, Audit Liaison
- Jessica Salquist, Regional Administrator
- Kathy Gold, Regional Administrator
- Rebecca Kane, Regional Administrator
- Jennifer Ullom, Administrative Assistant
- Maleia Press, QI Unit Manager

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We met with DSHS staff to discuss the process for how investigators complete a complaint investigation once it gets assigned to the field from the Complaint Resolution Unit (CRU). The process is nearly identical for both Nursing Homes and ICF/IID.

### **ICF/IID Process**

The complaint process starts when the CRU Manager links an intake to the applicable field unit, TIVA/STARS sends a "tickler" notification to both the Administrative Assistant and Field Manager for the applicable Field Unit informing them that an intake has been assigned in TIVA (**Control Activities**). This notification email is auto-generated in Outlook and includes the Facility Name, applicable Field Unit ("Provider Office"), Intake ID#, and Investigation Due Date. The Investigation Due Date is automatically generated from TIVA/STARS when the CRU Manager submits the intake (based on the assessed priority level, the system will calculate the # of working days allowed to pass before the investigation must be initiated).

After receiving the intake notification, the AA3 logs into TIVA to assign it to an investigator. On a daily basis, AA3's assign complaints within TIVA to the investigator by consulting the staff list to identify which investigator is responsible for that facility. If it is a 2 day complaint, the AA3 will call the investigator to inform them that they have a high priority assignment. Any additional instructions are attached to the complaint. RCS has a list of ICF/IID surveyors with the names of the facilities assigned to each for complaint investigations. This list is currently not being utilized because of COVID19, the manager will review each case before assigning them to surveyors to ensure that the workload is evenly distributed during this time. The complaint assignment is based on the list unless the surveyor is currently on another survey site visit or their workload is too heavy, in which case the ICF/IID manager is consulted to assign to another investigator.

Once the complaint has been assigned, a (printed) copy of the intake along with the CRU's priority assessment and copies of any other intakes associated with the same incident are provided to the investigator. Because the investigators cannot always access TIVA while on-site, PDF copies of the intake are attached by email as back-up. If the investigator determines that the priority assigned to the complaint needs to be changed based on the criteria or any other issues that are known for that provider or client, the investigator will submit a request to the field manager. The field manager will review and approve the explanation for a priority redetermination request that is then emailed to CRU by the investigator and cc'ed to the field manager along with a notification of whether the CRU should forward the intake to notify additional agencies, such as Medicaid Fraud Control Unit (MFCU), Adult Protective Services (APS), or law enforcement.

We inquired about how the ICF/IID unit monitors complaints that have not been assigned. The assignment list in TIVA is monitored daily to ensure no complaints are left open.

After the complaint has been assigned, the investigator will start conducting a preliminary review of any other allegations that were submitted for the provider and/or client. As part of the preparation, the investigator will coordinate an on-site visit with the assigned APS investigator, if applicable, and follow the appropriate process for communicating with APS. The investigator must also contact and interview the complainant prior to going on-site to ensure to gather any additional information that may be necessary to conduct the investigation. The investigator will

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document all attempts to contact the complainant in the Investigation Summary Report (ISR). If for any reason, the complainant cannot be interviewed, the investigator must communicate this with the field manager and document it in the working papers.

The investigator develops an investigation plan that will include focused interview questions and that protects the complainant's confidentiality and the characteristics of any other complaints or associated individuals. Regulatory requirements that may apply to the complaint and can be cited are also researched prior to the investigator going on-site. If law enforcement must be notified of the allegation, the Field Unit must coordinate a time for both parties to be on-site for the investigation at the same time.

The investigation must be conducted within the priority time frame that is assigned to the complaint. Initiation of the investigation must be done on-site, but if for any reason it has to be conducted by phone, then the investigator is responsible for obtaining prior approval from the Field Manager. Once the investigation has started, the investigator will first introduce themselves as the DSHS investigator and then make observations regarding the allegations of the complaint. To maintain confidentiality of the alleged victim, staff stated that the ICF unit will typically expand the sample of clients who are to be reviewed or will look at multiple areas of concern within the facility, so as not to isolate the complainant or alleged victim. All documentation is required to be kept confidential even if the complainant stated that they do not wish to remain anonymous. The complaint intake form that is sent from CRU is one document that cannot be taken on-site at any time. In most situations, investigators are encouraged to keep the intake forms in their locked vehicles so that they stay secure.

Investigators document their observations in investigator field notes (hard-copy, not electronic), ASPEN (for Nursing Homes and ICF/IID), Facility Management System (FMS); for all other facility types) and TIVA. Information included in TIVA includes the investigator's finding (substantiated, or unsubstantiated) and the status of deficiencies communicated to the facility. Once the investigation is complete, the investigator will then inform the facility administration that they are done and will no longer be on-site. They will also let the facility know what to expect next and provide an approximate timeline for any other actions that need to be completed by the facility.

After completing those steps, the investigator will review and analyze all the data that they received while being on site to determine if the provider failed any practices that they are required to follow. Any enforcement recommendations that are made will be made with the help of the field manager to ensure that the recommendations are adequate for the findings being issued. After this has been completed, the investigator then proceeds to call the facility administrator to let them know about the results of the investigation. They will also call the complainant about the results and that an Investigation Summary Report (ISR) will be drafted and they are able to obtain one if requested.

The investigator will then proceed to draft a Statement of Deficiency (SOD) which must be mailed out to the ICF/IID facility within ten (10) working days of the exit date. Once the SOD has been approved by the field manager, the SOD is mailed to the facility via certified mail within the required time frame. If the complainant asked to be notified of the outcome, the investigator will then check a box noted as "Follow-Up Requested" within the TIVA system so that it generates a Public Outcome Letter and attaches a copy of the ISR along with instructions on how to read the report. Staff stated that the ISR cannot be mailed out until the SOD has been received by the facility and the certified mail notification has been received by the Department. This allows the facility to first be made aware of any citations before the public can be informed. After all

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the required reports and letters have been sent, the next step is to enter all the data into the tracking systems. This includes entering the end dates of the investigation into TIVA. Once that has been completed and all documents have been approved by the field manager, the investigation can be closed out.

### **Nursing Home Process**

We also met with the Nursing Home Unit staff to go over the process for complaint investigations assigned to the Nursing Home Units. We were informed that the intake notification procedures are identical to those in place for ICF/IID complaints. Nursing Home Unit staff are aware of intakes linked to the field units and receive the same electronic notification in TIVA and assign the investigations to staff at their discretion. Staff follow the same process as the ICF/IID unit in assigning investigator information to the intake within the TIVA tracking system.

### **Monitoring Process to Ensure Timelines are Met**

We asked what steps are taken to determine what monitoring controls are in place to ensure Nursing Home and ICF/IID Complaints are followed up in a timely manner. At the headquarters level is a Complaint Backlog report from TIVA. The Complaint Backlog report is prepared monthly by the RCS Business Analysis Unit on the 10th of every month and is shared with the Director of Residential Care Services, the Nursing Home and ICF/IID Office Chiefs, and the Regional Administrators. The management team reviews the reports to identify complaints that have not been assigned to the field, and identifies the shortfalls or circumstances contributing to staff not initiating investigations timely with the Regional Administrators and their Field Managers (**Key Control #4 Control Activities/Monitoring**).

### **Summary of Key Controls**L.5 Investigations

**Key Control #4** (continuation from list under CRU procedures): The Complaint Backlog report is prepared monthly by the RCS Business Analysis Unit and is shared with the Director of Residential Care Services, the Nursing Home and ICF/IID Office Chiefs, and the Regional Administrators. The management team reviews the reports to identify complaints that have not been assigned to the field, and identifies the shortfalls or circumstances contributing to staff not initiating investigations timely with the Regional Administrators and their Field Managers (**Control Activities/Monitoring**).

**Evaluation of Results:** No control deficiencies were identified.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

### **L.6.PRG - ST5 Provider Health and Safety Standards NH**

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**Procedure Step:** Special Test 5 - Provider Health and Safety Standards - NH - Internal Control Identification  
**Prepared By:** CL, 11/18/2022  
**Reviewed By:** RJC, 11/29/2022

## Purpose/Conclusion:

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards - **Nursing Homes:**

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 5 - Provider Health and Safety Standards - **Nursing Homes.**

### **Source:**

Jessica Salquist, Regional Administrator - Region 1  
Kathy Gold, Regional Administrator - Region 2  
Rebecca Kane, Regional Administrator - Region 3  
Amanda Jackson, Compliance and Enforcement Unit Manager  
Yun Yun Lu, Compliance Specialist  
Jennifer Bourgeois, AA  
Vicky Bouvier, Policy Manager  
Molly McClintock, Nursing Home Policy Program Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - Nursing Homes, we assessed preliminary control risk as low.

## Testing Strategy:

### **Step 1: Assess Inherent Risk (IR)**

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### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

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Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as **“LOW”** when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee's internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria:

Record of Work Done:

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - Nursing Home requirements. We identified the following:

*Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the State Plan.*

***Audit Objective*** - Determine whether the state ensures that hospitals, nursing facilities, and ICF/IID that serve Medicaid Patients meet the prescribed health and safety standards.

We reviewed 42 CFR Section 488 and identified the following requirements.

488.308 Survey frequency.

(a) *Basic period.* The survey agency must conduct a standard survey of each SNF (skilled nursing facility) and NF (nursing facility) not later than 15 months after the last day of the previous standard survey

(b) *Statewide average interval.*

(1) The statewide average interval between standard surveys must be 12 months or less, computed in accordance with paragraph (d) of this section.

We reviewed RCS Chapter 7 - Enforcement and found the following relevant information for our understanding.

*Chapter 7B2 - Statement of Deficiencies in NH*

As a part of the enforcement process, the compliance specialist reviews the Statement of Deficiency (SOD) and any supporting documentation



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when making a compliance determination.

### *Chapter 7B3 - Electronic Plan of Correction (EPOC) in NH*

The Department will review the ePOC within 5 working days of receipt and will verify that it is acceptable. The Nursing Home (NH) may specify in the ePOC that they are not in agreement with the findings within the SOD report but this does not alter the NH's responsibility to submit an acceptable ePOC.

We reviewed RCS Chapter 17 - Nursing Homes and found the following relevant information.

### *Chapter 17C10 – Recertification Survey Process*

- Explain the timeline for the CMS-2567 and the Plan of Correction.
- The CMS-2567 will be provided to the facility within 10 working days.
- The facility will have 10 calendar days after the receipt of the CMS-2567 to submit a Plan of Correction.

### *Chapter 17C11 - Recertification Survey Process Off-Hour Surveys*

2. Federal regulations (42 CFR Section 488.307), and the State Operations Manual (SOM), Chapter 8, Section 7207, requires that at least ten percent (10%) of all recertification surveys must be conducted as off-hour surveys and the off-hour surveys must occur on consecutive days. MB Rescinded

## **Understanding of Internal Controls**

### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We met with staff to go over the Survey Process on 10/27/2022 Date.

The Regional Administrator walked us through the ASPEN Central Office (ACO) system which is used to store all survey results for both ongoing and completed surveys, as well as complaint investigations by RCS. We identified links to Statement of Deficiencies (SOD) letters, as well as electronic Plans of Correction (POC), along with the posting dates which are electronically time stamped in ACO once performed by the administrative assistant. We will plan to utilize this information to determine whether SOD letters and POCs were sent out and received from the provider within the required timeframe.

The regional administrator walked us through the survey process.

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## ***Survey Process***

We were able to identify the following four major components of each Nursing Home survey:

- Pre Survey Tasks
- Survey Stage 1
- Survey Stage 2
- After Survey Follow up

The Department utilizes a federal system called ASE-Q to ensure that all required elements of a Nursing Home recertification survey are included in the recertification survey. They then use the LTCSP program to complete the survey which has all required survey elements according to the SOM and CFR. **(Control Activities)**.

## ***Pre Survey Tasks***

This stage begins with the meeting prior to the survey with all team members. Each survey team member installs the "shell file", an electronic blank survey, on their laptop and then they begin their review of the file. The shell file will contain any complaints received in the last five years regarding the specific facility they are preparing to survey. This information is obtained from the ASPEN database. During the pre survey process, the system also generates the entrance letter that is to be provided to the Facility Administrator during the Entrance Conference. This letter indicates specifically the documentation the facility is required to provide to the surveyors within designated time periods (i.e. 1 hour, 4 hours, or 24 hours).

## ***Survey Stage 1***

Once the Surveyors arrive at the facility they organize an entrance meeting with facility administrators and present the entrance letter and documentation requests. Survey teams are generally a minimum of four members and CMS has its survey program set for 4 members, with four shell areas to be uploaded.

The first tasks to be conducted after the entrance includes a tour of the kitchen to inspect for deficiencies as well as a reconciliation of residents to the latest information provided by CMS to ensure the resident count and identity of all residents is known. This information is then synchronized into the LTCSP system to allow the selection of the Stage 1 resident sample. The Census Sample, which is calculated in LTCSP based on the resident population, will usually consist of about 40 current residents (all if there are less than 40 residents in the facility) to be

## State of Washington

interviewed using a questionnaire with 17 categories with at least 33 questions. The system also uses a Minimum Data Set (MDS) to generate a sample of discharged residents (either transferred/released, or deceased) of 30 clients. The surveyors complete the required areas for both samples. If negative responses are received, the survey adapts to ask further questions in these areas. This stage of the survey also includes observation, staff interview, record review, and family interview. Family interviews are done by posting contact information on boards and doors that a survey is in process and anyone wishing to be interviewed should contact the survey team. However, each survey requires at least three family member (or caregiver/fellow resident, if client has no family) interviews to be conducted (regardless of the sample size for the facility).

The Admissions Sample is used to select about 30 residents with either active or closed records to review for the completeness of the records with specific areas to review such as:

- Community discharge
- Death, Hospitalization
- Pressure Ulcers
- Planned Weight Loss
- Weight Loss

A sample of 10 residents is also selected to review pharmaceutical protocols.

Other Mandatory Facility tasks include:

- Dining Observation
- Infection Control & Immunization
- Kitchen/Food Service Observation
- Medication Administration and Storage
- Quality Assessment and Assurance Review
- Interview with Resident Council President/Representative

Non-Mandatory Facility Tasks include (based on sample interviews/complaints and/or previous reports):

- Abuse Prohibition Review

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- Admission, Transfer, and Discharge
- Environmental Observations
- Personal Funds
- Sufficient Nursing Staff Review

At the end of Survey Stage 1, the team will meet once again and sync their laptops so the QIS system can evaluate the responses received by each surveyor. Based on the responses received, and a CMS established threshold for each area, it will outline areas that should be investigated further. If an area did not meet the threshold for further review but the surveyor feels it needs to be reviewed further, the surveyor can pursue the areas based on surveyor judgment. Once again the surveyors sync their survey files and move on to Stage 2, at which point each surveyor uploads the file to their individual laptop.

### *Survey Stage 2*

The system reports provide guidance to the specific areas to be reviewed and the specific residents that need to be interviewed for the completion of the survey. This process will begin as soon as possible and include review of patient records to validate the information received in resident interviews. All the questions are "YES/NO" in the system, with negative responses triggering F-tags (which populate the potential citations portion of the report in the form "F - ###" with the number of the potential exceptions per the survey tool). There is also space for surveyor comments to add specifics in the potential citation field. This is the beginning of the Statement of Deficiencies (SOD), with the surveyor assigning a preliminary level of severity.

After each surveyor has completed this portion of Stage 2, there is a team meeting where all surveyors together review each surveyor's work to ensure there is agreement on the information and the determination for potential citations made. There are two questions asked at this time:

- "Are there any concerns of Immediate Jeopardy?" - If so, STOP the meeting and follow up immediately (Immediate Jeopardy is a situation where non-compliance has caused or is likely to cause serious injury, harm, impairment, or death to a resident.)
- "Are there any situations noted that have the potential to cause harm, or have already caused harm?"

Once all staff have agreed on their survey results, their separate surveys are loaded via thumb drive to be synced to the Lead Surveyor's computer, and a report calculates potential citations which define each area that has exceeded the minimum acceptable threshold for that area (example: National standard is 5%, sample rate is 10%). Each area will be reviewed even if it has not exceeded the threshold, which allows a surveyor to interject judgment if they feel an area should be looked at further, but did not meet the threshold to trigger an investigation. For each area over the threshold or determined to need review, the system will select three residents to interview to confirm the exception.

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After confirmation and reinvestigation, the team will again sync all of their surveys to the Lead Surveyor's computer to provide a final Potential Citation List. The team needs to be in agreement for each potential citation. The team then meets with facility administration and staff to go over the findings to inform them of the potential citations and serve as an exit conference.

### *Investigation of Complaints*

As part of the survey process, the surveyors will also investigate any complaints that were received by RCS' Complaint Resolution Unit. These complaints are assigned based on the priority of the complaint and then sent to the appropriate field manager to be reassigned to the surveyor for the facility. Timeliness of complaint investigations are being reviewed separately for the Medicaid audit, under Special Test #5 - Provider Health and Safety Standards - Complaint Resolution Procedures. To review the State's process for reviewing complaints and priority assignments in further detail (See. ST5 Provider Health and Safety Standards CRU) L.6 Id of IC

### *After Survey Follow Up*

Once exiting with the facility, the last day on site is considered the survey completion date. After the SOD is completed by the survey team, the Team Coordinator will complete the NH Tracking Cover sheet and the survey documents and send to the Field Manager. The Field Manager reviews the cover sheet and the survey documents and sign off on the cover sheet indicating the review to ensure that the surveys are completed accurately and completely. **(Control Activities)**. The team then loads the citations into a Statement of Deficiencies (SOD) template on their laptops, and the completed SOD will be sent to the facility within 10 working days of the end of the survey. The surveyors document deficiencies in the SOD only if the area(s) evaluated by that surveyor resulted in deficiencies. The facility then has 10 calendar days to submit an acceptable Plan of Correction (POC) on the provided Form CMS 2567-L for each of the deficiencies noted. The survey team reviews the POC and makes a determination about the planned correction as to whether it has the potential to correct the deficiency. If so, this agreement will be transmitted to the facility with a specified timeframe for the corrections to be made. If the submitted plan is not deemed acceptable, the facility will be contacted to refile a POC that will adequately address the deficiency. The SOM 7305.1.1(f) states that "an acceptable plan of correction is required in response to deficiencies listed on the Form CMS-2567 and must be received within 10 calendar days of the facility's receipt of the CMS-2567".

If deficiencies are identified during the certification survey, a re-visit will need to occur once the facility submits a Plan of Correction to address the identified issues. QIS is equipped with a post-survey revisit template should RCS wish to conduct an additional compliance visit after the initial survey is concluded. The system requires three residents to be reviewed for each federal citation (CFR) that was not met by the provider during the initial visit.

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## *Tracking Process*

We met with staff on 10/28/2022 Date and proceeded to discuss the process for how the Department ensures that the 12.9 month, 15.9 month and the 10% staggered survey requirements are met due to the finding we issued last year. We determined that the corrective action plan stating that each region and field office unit will establish master survey schedules, and that the Regional Administrators and Office Chiefs will be directed to monitor the scheduled surveys on a monthly basis to meet the statewide federally required averages by the end of the federal fiscal year had not been implemented during SFY22. However due to CMS guidance suspending survey activities, the Department does not have to meet the required federal averages and timelines for FY22. We documented the prior years' process. No weakness identified for FY2022.

### *Timeliness - 15.9 month survey interval; 12.9 month statewide average; 10% staggered survey*

CMS also requires that at least 10 percent of surveys be conducted as "staggered" (started outside of normal business hours) surveys. To meet this requirement, the state must begin some inspections on weekends or holidays, some in the early morning (before 8:00 am), and some in the evening (after 6:00 pm). The Department has observed over a 20% staggered survey rate over the past fiscal year. Each region has a different spreadsheet that they use individually to track staggered surveys to ensure they continue to meet this requirement. RCS is required to report this information in CASPER.

The Department utilizes the 365 day report to ensure that survey timeline requirements are met. The Field Managers and Surveyors stay on top of surveys that are coming due using the projection. Each Field Manager will send their internal tracking spreadsheet to the region manager who then sends their regions 365 average report monthly to headquarters. The Program Manager aggregates all the 365 day average reports sent from the regions and sends to the Office Chief and Regional Administrators for review to ensure the 12.9 month, 15.9 month, and the 10% staggered survey requirements will be met. **(Control Activities/Monitoring)**

The Department has begun using Quicksight from Amazon Web Services to show survey intervals and work in tandem with the 365 day report to track data more precisely. Add info

### *Delivering Statements of Deficiencies and Reviewing Plans of Correction*

The EPOC system tracks each critical deadline in the survey process and can be accessed in real time by the Team Coordinator, Field Manager or anyone else from RCS Management. **(Information/Communication)**. EPOC tracks both the time from the survey to the SOD, and from the SOD received date to the POC date. We noted the system projects the POC due date by adding 10 calendar days to the day the SOD is received by the facility. The Department will only follow up with providers if a POC is not received by the 10th calendar day. They clarified that this almost never happens without advance notice from the facility stating why their plan will be submitted late.

According to Sonya, a notification is received from the ePOC system by the Field Manager and Administrative Assistant for the appropriate field unit once a Plan of Correction is submitted to the Department for review. Field Managers and Administrative Assistants receive an automated notification in Outlook each time a POC is submitted, and the Administrative Assistants notify the survey Team Coordinators of which facility the

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POC is ready for review. The Administrative Assistant will generate weekly SOD reports for their Field Manager for review. The Field Manager reviews and then addresses any delinquent SODs and ensures SODs and POCs are mailed within the appropriate timeframe.

Surveyors must complete the training described on the RCS Staff Orientation Checklist (See: [Staff Orientation ChecklistMissing Attachment](#)) before they are qualified to conduct surveys beyond a training capacity. These trainings include understanding the CMS 2 day and 10 day timelines laid out in the SOM. The ePOC system automatically notifies surveyors of SOD/POC timelines, and staff are trained by the department to ensure that notifications are followed and timelines are met. **(Control Activities)**. Managers use this training to ensure surveyors are aware of timeliness requirements in conjunction with ePOC notifications.

Survey teams document their review of the Plan of Correction for appropriateness using a standardized review form. Each team member must date next to their name when completing the review, and if a particular tag is not sufficiently addressed by the facility's responsive action, the surveyor must note the reason(s) why and request the Team Coordinator to concur so that a new POC can be requested from the facility. Teams work with the facilities to resolve corrective action issues and achieve compliance, notifying CMS after 60 days have passed from the survey exit date, if the issues have not been resolved. In extreme cases, CMS will work with the provider and the Department to determine the extent of the outstanding noncompliance and come up with an agreeable solution to resolve the issues.

### **Summary of Key Controls:**

**Key Control #1:** The Department utilizes a federal system called ASE-Q to ensure that all required elements of a Nursing Home recertification survey are included in the recertification survey. They then use the LTCSP program to complete the survey which has all required survey elements according to the SOM and CFR. **(Control Activities)**

**Key Control #2:** The Field Manager reviews the cover sheet and the survey documents and sign off on the cover sheet indicating the review to ensure that the surveys are completed accurately and completely. **(Control Activities)**

**Key Control #3:** The Program Manager aggregates all the 365 day average reports sent from the regions and sends to the Office Chief and Regional Administrators for review to ensure the 12.9 month, 15.9 month, and the 10% staggered survey requirements will be met. **(Control Activities/Monitoring)**

**Key Control #4:** The ePOC system automatically notifies surveyors of SOD/POC timelines, and staff are trained by the Department to ensure that notifications are followed and timelines are met. **(Control Activities)** [Lets update these controls](#)

**Evaluation of Results:** No control deficiencies were identified.

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## **Preliminary Control Risk Assessment**

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## **L.7.PR.G - ST5 Provider Health and Safety Standards DOH Surveys**

*Procedure Step:* Special Test 5 - Provider Health and Safety Standards -Hospital Surveys - Internal Control Identification

*Prepared By:* SNK, 1/9/2023

*Reviewed By:* SAG, 5/8/2023

Purpose/Conclusion.

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 5 - Provider Health and Safety Standards-**Hospital and HHA Surveys**.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 5 - Provider Health and Safety Standards - **Hospital and HHA Surveys**.

### **Source:**

Jeff Arbuckle-External Audit Manager

Rodel Carlos-Performance and Case Management Administrator

Sara Moriarty-Operations and Case Management Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 5 - Provider Health and Safety Standards - Hospital and HHA Surveys, we assessed preliminary control risk as low.

Testing Strategy.

## **Step 1: Assess Inherent Risk (IR)**



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### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: States are required as part of their Medicaid State Plans to maintain a MFCU, unless the HHS Secretary determines that a MFCU would not be cost-effective.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

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Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria:

Record of Work Done:

## **INHERENT RISK OF NONCOMPLIANCE**

### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

## **Gather Information**

### **Step 2**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - Hospital & HHA Survey requirements. We identified the following:

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and available program guidelines to determine the Special Test 5 - Provider Health and Safety Standards - Hospital & HHA Survey requirements. We identified the following:

### **State Plan:**

#### **4.11 Relations with Standard-Setting and Survey**

##### **Agencies**

(a) The State agencies utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients as contracted by the Centers for Medicare and Medicaid Services (CMA). These agencies are: the Department of Social and Health Services and the Department of Health.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients are: the Legislature, State Board of Health, State Fire Marshall, the Department of Social and Health Services, and the Department of Health.

(c) Attachment 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Center for Medicare and Medicaid Services on request.

#### **4.11 Relations with Standard-setting and Survey Agencies – continued**

(d) The Department of Social and Health Services is the state agency responsible for licensing and surveying long-term care health institutions and

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determines if institutions and agencies meet the requirements for participation In the Medicaid program. The requirements in 42 CFR 431.610(e)(f) and (g) are met.

(e) The Department of Social and Health Services is the state agency responsible for surveying and certifying ICF/IID facilities. The requirements in 42 CFR 483.400 through 483.480 and 42 CFR 440.150 are met.

(f) The Department of Health is the contracted survey agency for the Centers for Medicare and Medicaid (CMS) to survey non- long- term care health institutions and to make recommendations to CMS that a facility meets the federal Medicare requirements according to the State Operations Manual and the Mission and Priority document (published yearly) for participation in the Medicare program. The requirements in 42 CFR part 431.610 (e) and (f) are met.

Additionally, Attachment 4.11-A in the State Plan:

The standards specified in paragraphs (a) and (b) on Page 42 of the Plan are as follows:

A. General Hospitals                      Centers for Medicare and Medicaid Services (CMS)  
State Manual and Mission and Priority Document

Surveys are conducted by the Department of Health (DOH), Health Systems Quality Assurance Division in accordance with the Mission and Priority document published annually by CMS.

At the request of and funded by Medicare as specified in the Mission and Priority document, DOH's Health Systems Quality Assurance Division surveys facilities participating in the Medicare program. The surveys satisfy Medicare requirements as to survey frequency, content, scope, and documentation, and meet the standards and conditions of participation for contracted hospitals in both Medicare and Medicaid programs established by 42 CFR 482.

The Health Systems Quality Assurance Division conducts Medicare qualifying surveys on a schedule that meets criteria established by the Centers for Medicare and Medicaid Services (CMS).

Other agents having deemed status from CMS for performing Medicare hospital surveys, such as the Joint Commission, are deemed agents for Medicare surveys.

## Part 4 of the Compliance Supplement:

### 5. Provider Health and Safety Standards

**Compliance Requirements** Providers must meet the prescribed health and safety standards for hospital, nursing facilities, and ICF/IID (42 CFR part 442). The standards may be modified in the state plan.

**Audit Objectives** Determine whether the state ensures that hospitals, nursing facilities, and ICF/IID that serve Medicaid patients meet the prescribed health and safety standards.

#### **Suggested Audit Procedures**

- a. Obtain an understanding of the state plan provisions that ensure that payments are made only to institutions that meet prescribed health and safety standards.

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b. Select a sample of providers who received payments for each provider type (i.e., hospitals, nursing facilities, and ICF/IID) and ascertain if the SMA has documentation that the provider has met the prescribed health and safety standards.

### Program Background:

The Washington State Department of Health (**DOH**) is responsible for ensuring that providers and health facilities are properly credentialed in order to render health care services furnished under Medicaid. The Office of Health Systems Oversight (**OHSO**) within the Department is responsible for ensuring that all hospitals and Home Health Agencies (**HHAs**) that receive Medicaid funding are surveyed for compliance with federal health and safety requirements at regular intervals.

Based on the FY20 Mission & Priority Document, which outlines the federal survey requirements to States for various facility types that participate in Medicare & Medicaid, the Centers for Medicare & Medicaid Services (**CMS**) requires that all hospital facilities receive a survey no less than every 5 years. HHAs are required to be surveyed no less than every 36.9 months. In addition, CMS requires that States survey at least 1, but not less than 5% of the non-deemed hospitals, 5% of the non-deemed psychiatric hospitals and 5% of non-deemed Critical Access Hospitals (**CAHs**) in the State, selected by the State based on State judgement regarding those most at risk of providing poor care. *Note: CMS sets prioritization for survey activities and assigns them into four priority tiers. The Mission & Priority Document explicitly states that States must assure that higher tiered work will be completed as a pre-requisite to planning for subsequent tiers. However, it is not necessary to complete the higher tiered work before beginning work on a lower tier.*

The Department informed us that there are some hospitals that are surveyed by an Accreditation Organization (**AO**) instead of by the Department. Choosing an Accreditation Organization is voluntary and not required for Medicare certification. AO's must demonstrate the ability to meet or exceed the Medicare conditions of participation/coverage as cited by the appropriate Code of Federal Regulations. The codes set forth procedures for reviewing and approving national accreditation organizations that request recognition as providing reasonable assurance that its standards meet or exceed Medicare conditions.

If a hospital is certified by an AO, the **hospital** is responsible for ensuring that its surveys are completed within the required time frame, not DOH. The Department stated that hospitals would not lose their state license for not completing their survey within the required time frame.

We have elected not to test hospital facilities with a "deemed" status as the AOs that survey these entities report directly to CMS on their observations and do not communicate this information to Department of Health. Additionally, the Department is not required under the State Operations Manual, Appendix A, nor does it state in Washington's Title XIX Medicaid Plan that the Department will oversee these AO surveys to ensure compliance with federal survey requirements.

### Understanding of Internal Controls

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

During the FY21 audit of this area, we asked the Department for their internal controls. The Department has confirmed that their controls were the same for FY22 as detailed below:

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A meeting was held on September 29, 2022 to gain an understanding of how the agency manages Hospital and Home Health Agency (HHA) surveys. The following were in attendance:

- Jeff Arbuckle-External Audit Manager
- Rodel Carlos-Performance and Case Management Administrator
- Sara Moriarty-Operations and Case Management Manager

Non-deemed Hospital and Home Health Agency Surveys - The survey process for non-deemed hospitals that are certified and monitored by the Department:

Each hospital survey team includes both experienced nurses and public health advisors. Nurses are responsible for assessing the clinical aspects of the hospitals and the public health advisors are responsible for inspecting the physical aspects for environment of care issues.

In addition to these surveys, the Department coordinates survey scheduling with the state fire marshal to inspect for fire, life, and safety standards. Both types of surveys are required to be unannounced to the hospital and home health agencies. The team lead begins the process by completing the pre-survey activities such as verifying that the facility's license is up to date in the Integrated Licensing and Regulatory System (ILRS) licensing system, checking for complaints received about the facility since the last visit was conducted, and determining whether the facility has either modified their business plan or have elected to change their "non-deemed" Medicaid status.

Since the survey process is the same for both Home Health Agencies (HHA) and Hospitals, once the Department has received the CMS Mission & Priority (M&P) document, see FY2022 CMS Mission and Priority for the current federal fiscal year, both the hospital survey and HHA survey managers sit down to determine what surveys need to be completed during the upcoming fiscal year. To determine which surveys need to be completed within the required time lines, survey managers will first pull a report that is generated from the ASPEN Central Office system that details the last survey date for each of the non-deemed facilities. An ASPEN report is reviewed on a monthly basis by the manager so that the manager can sit down with surveyors and work on the survey schedule for the next two months (Monitoring). The schedules are posted in an Excel spreadsheet on the team's shared drive for review. In an Excel spreadsheet that details the facility name and last survey date, the manager will categorize the facilities by which tier they fall under on the table from the M&P document.

They also run quarterly reports from ASPEN and ILRS to show facilities that have transferred to "non-deemed" status during the previous fiscal year. The Department stated it is the responsibility of the Accrediting Organization for facilities transferring to "non-deemed" status to notify CMS who will then notify DOH that they will be responsible for certification. This is to ensure that DOH has accounted for all facilities that it is responsible for surveying. Managers are responsible for developing a team schedule and assigning surveyors to survey teams to complete in the scheduled month.

OHSO staff confirmed that the Survey Managers compile the data into a spreadsheet called the Mission & Priority Scheduling Spreadsheet and create a projection which outlines the "drop dead" date on which the next survey must be completed (**Key Control #1 - Monitoring**). The data is pulled from the "Next examination due report" which outlines both licensing and Medicare/Medicaid survey dates for the facilities. This "drop dead" date is used to project the last day that DOH has to complete the survey for that particular facility. For HHAs, the calculation drop dead date is set to exactly 36 months to ensure that all surveys are completed well before the 36.9 month requirement. Each year, for hospital surveys, CMS outlines 4 separate tiers for performance measures to be met by the

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State, however the federal requirement prevailing in all states is that surveys occur no more than 5 years apart, so we will focus on this for control and compliance testing.

Per CMS' website, "CMS develops Conditions of Participation (**CoPs**) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries." We determined the CoPs are a critical element to ensuring that Hospitals and HHAs are meeting the Health and Safety Standards. Survey teams use a checklist to indicate that all conditions of participation were reviewed during hospital surveys. (**Key Control #2 - Control Activities**) HHA surveyors complete the HHA Survey and Investigation Worksheet to document their review of the conditions of participation. (**Key Control #3 - Control Activities**)

Once the surveyors have completed their survey work at the facility, an exit conference is held with facility management to discuss issues found. Rodel explained that some of the issues that can be found are often due to unavailability of data including resident records or other information while conducting the visit. In these instances, the Department allows the provider up to 72 hours to provide additional information for consideration that may alleviate the surveyor's concerns. This is referred to as the "Post-Survey Data Collection Period," and CMS allows for the Department to begin this process if the Department feels it is necessary prior to drafting a written assessment to the facility. The Mission & Priority Document, as well as the State Operations Manual (SOM) Appendix A require that the Department prepare a written Statement of Deficiencies (**SOD**) to document any citations of noncompliance discovered during the survey, and send this SOD to the provider via mail or e-mail. The SOD certifies in writing that the Department is citing the facility for violations with federal health and safety requirements and stipulates that corrective actions must be taken to address the violations.

Since the survey team can have any number of surveyors, depending upon how many areas and patients are reviewed as part of the survey, there can be many citations. Each surveyor's observations and citations are sent to the survey lead, who combines all the citations to make one SOD. The survey lead will send the draft to a team member for peer review. Once the peer review is completed, and the team has reached a consensus regarding the issues found, a draft SOD is forwarded to the Manager for their final review. The Manager verifies the deficiencies described in the SOD are assigned the appropriate citation tags, the information is presented clearly and accurately, and that all deficiencies are adequately supported by surveyor observations. Once this is done and no concerns remain from the manager, a final copy of the letter is sent by the survey lead to the facility. The Department is allowed 10 working days from the final day of data collection to issue the SOD to the facility. For Hospitals, the lead surveyor and the survey manager compare the submission dates in the Integrated Licensing Resource System (**ILRS**) to the dates on the draft Statement of Deficiencies (**SOD**) to ensure they are meeting federal time lines for mailing the SOD (**Key Control #4 - Monitoring**). The HHA manager tracks the due dates for SOD on the HHA Survey Tracking Tool to ensure they are meeting federal time lines for mailing the SOD (**Key Control #5 - Monitoring**).

Federal requirements mandate that the SOD (also referred to as CMS-2567) be included with a cover sheet in the documentation, and the provider is asked to provide an acceptable Plan of Correction (**POC**) to the Department within 10 calendar days of receiving the SOD. DOH also stated that when a POC is not received by the 10th calendar day from the provider, the manager contacts the provider to determine why a plan has not been provided. The Department did state that sometimes facilities provide POC's that do not adequately address the issues reported, and DOH has to send a rejection letter and request another POC be completed. CMS also allows a maximum of 70 days from the survey completion date to resolve outstanding issues before Medicaid decertification can be initiated.

Reviews of Plans of Correction happen at the team level first. The survey team reviews the facility's Plan of Correction (**POC**) and documents the results of its

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review in a letter to indicate whether the Plan meets all minimum required elements of an acceptable plan (per CMS guidelines) (**Key Control #6 - Information and Communication**). If the plan is rejected, DOH will inform the provider that its POC does not meet the Department's minimum requirements for an acceptable plan and states the reason(s) for the decision. The provider must then re-submit a POC within the time frame stipulated by the Department. CMS encourages the Department to work with the providers as much as possible to resolve the deficiencies and requires this be done within 70 calendar days of the survey completion date. DOH contacts CMS if no resolution can be reached so that CMS may determine the appropriate course of action with regard to the facility's Medicaid certification status.

### Summary of Key Controls:

**Key Control #1:** The survey manager uses the "CMS Mission and Priority Document" to determine frequency of surveys the state agency is responsible for conducting during the federal fiscal year. Based on the MPD survey frequency, the survey manager tracks all non-deemed facilities required to have a survey on a spreadsheet.

Hospitals - **Key Control #2:** The team coordinator, who is responsible for ensuring all survey activities are completed per SOM, use a checklist to indicate that all conditions of participation were reviewed.

HHAs - **Key Control #3:** Each surveyor completes the HHA Survey and Investigation Worksheet, which follows the SOM tiered review requirements, to document their review of the conditions of participation for each Home Health Agency.

Hospitals - **Key Control #4:** The lead surveyor and the survey manager compare the submission dates in the Integrated Licensing Resource System (ILRS) to the dates on the draft Statement of Deficiencies (SOD) to ensure they are meeting federal time lines for mailing the SOD.

HHAs - **Key Control #5:** The HHA manager tracks the due dates for SOD on the HHA Survey Tracking Tool to ensure they are meeting federal time lines for mailing the SOD.

**Key Control #6:** The survey team reviews the facility's Plan of Correction and document the results of its review in a letter to indicate whether the Plan meets all minimum required elements of an acceptable plan (per CMS guidelines).

### **Evaluation of Results:**

We did not identify any control deficiencies.

### Preliminary Control Risk Assessment

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing below to determine if we can place reliance on the controls.

### M.1.PR.G - ST6 Medicaid Fraud Control Unit (MFCU) HCA

*Procedure Step:* Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls



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**Prepared By:** KWF, 3/30/2023

**Reviewed By:** SAG, 4/19/2023

### Purpose/Conclusion:

**Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 6 - Medicaid Fraud Control Unit (MFCU): Fraud Referrals.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 6 - Medicaid Fraud Control Unit: Fraud Referrals.

**Source:**

Carrie Bashaw, Senior Counsel (ATG)  
Betty Fraser, Accounting Supervisor (ATG)  
Melanie Griffith, Lead Support (ATG)  
Melanie Nevares, Accounting Director (ATG)  
Amanda Seaunier, Fiscal Analyst (ATG)  
David McDonald, Fiscal Examiner (ATG)  
Hana Nguyen, Accounting-Financial Analyst (ATG)  
Kari Summerour, External Audit Manager (HCA)  
Scott Best, Clinical Review Section Manager (HCA)  
Susan Williams, Audit Investigations Unit Supervisor (HCA)  
Sally Riley, Fraud Coordinator (HCA)

**Conclusion:**

Based on our understanding of internal controls over Special Test 6 - Medicaid Fraud Control Unit, we assessed preliminary control risk as LOW.

### Testing Strategy:

## Step 1: Assess Inherent Risk (IR)

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### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: States are required as part of their Medicaid State Plans to maintain a MFCU, unless the HHS Secretary determines that a MFCU would not be cost-effective.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

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Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria:

Record of Work Done:

## **Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls**

### **Inherent Risk of Noncompliance**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

### **Gather Information**

#### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement, and any available program guidelines to determine the Special Test #6 Medicaid Fraud Control Unit (MFCU) requirements. We identified the following, "States are required as part of their Medicaid state plans to maintain a MFCU, unless the HHS secretary determines that a MFCU would not be cost effective. States must have an agreement between the MFCU and the SMA, which includes methods of coordination and procedures for referring potential fraud, including potential fraud arising in managed care networks." This agreement can be seen at ([Understanding Memo Between HCA and MFCD](#)). [M.1 ST6 Id of IC](#)

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

On August 9, 2022, we met with the following Medicaid Fraud Control Division (MFCD) staff at the Attorney General's Office who oversee fraud investigations and recoveries as the WA state MFCU:

- Carrie Bashaw, Senior Counsel
- Betty Fraser, Accounting Supervisor
- Melanie Griffith, Lead Support

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- Melanie Nevares, Accounting Director
- Amanda Seaunier, Fiscal Analyst
- David McDonald, Fiscal Examiner
- Hana Nguyen, Accounting-Financial Analyst

During this meeting, we discussed how settlements and recoveries are processed, including how they are reported to the Health Care Authority (HCA).

Generally, Managed Care Organizations (MCOs) notify HCA of potential fraud cases. While financial fraud cases come mostly from HCA, they could come from the Department of Social and Health Services (DSHS) as well. Their intake teams review these cases before the referrals are sent to MFCU. Once MFCU receives these referrals, they determine if they will pursue the case or not by taking multiple factors into account. These factors include - but are not limited to - the dollar amount and materiality of the occurrence; the details and substance of the case; the current bandwidth of the team to review cases based on the amount of cases currently open.

Once a verdict has been given on a case in court, the process for recovery is different for MFCU depending on the type of settlement:

- Criminal Restitution: If the recovery type is criminal restitution, the court order from the presiding judge is sent to DSHS, where the Office of Financial Recovery (OFR) manages them. MFCU sends DSHS any additional materials they might need to assist with the recovery process.
- Global Settlements/Resolutions: Global settlements occur when the defendant must pay multiple governments. According to Carrie, 29 states (including Washington), Washington D.C., and the federal government participate in the global settlements program. Each entity has their own rules, but many of their core rules are the same. The defendant includes all governments' shares of payment in one check to the New York District Attorney's Office. Eventually, WA, along with all other governments will get their share from NY.
- In-State Settlements: There are some in-state settlements that include federal portions. In those cases, when the federal government was a partner in the investigation, the check is sent to the NY Attorney General's Office. Otherwise, the check will be sent directly to the WA Attorney General's Office. We noted that the federal government is not a partner in every investigation, as they will generally not be involved in smaller cases by their determination. Once a check is received by the WA Attorney General's Office, David McDonald will determine the correct Federal Medical Assistance Percentage (FMAP) allocation and account for it properly.

According to Hana Nguyen, in the first week of every month, a reconciliation is done for all the money received in the prior month (Control Activities). The money is classified as state or federal and a Journal Voucher (JV) is processed. A payment for the federal funds is then sent to HCA along with an email to Cheri Wright, Medicaid Accounting Manager (HCA) to inform them of the payment. (Control Activities) Although HCA has a year to reimburse the payment to the federal government, they will generally reimburse on a quarterly basis. Checks that are sent don't always clear quickly, so Dawn Wiesner (ATG) makes sure the accounting data in the reconciliation is accurate.

On August 18th, 2022, we held an initial understanding meeting with the following Health Care Authority staff for purposes of identifying key controls over the process of referring allegations of credible fraud to the MFCU:

- Kari Summerour, External Audit Manager
- Scott Best, Clinical Review Section Manager

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- Susan Williams, Audit Investigations Unit Supervisor
- Sally Riley, Fraud Coordinator

Staff first explained that all leads of potential Medicaid fraud are the responsibility of the Program Integrity Unit and that leads may come into the division from a variety of sources, but that they are all funneled through their HotTips centralized database/interface. Sources of leads include by are not limited to email, program integrity audits, quality management reviews, Medicaid Service Verifications (MSVs), program staff or managers, data mining, or performance of trend analysis to identify outliers.

The Intake Coordinator is responsible for continuously monitoring leads coming in through HotTips and when a lead is received, the Intake Coordinator first inputs the information provided and documents the lead details within a fraud tracker spreadsheet (Control Activities). Sally explained that leads are not specific to only provider frauds and can include client, provider, contractor, staff and other frauds, but that only provider frauds are required to be referred to the MFCD. Each Monday, a planning meeting is held which includes the intake team and coordinator: Sally, Rhonda, Susan, and at least one member of the Clinical Review Unit (CRU). The weekly Monday planning meeting's purpose includes a variety of topics, but the agenda always includes, if applicable for the week, time to discuss fraud leads received. Once all items are reviewed, the draft referral(s) are added to the agenda to be discussed at the weekly Case Management Team (CMT) meetings held on Wednesdays.

On each Wednesday, CMT will review fraud leads to determine if a referral is the appropriate next step. They will also determine if another location would better suit the lead, such as being sent to Audit and Accountability or another state agency. We then asked if the Authority has any written criteria or matrix for deciphering whether a lead is a potential fraud and if they had a definition or standard of the word "credible" and they explained that they do not. Susan said that the review is more general in nature, as each potential case is unique, therefore there is no specific criteria that they utilize in making a determination as to whether a lead may be a credible fraud allegation. If a lead is determined credible, a Fraud Referral Form is completed by the fraud team and submitted to the Section Manager for review and approval **Key Control 1 (Control Activities/Monitoring)**. If the Fraud Referral Form is approved, the fraud team then submits it to MFCD. Once a referral is sent to MFCD, they decide if they will pursue the referral. If they pursue, Sally tracks the progress of the referral in a spreadsheet, making updates as they are received from MFCU (**Key Control 2 - Control Activities**). If MFCD decides it will not pursue a referral, because it will not stand in criminal court, they will refer it to a civil unit and inform CMT.

On September 7, 2022 we met with the following HCA staff to discuss how HCA ensures the federal portion of fraud settlements are reported as a credit on CMS-64 timely:

- Dan Ashby, Accounting Section Manager
- Cindy Raves, Internal Auditor
- Kari Summerour, External Audit Manager

During this meeting, Dan explained that they rely on the process they have coordinated with MFCD, which is that as soon as a settlement is reached, MFCD will let HCA know. Once HCA understands what the federal portion of the settlement is, Dan discusses with Cheri Wright, Medicaid Accounting Manager, whether

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or not to return the full amount, as some or all of the federal portion may have already been sent. Once HCA knows the correct federal portion to return, accounting staff prepares a journal voucher, which is reviewed and approved by Dan (**Key Control 3 - Control Activities**). It is reported on the CMS-64 utilizing a feeder form. As the settlement payments come in, they return the federal portions in the same quarterly period, well within the required 1-year time frame. Dan mentioned that he has been working on a procedures briefing paper that discusses the needs regarding fraud reporting and the process to accomplish these needs.

On September 7, 2022 we met with the following HCA staff to discuss the reporting of fraud overpayments on the CMS-64:

- Jill Arlow, Federal Reporting Manager
- Cindy Raves, Internal Auditor
- Kari Summerour, External Audit Manager

During this meeting, Jill stated the Form CMS 64.9C1 feeder form is used to provide detail about the fraud, waste and abuse collection efforts and flows into line 9c of the Form CMS 64. Jill mentioned that items related to the Medicaid Fraud Control Unit (MFCU) are reported on lines 9C1 and 9C2. The Form CMS 64.9O feeder form that flows into line 10c of the Form CMS 64 is used to provide detail about overpayments that have been identified but not yet collected. Jill explained that during the CMS-64 report preparation process, overpayments are identified in the AFRS data based on specific coding (combination of allocation code and program index), and if the amount is a negative, it is returned to the feds and reported on the CMS-64 each quarter. This coding automatically identifies the federal/state split from the total computable amount reported. The items processed through MOMS are reported on line 10c. We separately reviewed this overpayment process at [ST7 Overview](#).

Federal Financial Report (FFR) Staff will go into the WEB-based Medicaid and CHIP Budget and Expenditure System (MBES) to input the information from the system generated report into input sheets. After creating the quarterly report, staff will reconcile the summary reconciliation against the report and AFRS data to ensure it is accurate and complete. Once the claim is entered, all information has been input into MBES, and everything reconciles, FFR staff will inform Jill that the report is complete. The FFR Staff will provide Jill with the supporting documentation so that she can review the report to ensure that it is accurately completed. Jill will do spot checks on selected entries and ensures all forms are complete. She verifies each line item to ensure that the totals input on the report match the ones from the AFRS report as well as the mapped data report. She also checks to see that certain audits were performed and corrections from any prior submittals were completed. Once Jill has completed her review and determines that there are no errors, she will certify the CMS-64 report in MBES since she is the one that has that authority (**Key Control 4 - Control Activities/Monitoring**).

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On April 3, 2023, we met with the following MFCD staff at the Attorney General's Office to discuss the their interpretation of the compliance requirements:

- Carrie Bashaw, Senior Counsel
- Melanie Nevares, Accounting Director
- Bill Stephens, Senior Counsel
- Larissa Payne, Division Chief

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- Matt Kuehn, Managing Assistant Attorney General

When we inquired about how MFCD notifies the provider or HCA in writing prior to administrative or judicial proceedings (final written notice per 42 CFR 433.304 and 42 CFR 433.316), Carrie informed us that they do not give a written notice to the provider specifying an overpayment amount, although internally they have determined an amount that they believe was overpaid. Instead, they give the provider a ballpark figure of what they could stand to lose in trial in order to begin negotiations. If negotiations fail, MFCD's next step is to file legal action. Additionally, when a case is filed, MFCD is not required to disclose a dollar amount they are seeking judgement for, and they generally opt not to. For civil cases, they are only required to reference that they paid money to a defendant, but do not have to specify an amount. For criminal cases, they are only required to assert that they are seeking over \$5,000 and this is generally what they do. This is because if they provide a dollar amount they are seeking, it is difficult to seek more if new information comes to light during the trial, and they do not want to be potentially locked into a lower judgement amount than what they otherwise could obtain by not specifying an amount. When we inquired if they provide written notice to HCA of intent to file a court case, Carrie responded that they do not, but they will generally either discuss it verbally in a meeting or simply update a spreadsheet which tracks the status of investigations. More specifically, usually every 2-3 weeks, once a month at minimum, MFCD will meet with HCA to discuss progress investigation status and update their tracking spreadsheet. At one time they used to use emails, but found that meetings were easier and now continue with that method of communication. When asked if there were any policies or procedures around this process, she said there is not. She went on to say that once a case is filed, it is public record, so anyone, including HCA can view the details.

Carrie informed us that MFCD will not provide a written notice specifying an overpayment amount to the provider until a judgement has been determined in court. This is what they believe to be the final written notice. They do this because, although they have an overpayment amount that they have determined internally, they do not feel this is necessarily the correct amount until final judgement has been decided in court. She also asserted that the process is similar for all US states and territories.

## **Referrals:**

**Key Control 1 (Control Activities/Monitoring)** - Fraud Team members review leads, complete investigations and if a lead is determined credible, submit a Fraud Referral Form to the Section Manager for review and approval. M.1 ST6 Id of IC

**Key Control 2 (Control Activities)** - A Fraud Team member submits Fraud Referral Forms approved by the Section Manager to MFCU and the Fraud Coordinator maintains a spreadsheet to record and track the status of referrals.

## **Reporting:**

**Key Control 3 (Control Activities)** - The Medicaid Accounting Manager reviews the JV and the settlement agreement and supporting documents to ensure the coding is correct and the federal overpayment amount is correct.

**Key Control 4 (Control Activities/Monitoring)** - The HCA Federal Accounting and Reporting Manager reviews the quarterly CMS-64 report and its supporting documents to ensure that the CMS-64 is properly prepared before certifying the reports.

## **Evaluation of Results:**



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We did not identify any control deficiencies.

## **Preliminary Control Risk Assessment**

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## **M.2.PRG - ST6 Medicaid Fraud Control Unit (MFCU) ALTSA**

***Procedure Step:*** Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls

***Prepared By:*** SNK, 11/16/2022

***Reviewed By:*** RJC, 11/30/2022

Purpose/Conclusion.:

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 6 - Medicaid Fraud Control Unit.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 6 - Medicaid Fraud Control Unit.

### **Source:**

Cheryl Timmons, DSHS HCS Program Integrity Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 6 - Medicaid Fraud Control Unit, we assessed preliminary control risk as low.

Testing Strategy.:

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### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: States are required as part of their Medicaid State Plans to maintain a MFCU, unless the HHS Secretary determines that a MFCU would not be cost-effective.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably*

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*addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal***

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***controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria:

Record of Work Done:

### **Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls**

#### **Inherent Risk of Noncompliance**

##### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

#### **Gather Information**

##### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Medicaid Fraud Control Unit (MFCU) requirements. We identified the following:

States are required as part of their Medicaid State plans to maintain a MFCU, unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement.

**Audit Objective** - To determine whether the State ensures suspected criminal violations are referred to an office with authority to prosecute cases of provider fraud.

#### **Understanding of Internal Controls**

##### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

Based on review of the policies, procedures, information request responses and internal control letter responses, we determine ALTSA has not had any changes to the fraud referral process from SFY21. We received the above listed documents on 9/22/2022 from Laura Holloway and Cheryl Timmons. In addition, we confirmed no changes took place on 11/9/2022 when we met with ALTSA staff.

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We gained an understanding of the Medicaid Fraud Control Unit referral process. The process of referring credible allegations of fraud to the State's MFCU is handled by DDA Central Office and ALTSA Program Integrity Unit. The administration relies on the case managers and field staff to help identify suspected provider fraud because they have the most knowledge regarding the client/provider situations as well the main contact when any suspicious activities occur.

Before a referral is made to the Administrations, a preliminary review is conducted by field staff to determine whether there is credibility to the claim and whether fraud is involved. As part of the preliminary review, the field staff may gather more information by talking to the client, requesting the provider's time sheets/records of services provided to review and confirm care plan and compare it to what is being delivered, review invoices, staff logs, etc and review the provider's contract file for relevant information. The field staff will then go to their immediate supervisor and together they will determine if there are other actions that should be taken before the referral is made. If the supervisor identifies indicators that would support the conclusion that the allegation is credible, then they proceed with the referral. They will submit the referral to a Regional Payment Specialist. After the payment specialist has reviewed the referral and supporting documents, they will forward the complete referral to submit the referral to ALTSA via the ADSA in box.

After the referral has been received, Cheryl at ALTSA will review the referral and its supporting documentation to determine if any additional information is needed from the field staff, since the referral must have enough supporting documentation to ensure that it can be a credible allegation for investigation before it is referred to MFCU. Once Cheryl determines that the allegation is credible, then she will proceed to look in the Comprehensive Assessment Reporting & Evaluation (CARE) system to review case notes for any past issues that may have been reported regarding the provider. **Key Control # 1- All allegations are reviewed by Cheryl Timmons, Program Integrity Manager (ALTSA) prior to being submitted to MFCU (Control Activities/Monitoring).**

Once Cheryl determines the allegation should be referred to MFCU, she completes the Medicaid Provider Fraud Referral and attaches the documentation received from the field which is then emailed to MFCU. She then saves the documentation on the appropriate share drive. Once the referral has been made to MFCU, the case manager and/or field worker will be notified that the referral was made. The initial email that was sent from the field staff with the referral is moved over to the in box labeled "Referred to MFCU/OFA." The referral will be added to the Sharepoint tracking system with documentation attached.

When a response from MFCU is received on a case that was submitted, a brief description of the response is then entered into the Sharepoint site and a copy of the email is attached. If MFCU decides not to proceed with the referral because it will not stand up in criminal court, the referral will be referred over to a civil unit and MFCU will communicate this outcome to the Administration. Once the Administration receives the denial, they will update the status of the referral to declined on the sharepoint site. If MFCU accepts the referral for further investigation that decision will be communicated to the Department and Sharepoint will be updated accordingly. **Key Control # 2- The Administration uses an online tracking system for all referrals that are made to MFCU (Control Activities/Monitoring)**

**Evaluation of Results:** No control deficiencies were identified.

### Summary of Identified Key Controls

**Key Control # 1-** All allegations are reviewed by Cheryl Timmons, Program Integrity Manager at ALTSA prior to being submitted to MFCU (**Control Activities/Monitoring**).

**Key Control # 2-** The Administration uses an online tracking system for all referrals that are made to MFCU (**Control Activities/Monitoring**)

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## **Preliminary Control Risk Assessment**

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## **M.3.PR.G - ST6: Medicaid Fraud Control Unit (MFCU) DDA**

***Procedure Step:*** Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls

***Prepared By:*** SNK, 12/21/2022

***Reviewed By:*** RJC, 5/18/2023

Purpose/Conclusion.*
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 6 - Medicaid Fraud Control Unit:

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 6 - Medicaid Fraud Control Unit.

### **Source:**

Amy Hoogendoorn-Individual Provider Payment Program Specialist  
Joshua Church-Payment Systems and Eligibility Unit Manager  
Geoff Nisbet-Audit Liaison and Public Records Unit Manager

### **Conclusion:**

Based on our understanding of internal controls over Special Test 6 - Medicaid Fraud Control Unit, we assessed preliminary control risk as low.

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Testing Strategy:

### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the **Inherent and Internal Control Risk Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

Compliance Requirements: States are required as part of their Medicaid State Plans to maintain a MFCU, unless the HHS Secretary determines that a MFCU would not be cost-effective.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness*

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*likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with***



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***control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria:

Record of Work Done:

### **Special Test 6 -Medicaid Fraud Control Unit (MFCU) - Identification of Key Internal Controls**

#### **Inherent Risk of Noncompliance**

##### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at LOW.

#### **Gather Information**

##### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Medicaid Fraud Control Unit (MFCU) requirements. We identified the following:

States are required as part of their Medicaid State plans to maintain a MFCU, unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse and waives the requirement.

**Audit Objective** - To determine whether the State ensures suspected criminal violations are referred to an office with authority to prosecute cases of provider fraud.

#### **Understanding of Internal Controls**

##### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

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Based on the a review of the policies, procedures, information request responses and internal control letter responses we determine that DDA has not had any changes to the fraud referral process from SFY21. We received those documents on 9/31/2022 from Geoff Nisbet.

We gained an understanding of the Medicaid Fraud Control Unit referral process. The process of referring credible allegations of fraud to the State's MFCU is handled by DDA Central Office. The administration relies on the case managers and field staff to help identify suspected provider fraud because they have the most knowledge regarding the client/provider situations as well the main contact when any suspicious activities occur.

Before a referral is made to the Administrations, a preliminary review is conducted by field staff to determine whether there is credibility to the claim and whether fraud is involved. As part of the preliminary review, the field staff may gather more information by talking to the client, requesting the provider's time sheets/records of services provided to review and confirm care plan and compare it to what is being delivered, review invoices, staff logs etc and review the provider's contract file for relevant information. The field staff will then go to their immediate supervisor and together they will determine if there are other actions that should be taken before the referral is made. If the supervisor identifies indicators that would support the conclusion that the allegation is credible, then they can proceed with the referral. They will submit the referral to a Regional Payment Specialist. After the payment specialist has reviewed the referral and supporting documents, they will forward the complete referral to the DDA Central Office via the ADSA in box.

After the referral has been received, Amy at DDA will review the referral and its supporting documentation to determine if any additional information is needed from the field staff, since the referral must have enough supporting documentation to ensure that it can be a credible allegation for investigation before it is referred to MFCU. Once Amy determines that the allegation is credible, she will proceed to look in the Comprehensive Assessment Reporting & Evaluation (CARE) system to review case notes for any past issues that may have been reported regarding the provider. **Key Control # 1- All allegations are reviewed by Amy Hoogendoorn, Individual Provider Payment Program Specialist (DDA) prior to being submitted to MFCU (Control Activities/Monitoring).**

Once Amy determines the allegation should be referred to MFCU, she completes the Medicaid Provider Fraud Referral and attaches the documentation received from the field which is then emailed to MFCU. She then saves the documentation on the appropriate share drive. Once the referral has been made to MFCU, the case manager and/or field worker will be notified that the referral was made. The initial email that was sent from the field staff with the referral is moved over to the in box labeled "Referred to MFCU/OFA." The referral will be added to the Sharepoint tracking system with documentation attached.

When a response from MFCU is received on a case that was submitted, a brief description of the response is then entered into the Sharepoint site and a copy of the email is attached. If MFCU decides not to proceed with the referral because it will not stand up in criminal court, the referral will be referred over to a civil unit and MFCU will communicate this outcome to the Administration. Once the Administration receives the denial, they will update the status of the referral to declined on the sharepoint site. If MFCU accepts the referral for further investigation that decision will be communicated to the Department and Sharepoint will be updated accordingly. **Key Control # 2- The Administration uses an online tracking system for all referrals that are made to MFCU (Control Activities/Monitoring)**

**Evaluation of Results:** No control deficiencies were identified.

**Key Control # 1-** All allegations are reviewed by Amy Hoogendoorn, Individual Provider Payment Program Specialist (DDA) prior to being submitted to

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MFCU (Control Activities/Monitoring).

**Key Control # 2-** The Administration uses an online tracking system for all referrals that are made to MFCU (Control Activities/Monitoring)

## Preliminary Control Risk Assessment

### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

## N.1.PRG - ST7 Refunding of Federal Share of Medicaid Overpayments to Providers

**Procedure Step:** Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers - Identification of Key Internal Controls

**Prepared By:** AWW, 4/21/2023

**Reviewed By:** RJC, 5/29/2023

Purpose/Conclusion.*
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### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers.

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers.

### **Source:**

Jill Arlow, Federal Reporting Manager (HCA)

Cheri Wright, General Ledger and Reporting Manager (HCA)

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Laura Roberts, Federal Claims Manager (HCA)  
Terenna Eggebrotten, Fiscal Analyst 5 (HCA)  
Larry Reinier, Fiscal Analyst 3 (DSHS)  
Mark Allen, Policy and Financial Recovery Manager (DSHS)  
Linda McAuley, Fiscal Analyst 5 (DSHS)  
Colleen Snider, Office Chief (DSHS)  
Rick Meyer, External Audit Compliance Manager (DSHS)

### **Conclusion:**N.1 ST7 Id of IC

Based on our understanding of internal controls over Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers, we assessed preliminary control risk as low.

Testing Strategy:
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### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

Compliance Requirements: 42 CFR 433 subpart F outlines the requirements SMAs are to follow related to refunding the federal share of Medicaid overpayments made to providers. Pursuant to 1903(d)(2)(C) of the Social Security Act (the Act) (42 U.S.C. 1396b), States have up to one (1) year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS

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via Form CMS-64 Summary, Line 9C1- Fraud, Waste & Abuse Amounts, regardless of whether recovery is made from the provider. The State must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the 1-year period ends following discovery, whichever is earlier, with limited exceptions. Under 42 CFR 433.316(d), for overpayments resulting from fraud, if not collected within one year of discovery, the SMA has until 30 days after the final judgment of a judicial or administrative appeals process to return the Federal share.

Additionally, in accordance with 42 CFR 433.320(a)(4), the State will be charged interest for any non-recovered, non-refunded overpayment amounts. Any appeal rights offered to the provider does not extend the date of discovery per 42 CFR 433.316(h).

The repayment of the federal share is not required in cases where the State is unable to obtain recovery because the provider has filed for bankruptcy or the provider is otherwise out of business as outlined in 42 CFR 433.318.

42 CFR 433.320(c)(1) allows for downward adjustments previously credited to CMS if it is properly based on the approved State plan, federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures. States are not able to enter into settlement agreements with providers that reduces the federal share of the overpayment in order to avoid the expense of litigation. The Departmental Appeals Board (DAB) decision No. 1391 from February 19, 1993

( <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1993/dab1391.html>) addressed overpayment settlements between the States and providers. This decision affirmed that States may not reduce the federal share by settling overpayment receivables for less than the actual amount of the overpayment based on anticipated success in litigation or made simply to avoid administrative costs or litigation expenses.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and

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- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

### Evaluation of Results: Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### Step 4: Assess Preliminary Control Risk (CR)

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Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

**Note: This understanding was gained simultaneously with our CHIP Special Test in audit “D.6.PRG : S1Washington-SA22 : 4/12/2022 – 93.767-Children's Health Insurance Program (CHIP)”. The below control understanding write-up was pulled forward to procedure “N. Special Tests and Provisions: Refunding of Federal Share of CHIP Overpayments to Providers - Controls” and slightly modified for the referenced applicability of CHIP. The below write-up will have some references more specifically related to Medicaid (particularly in regards to reporting).**

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### **Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers: Identification of Key Internal Controls**

#### **INHERENT RISK OF NONCOMPLIANCE**

##### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- Multiple locations and/or departments are responsible for administering the requirement.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

#### **Gather Information**

##### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Refunding of Federal Share of Medicaid Overpayments to Providers requirements. We identified the following:

- Within one year from the date of discovery of the overpayment, recovery or attempt to recover the overpayment the federal share must be refunded to CMS via Form CMS-64 Summary, Line 9C1-Fraud, Waste & Abuse Amounts, regardless of whether recovery is made from the provider.
- States must credit the federal share to CMS as outlined under 42 CFR 433.320(a)(2) either in the quarter in which the recovery is made or in the quarter in which the one-year period ends following discovery, whichever is earlier, with limited exceptions.
- For overpayments resulting from fraud, if not collected within one year of discovery, the Authority has until 30 days after the final judgment of a judicial or administrative appeals process to return the federal share.



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### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

On November 8, 2022, we met with staff at the Health Care Authority (HCA) and on December 20, 2022, we met with staff at the Department of Social and Health Services (DSHS), to gain an understanding of the process for identifying and refunding the federal share of CHIP and Medicaid provider overpayments.

- Jill Arlow, Federal Reporting Manager (HCA)
- Cheri Wright, General Ledger and Reporting Manager (HCA)
- Laura Roberts, Federal Claims Manager (HCA)
- Terenna Eggebrotten, Fiscal Analyst 5 (HCA)
- Will Sogge, External Audit Liaison (HCA)
- Kari Summerour, External Audit and Compliance Manager (HCA)
- Larry Reinier, Fiscal Analyst 3 (DSHS)
- Jessica Boyd, Fiscal Analyst 2 (DSHS)
- Mark Allen, Policy and Financial Recovery Manager (DSHS)
- Linda McAuley, Fiscal Analyst 5 (DSHS)
- Colleen Snider, Office Chief (DSHS)
- Rick Meyer, External Audit Compliance Manager (DSHS)

In preparation for our meeting, we requested to receive copies of all applicable guidance related to the refunding of the federal share of Medicaid overpayments made to providers including applicable laws, regulation policies, procedures, desk manuals, or instructional guides. Terenna and Cheri provided copies of the T19 MOMS JV procedure as well as the instructions for the related interest (see: [T19 MOMS JV Procedures](#) and [MOMS Interest JV Instructions](#)). In

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addition, we inquired about any agreements that the Authority may have entered into with the Department of Social and Health Services (DSHS) for collaboration through the use of their Office of Financial Recovery (OFR). Rick Meyer, DSHS External Audit Liaison, provided a copy of Contract # 1161-35171 (HCA Contract #K492), effective November 1, 2012 through June 30th, 2013, as well as Service Level Agreement 3, Amendment 5 which extends the period between 07/01/2021 and 06/30/2023. (Note: the contract has been amended for extension continually since 2013.) We have included key takeaways from the Receivables and Recoveries section. Per the agreement OFR will provide services including recovery, collections, and general account maintenance activities that includes vendor overpayments. OFR is delegated the authority to change or negotiate accounts receivable in accordance with state law, policy, and procedure. OFR provides monthly summaries and account activity data/information. The Authority is required to reimburse OFR for first class postage and the filings related to real property liens.

When providers bill the Authority for services provided, the Authority pays the provider and then requests a reimbursement draw for the allotted federal medical assistance percentage (FMAP). Jill explained that about 96% of overpayments within ProviderOne (P1) are corrected using a claim adjustment where the overpayment is netted against the provider in current or future payments. These claim adjustments are processed on a weekly cycle and are applied as a decreasing item on the claim to offset the overpayment. When an overpayment is discovered at the program level and they cannot net against future payments, an overpayment bill is issued to the provider. The provider has 180 days to make payment on the bill, otherwise the bill is referred to OFR at DSHS. Providers may self report overpayments via a non-offset method or offset method. If they choose the non-offset method, it is automatically sent to OFR for collections. If offset is chosen, the ProviderOne system will deduct the overpayment from all paid claims submitted until the debt is satisfied within a six month period, after which it will be referred to OFR.

The remaining 4% of recoveries that cannot be adjusted are recouped via the Medicaid Overpayment Management System (MOMS) within the Authority's Program Integrity Unit, after being referred to OFR. OFR uses the

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Collections and Account Receivables System (CARS) to manage debt collections. When an overpayment referral is made to CARS, an interface automatically logs the line coding identified by the program. CARS will indicate non-offset overpayments as a non-offset to collections (NOC) if the claim was reprocessed or adjusted as a non-offset. Providers may request an administrative hearing through the Authority via sending a letter within 28 days of the remittance advice correspondence. The system sends letters to providers and revenue agents work to collect on the debts.

When MOMS refers overpayments over to OFR and the debt is booked in the system, a flag is created in the system to start the clock on attempting to collect on these amounts. For both Medicaid and CHIP overpayments, the Department has one year from the date of discovery of the overpayment to recover or attempt to recover the overpayment before the federal share must be refunded to CMS. In order to ensure that federal funds are not charged after this timeframe, CARS views the flags set by MOMs and on the 366th day, will automatically roll over all costs to state funds by switching the funding source coding (**Key Control 1 - Control Activities**). Colleen explained that even after this point, OFR will continue to attempt to collect on these funds up to the statute of limitations of six years. When providers make a payment, the cash unit system applies it automatically against its original coding from the overpayment referral.

For SFY22, Audrey Miklavicic, Fiscal Analyst 3, (Now Larry Reinier, FA3) at OFR sends 1070 reports to Terenna each month regarding the status of overpayment accounts, showing what has been collected or is still open for the month prior. The report has three sections: increasing, decreasing, and write off. Increasing indicates the new overpayment balance, while decreasing is an adjustment reducing a previously returned overpayment. Decreasing includes when the Authority overbilled the provider and the collection needs to be reduced. Write off is an adjustment when a balance is deemed uncollectible due to factors like business closure. The federal government forgives some of the balance, under specific criteria, which allows the State to collect a portion of the federal share.

Terenna prepares batch type journal vouchers (JV) for the overpayments to be returned to the federal government

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using the 1070 report. They use a standard Excel workbook template and import the OFR report into the worksheet tabs. Each JV type, increasing, decreasing, and write off, is prepared through the use of a preparation worksheet and a JV worksheet. The aging of receivables displays the program index, allocation, organization index, and other specific coding. Based on when the expenditure was originally made, the federal portion of items returned will be applied at the FMAP applicable to that particular timeframe, which is identified by the coding. For the preparation worksheet, Terenna enters the cost allocation code, the cost objective, and FMAP rate to have the spreadsheet manually calculate the appropriate increase or decrease. FMAP rates are determined through comparing the cost objective, allocation code, and federal fiscal year against a federal FMAP matrix. The Authority also publishes an internal cost allocation code to FMAP rate cheat sheet that is updated monthly. After the FMAP related data is calculated it is imported into the JV worksheet. The template uses pre-programmed calculations to prepare the JV, after which Terenna checks the work for correctness in areas such as positive/negative values and rounding errors, or after it is loaded into AFRS for error messages.

Next, the General Ledger and Reporting Manager, Cheri Wright, reviews the adjustments by comparing the report from OFR to the prepared journal voucher to ensure the coding is correct, the returned rate applied is accurate, and the returned amount was correctly calculated and supported by the report. She will then approve the JV for processing and will release to AFRS (**Key Control 2 – Monitoring**). After the JV is processed, the JV draw spreadsheet is emailed to OFR, including the date of the next Medicaid Assistance draw. Terenna will also fill in the date that the next federal draw is done after the release of the JV and will email a copy of the JV to Laura within the FFR unit.

The State is also required to calculate the accrued interest of the overpayment amounts that were non-recovered or non-refunded by the earlier of the CMS-64 quarterly report when recovery occurred or the CMS-64 for the quarter one year from the discovery as part of the JV process per 42 CFR 433.320(a)(4). Using the monthly JV sent from Terenna, the FA3 at OFR will input the data into CARS table maintenance which automatically calculates the interest amount due for the quarter. Interest calculation uses OFR data on the same JV spreadsheet as the FMAP

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calculations. If the overpayment is due to provider error, the overpayment is auto-flagged by the system to charge interest. A one percent simple interest is calculated daily, but applied monthly. The FA3 at OFR will then send the quarterly report back to Terenna who processes it along with her monthly JV. The interest collected is retained by the respective programs.

Once all JV adjustments are made for the quarter, the Authority is responsible for reporting the overpayments on the CMS-64 report. The Form CMS 64.9C1 feeder form is used to provide detail about the fraud, waste and abuse collection efforts and flows into line 9c of the Form CMS 64. Jill mentioned that items related to the Medicaid Fraud Control Unit (MFCU) are reported on lines 9C1 and 9C2. We separately reviewed MFCU at [ST6 Medicaid Fraud Control Unit \(MFCU\) HCA](#) , [ST6 Medicaid Fraud Control Unit \(MFCU\) ALTA](#), and [ST6: Medicaid Fraud Control Unit \(MFCU\) DDA](#). The Form CMS 64.9O feeder form that flows into line 10c of the Form CMS 64 is used to provide detail about overpayments that have been identified but not yet collected. Jill explained that during the CMS-64 report preparation process, overpayments are identified in the AFRS data based on specific coding (combination of allocation code and program index), and if the amount is a negative, it is returned to the feds and reported on the CMS-64 each quarter. This coding automatically identifies the federal/state split from the total computable amount reported. The items processed through MOMS are reported on line 10c.

Federal Financial Report (FFR) Staff will go into the WEB-based Medicaid and CHIP Budget and Expenditure System (MBES) to input the information from the system generated report input sheets. After creating the quarterly report, staff will reconcile the summary reconciliation against the report and AFRS data to ensure it is accurate and complete. Once the claim is entered, all information has been input into MBES, and everything reconciles, FFR staff will inform Jill that the report is complete. The FFR Staff will provide Jill with the supporting documentation so that she can review the report to ensure that it is accurately completed. Jill will do spot checks on selected entries and ensures all forms are complete. She verifies each line item to ensure that the totals input on the report match the ones from the AFRS report as well as the mapped data report. Once Jill has completed her review and determines that there are no errors, she will certify the CMS-64/CMS-21 report in MBES since she is the one that

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has that authority (**Key Control 3 - Control Activities/Monitoring**).

**Key Control 1** - The Collections and Account Receivables System views the flags set by MOMs and on the 366th day, will automatically roll over all costs to state funds by updating the funding source coding to ensure federal funds are not improperly charged.

**Key Control 2** - The General Ledger and Reporting manager reviews the adjustments by comparing the report from OFR to the prepared journal voucher to ensure the coding is correct, the returned rate applied is accurate, and the returned amount was correctly calculated and supported by the report. She will then approve the JV for processing and will release to AFRS.

**Key Control 3** - The HCA Federal Financial Reporting Manager reviews the quarterly CMS-21/CMS-64 report and its supporting documents to ensure that the CMS-21/CMS-64 is properly prepared before certifying the reports.

**Evaluation of Results:** We did not identify any internal control deficiencies over the requirements for Medicaid Special Test 7 - Refunding of Federal Share of Medicaid Overpayments to Providers.

### **Preliminary Control Risk Assessment**

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.

#### **O.1.PR.G - ST8 Medicaid National Correct Coding Initiative (NCCI)**

<b><i>Procedure Step:</i></b>	Special Test 8 - Medicaid National Correct Coding Initiative (NCCI) - Identification of Key Internal Controls
<b><i>Prepared By:</i></b>	CL, 9/20/2022
<b><i>Reviewed By:</i></b>	RJC, 9/26/2022

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Purpose/Conclusion.\*

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 8 - Medicaid National Correct Coding Initiative (NCCI):

To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 8 - Medicaid National Correct Coding Initiative (NCCI).

### **Source:**

Angela Skinner, IT System Admin Journey  
Ed Hicks, IT System Admin Journey  
Heidi Devries, IT Quality Assurance  
Kari Summerour, External Audit and Compliance Manager  
Cindy Raves, Internal Auditor filling in temporarily as External Audit Liaison

### **Conclusion:**

Based on our understanding of internal controls over Special Test 8 - Medicaid National Correct Coding Initiative (NCCI), we assessed preliminary control risk as low.

Testing Strategy.\*

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify,

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determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

**Compliance Requirements:** Effective October 1, 2010, SMAs were required to incorporate NCCI methodologies into the State Medicaid programs pursuant to the requirements of Section 6507 of the Affordable Care Act (section 1903(r) of the Social Security Act).

The purpose of the NCCI Program is to promote correct coding, prevent coding errors, prevent code manipulation, reduce improper payments and reduce the paid claims improper payment rate. The Annual Report to Congress - Medicare and Medicaid Integrity Programs - **Fiscal Year 2017** (<https://www.cms.gov/About-CMS/Components/CPI/Downloads/FY-2017-Medicare-and-Medicaid-Integrity-Programs-Report-to-Congress.pdf>) reported that the NCCI program saved at least \$698.1 million in Medicare in FY 2017.

In paying applicable Medicaid claims, States' MES are required to completely and correctly implement the following six Medicaid NCCI methodologies to ensure that only proper payments of procedures are reimbursed.

- (1) NCCI Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) claims.
- (2) NCCI PTP edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.
- (3) Medically Unlikely Edit (MUE) units of service (UOS) edits for practitioner and ASC services.
- (4) MUE UOS edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.
- (5) MUE UOS edits for durable medical equipment (DME) billed by providers.
- (6) NCCI PTP edits for durable medical equipment (added in October 2012).

States are also required to use:



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- all four components of each Medicaid NCCI methodology;
- the most recent quarterly Medicaid NCCI edit files for States;
- the Medicaid NCCI edits in effect for the date of service on the claim line or claim;
- the claim-adjudication rules in the Medicaid NCCI methodologies; and
- all modifiers for Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes needed for the correct adjudication of applicable Medicaid claims.

The NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual contain additional requirements for implementation of the NCCI methodologies.

The Medicaid NCCI methodologies must be applied to Medicaid fee-for-service claims submitted with, and reimbursed on the basis of, HCPCS codes and CPT codes. This includes claims reimbursed on a fee-for-service basis in State Medicaid Primary Care Case Management managed care programs. Application of NCCI methodologies to fee-for-service claims processed by other entities, including limited benefit plans or Managed Care Organizations, is not required; however, if SMAs require the application of NCCI methodologies to fee-for-service claims processed by such entities, then such entities must meet NCCI program requirements, including compliance with the NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### **Step 3: Gain an Understanding of Internal Controls**

*Obtaining an understanding of internal control involves evaluating the design of a control and determining*

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*whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or

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2. The auditee's internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria:

Record of Work Done:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are complex and involve many processes requiring the Agency to reformat the original data to meet HCA system requirements in ProviderOne.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

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### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Medicaid National Correct Coding Initiative (NCCI) requirements. We identified the following:

**Compliance Requirements** Effective October 1, 2010, SMAs were required to incorporate NCCI methodologies into the State Medicaid programs pursuant to the requirements of Section 6507 of the Affordable Care Act (section 1903(r) of the Social Security Act).

The purpose of the NCCI Program is to promote correct coding, prevent coding errors, prevent code manipulation, reduce improper payments and reduce the paid claims improper payment rate.

In paying applicable Medicaid claims, States' MES are required to completely and correctly implement the following six Medicaid NCCI methodologies to ensure that only proper payments of procedures are reimbursed.

- (1) NCCI Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) claims.
- (2) NCCI PTP edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.
- (3) Medically Unlikely Edit (MUE) units of service (UOS) edits for practitioner and ASC services.
- (4) MUE UOS edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services.
- (5) MUE UOS edits for durable medical equipment (DME) billed by providers.
- (6) NCCI PTP edits for durable medical equipment (added in October 2012).

States are also required to use:

- all four components of each Medicaid NCCI methodology;
- the most recent quarterly Medicaid NCCI edit files for States;
- the Medicaid NCCI edits in effect for the date of service on the claim line or claim;

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- the claim-adjudication rules in the Medicaid NCCI methodologies; and
- all modifiers for Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes needed for the correct adjudication of applicable Medicaid claims.

The NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual contain additional requirements for implementation of the NCCI methodologies.

The Medicaid NCCI methodologies must be applied to Medicaid fee-for-service claims submitted with, and reimbursed on the basis of, HCPCS codes and CPT codes. This includes claims reimbursed on a fee-for-service basis in State Medicaid Primary Care Case Management managed care programs. Application of NCCI methodologies to fee-for-service claims processed by other entities, including limited benefit plans or Managed Care Organizations, is not required; however, if SMAs require the application of NCCI methodologies to fee-for-service claims processed by such entities, then such entities must meet NCCI program requirements, including compliance with the NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual.

Audit Objectives - To determine whether SMAs have implemented the required six NCCI methodologies and met the NCCI program requirements, as described in the NCCI Medicaid Policy Manual and the NCCI Medicaid Technical Guidance Manual.

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We sent the Authority the Medicaid Information Request to Kari Summerour, External Audit and Compliance Manager. Response received from Kari on September 2, 2022 see, [ST 8 - NCCI - HCA response to Information Request](#). Additionally, we sent the Agency Identified Internal Controls Request document to Kari and received the

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response on September 2, 2022 see, [ST 8 - NCCI - HCA response to request for Internal Controls](#).

We requested the Agency's policies and procedures related to Special Test #8 - National Correct Coding Initiative to gain an understanding of this area. The Agency informed SAO that they do not have any internal policies and procedures because this is a national initiative, they use the standards provided by the Federal Government. This includes the NCCI policy manual, and the technical guidance, posted on the Centers for Medicaid and Medicare Services (CMS) website.

On September 19, 2022 we met with Angela Skinner, IT System Admin Journey, Ed Hicks, IT System Admin Journey, Heidi Devries, IT Quality Assurance and Cindy Raves, Internal Auditor, filling in temporarily as External Audit and Compliance Manager, to gain an understanding and identify internal controls over Special Test #8 - NCCI. Angela clarified the internal control process. She receives a notification from the Medicaid Integrity Institute (MII). This tells her when the NCCI edits are available or if they are update for edits that were currently released (**Key Control #1 -Control Activities/Monitoring**). She logs into the Regional Information Sharing Systems (RISSNET), where she goes to the MII portal to find the quarterly NCCI edit files that are posted for each of the 6 type of files:

1. NCCI Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) claims. (PTP-PRA)
2. NCCI PTP edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services. (PTP-OPH)
3. Medically Unlikely Edit (MUE) units of service (UOS) edits for practitioner and ASC services. (MUE-PRA)
4. MUE UOS edits for outpatient hospital services including emergency department, observation care, and outpatient hospital laboratory services. (MUE-OPH)
5. MUE UOS edits for durable medical equipment (DME) billed by providers. (MUE-DME)
6. NCCI PTP edits for durable medical equipment (added in October 2012). (PTP-DME)

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Angela Skinner, IT System Admin Journey, downloads the files from RISSNET and organizes them into a folder of the edits for that quarter. She sends a copy of the downloaded file to Internal Policy for their review of the code set to ensure compliance with NCCI coding and to Managed Care Policy to ensure compliance with Medicaid State Plan. (Control Activities). She then reformats the files so that the ProviderOne system can read the edits correctly by consolidating the files to under 10,000 kb and adding new rows into the edits provided. Each morning Angela would get a report that would show the errors from the prior day's batch. To correct these errors, she would upload codes one at a time. Once there are no errors she would test the new edits in a testing environment to make sure the new edits were working. After she completes testing of the new edits in the ProviderOne test environment, she notifies the IT Quality Assurance (QA) team that the edits are ready for review. The QA Manager reviews the edits in the test environment to make sure the edits are working and all edits were downloaded from the federal site (**Key Control #2 – Monitoring**). Once approved by the QA Manager, Angela uploads the edits into the production environment starting on the first day of the quarter and 30 days before the end of the month of the quarter.

### Summary of Key Controls

**Key Control #1 (Control Activities/ Monitoring)** - The IT Systems Admin receives a notification from the MII Portal and downloads the files and works the edits to ensure they are implemented timely.

**Key Control #2 (Monitoring)** - Before the edits are implemented into the production environment, the IT Quality Assurance reviews the edits to make sure they are working properly and confirms all edit files were obtained from the federal site.

### **Evaluation of Results:**

We did not identify any control deficiencies for Special Test #8 - National Correct Coding Initiative (NCCI) for SFY21.

### Preliminary Control Risk Assessment

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant

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requirements. We will perform testing to determine if we can place reliance on the controls.

### P.1.PR.G - ST9 Medical Loss Ratio (MLR)

*Procedure Step:* Special Test 9 - Medical Loss Ratio (MLR) - Identification of Key Internal Controls

*Prepared By:* ES, 10/20/2022

*Reviewed By:* RJC, 10/31/2022

Purpose/Conclusion.*
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#### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 9 - Medical Loss Ratio (MLR).

#### **Source:**

Kari Summerour, External Audit Liaison

Will Sogge, External Audit Liaison

Christy Vaughn, SECTION MANAGER HEALTHCARE RATES & FIN

Madina Cavendish, SECTION MANAGER HEALTHCARE RATES & FIN

Sarah Cook, FORECAST, FINANCE & MANGED CARE UNIT MGR

HCA website

#### **Conclusion:**

Based on our understanding of internal controls over Special Test 9 - Medical Loss Ratio (MLR), we assessed



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preliminary control risk as low.

Testing Strategy:
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### Step 1: Assess Inherent Risk (IR)

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

**Compliance Requirements:** For all contracts, the state must ensure that each MCO, PIHP, and PAHP submits a report with the data elements specified in 42 CFR sections 438.8(k) and 438.8(n). The report should contain the required 13 data elements in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the calculation of the MLR. The state should have a policy and procedure to indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation payments are revised retroactively.

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

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*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or

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detected on a timely basis, or

2. The auditee's internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.:

Record of Work Done.:

### **INHERENT RISK OF NONCOMPLIANCE**

#### **Step 1**

We do not believe there are any inherent risks that increase the risk of material noncompliance.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at **LOW**.

### **Gather Information**

#### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Medical Loss Ratio (MLR) requirements. We identified the

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following:

For all contracts, the state must ensure that each MCO, PIHP, and PAHP submits a report with the data elements specified in 42 CFR sections 438.8(k) and 438.8(n). The report should contain the required 13 data elements in the regulation, reflect the correct reporting years, and contain an attestation of accuracy regarding the calculation of the MLR. The state should have a policy and procedure to indicate when the report(s) are due from plans and should not accept multiple submissions from plans unless the capitation payments are revised retroactively.

For reference below: Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plan (PAHP)

### **§ 438.8 Medical loss ratio (MLR) standards.**

- (a) Basic rule. The State must ensure, through its contracts starting on or after July 1, 2017, that each MCO, PIHP, and PAHP calculate and report a MLR in accordance with this section. For multi-year contracts that do not start in 2017, the State must require the MCO, PIHP, or PAHP to calculate and report a MLR for the rating period that begins in 2017.*
- (c) MLR requirement. If a State elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness under § 438.4(b)) and the MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section.*
- (k) Reporting requirements.*
  - (1) The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:*

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- (i) Total incurred claims.*
- (ii) Expenditures on quality improving activities.*
- (iii) Fraud prevention activities as defined in paragraph (e)(4) of this section.*
- (iv) Non-claims costs.*
- (v) Premium revenue.*
- (vi) Taxes, licensing and regulatory fees.*
- (vii) Methodology(ies) for allocation of expenditures.*
- (viii) Any credibility adjustment applied.*
- (ix) The calculated MLR.*
- (x) Any remittance owed to the State, if applicable.*
- (xi) A comparison of the information reported in this paragraph with the audited financial report required under § 438.3(m).*
- (xii) A description of the aggregation method used under paragraph (i) of this section.*
- (xiii) The number of member months.*

*(2) A MCO, PIHP, or PAHP must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year.*

*(3) MCOs, PIHPs, or PAHPs must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that MCO, PIHP, or PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, PIHP, or PAHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.*

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*(n) Attestation. MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.*

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

We met with the following staff at HCA on 10/17/2022 to gain an understanding of the Authority's internal controls over Medical Loss Ratio reporting:

- Christy Vaughn, Section Manager Healthcare Rates and Fin
- Madina Cavendish, Section Manager Healthcare Rates and Fin
- Sarah Cook, Fiscal Information & Data Analyst

During our meeting, Christy (Section Manager Healthcare Rates and Fin) explained that although this report is a CMS requirement, HCA does not validate or find the information provided by the MCO's of particular use. Instead, HCA utilizes a Gain Sharing calculation to determine the profitability of the Managed Care Program, accomplished through an actuarial analysis of HCA premium payments and service-based enhancement payments compared to audited financial statements of Managed Care Organizations and reports to the State Insurance Commissioner. There are five MCOs who are required to submit an MLR report as part of their Integrated Managed Care (IMC) contracts. Additionally, Coordinated Care of Washington is required to submit an MLR applicable to their Integrated Foster Care contract, however this is a state only funded contract and therefore not applicable to this federal requirement. Although this requirement is applicable to both Medicaid and CHIP, they are only required to

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submit one report to CMS. There is no differentiation between the MLR reporting processes for the two programs.

The contracts with each MCO, PIHP, and PAHP require the entities to submit a report by May 31st each year, reflect the correct reporting years, and contain the required 13 data elements. The reports submitted for FY22 contain the data received from the MCOs from calendar year 2021. **Key Control #1 (Information and Communication)** The contract contains an exhibit with the reporting template and instructions, which includes the requirement to contain an attestation of accuracy from the entity regarding the calculation of the MLR. The contract template was created by Division of Behavioral Health and Recovery (DBHR) which HCA continues to use as their Exhibit. We obtained the 2021 Apple Health Managed Care contract (*See. [MLR Contract Excerpts](#)*) provisions for Medical Loss Ratio Reporting, which are captured in Section 5.5 as well as Exhibit F. Per the Managed Care Contract, MLR is defined as: *"the measurement of the share of Enrollee premiums that the Contractor spends on medical claims, as opposed to other non-claims expenses such as administration or profits."* Federal law requires States to set a minimum acceptable MLR of 85 percent, meaning that MCO's and other contractors must incur and pay Enrollee claims equating to at least 85 percent of total revenues.

For MLR reporting, the MCTrack system is primarily used to transmit and receive information from MCO's including the reports required under the Apple Health Contract. The Managed Care Oversight Division of Program Integrity staff receive notifications from the MCTrack System when MCOs submit required reports if they are inside the MCTrack application. HCA requires MCO's submit the report by May 31st of each year. This leaves a two-month gap between when MCO's are required to submit their MLR reports and when the MLR summary must be submitted to CMS to ensure that the report is submitted timely.

Once Sarah (Fiscal Information & Data Analyst) logs into the MCTrack system, she can view the notifications for all of the MCO submissions that were made. Generally, Sarah waits until the day after the reports are due, June 1. She then reviews each report submitted by MCOs for accuracy and completeness, and documents her review through the MC Track system by updating the report status to "verified". If she finds any incomplete or incorrectly

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formatted items on the report template, she will reject the submission in MCTrack so the MCO can fix it and resubmit. There is no penalty if an MCO has to resubmit a report after the deadline on May 31. Once she reviews the final version of each submission, the reports are retained in the MCTrack system. **Key Control #2 (Control Activities/Monitoring)**: Once the reports have been downloaded from MC Track, reviewed by the fiscal information and data analyst for accuracy, and corrected (if necessary), a summary file compiling the data in the 5 MCO reports is created in the CMS required format and the analyst sends the reports to CMS. Sarah sends it to Rick Dawson from CMS. CMS requires the MLR summary report be submitted by July 31 each year. Rick will correspond with HCA if there are any issues about the report submission.

### Summary of Key Controls

**Key Control #1 (Information and Communication)**: The contracts with each MCO, PIHP, and PAHP require the entities to submit a report to MCTrack by the end of May each year, reflect the correct reporting years, and contain the required 13 data elements. The contract contains an exhibit with the reporting template and instructions, which includes the requirement to contain an attestation of accuracy from the entity regarding the calculation of the MLR.

**Key Control #2 (Control Activities/Monitoring)**: The reports are downloaded from MC Track, reviewed by the Fiscal Information and Data Analyst for completeness, and corrected (if necessary), and a summary file is created in the CMS required format and sent to CMS.

### **Evaluation of Results:**

No internal control weaknesses noted.

### Preliminary Control Risk Assessment

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant



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requirements. We will perform testing to determine if we can place reliance on the controls.

### Q.1.PRG - ST10 Managed Care Financial Audit

*Procedure Step:* Special Test 10 - Managed Care Financial Audit - Identification of Key Internal Controls  
*Prepared By:* SAG, 9/23/2022  
*Reviewed By:* RJC, 9/26/2022

Purpose/Conclusion.
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#### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 10 - Managed Care Financial Audit.  
To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 10 - Managed Care Financial Audit.

#### **Source:**

Mike Brown, Medicaid Program Integrity Assistant Director  
Ming Wu, Program Integrity Deputy Division Director  
Kathy Cleeves, Program Integrity Managed Care Oversight Unit Supervisor  
Kari Summerour, External Audit and Compliance Manager

#### **Conclusion:**

Based on our understanding of internal controls over Special Test 10 - Managed Care Financial Audit, we found the agency does not have adequate internal controls to prevent material noncompliance. Therefore we assess preliminary control risk as high and will report a finding for a material weakness at FI\_S1Washington\_SA22\_HCA-M01\_Medicaid/CHIP\_Special Test 10\_Managed Care Financial Audits. No internal control testing is necessary in this instance.

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Testing Strategy:

### **Step 1: Assess Inherent Risk (IR)**

#### Inherent Risk of Noncompliance

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk Guidance*** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### **Step 2: Gather Information**

**Compliance Requirements:** Two types of audits are required for managed care:

1. Audited Financial Reports – The contract with each MCO, PIHP, and PAHP must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. These audits must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR section 438.3(m)).
2. Periodic Audits – Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR section 438.602(e) and (g); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920).

Review the following that apply to the audit period:

- Medicaid State Plan

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- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

### Evaluation of Results: Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

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### Step 4: Assess Preliminary Control Risk (CR)

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

Guidance/Criteria.\*

Record of Work Done.\*

### **Special Test 10 - Managed Care Financial Audit - Identification of Key Internal Controls**

#### **Inherent Risk of Noncompliance**

##### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- The compliance requirements are relatively new to the agency. Actions over the audited financial reports and periodic audit requirements have had limited audit exposure.

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- The compliance requirement involves a relatively large degree of subjectivity by the agency in interpreting and carrying out the objectives of the program.

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

### **Gather Information**

#### **Step 2**

##### Review scope of work

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine Managed Care Financial Audit requirements. We identified the following:

1. Audited Financial Reports - The contract with each MCO, PIHP, and PAHP must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. These audits must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards (42 CFR section 438.3(m)).
2. Periodic Audits - Effective no later than for rating periods for contracts starting on or after July 1, 2017, the state must periodically, but no less frequently than once every three years, conduct, or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each MCO, PIHP, and PAHP and post the results of these audits on its website (42 CFR section 438.602(e) and (g); May 6, 2016, *Federal Register* (81 FR 27497); OMB No. 0938-0920).

### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step.

On September 2, 2022, we met with the following HCA personnel to discuss the internal controls in place to ensure the compliance requirements for this area are met:

- Ming Wu, Program Integrity Deputy Division Director
- Mike Brown, Division of Program Integrity Assistant Director
- Kathy Cleeves, Program Integrity Managed Care Oversight Unit Supervisor

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- Kari Summerour, External Audit and Compliance Manager

### Audited Financial Reports

Because in the prior audit we found noncompliance over the audited financial report requirements, we first asked what progress has been made towards compliance with these requirements. Mike and Ming shared that they had drafted up language to modify the MCOs' contracts to include the following statement:

"In accordance with 42 C.F.R. Section 438.3(m), the Contractor shall submit an Audited Annual Financial Report to HCA that is specific to this Contract. The Contractor shall submit the report to HCA via MC-Track no later than June 5 of each year. The first report is due June 5, 2023, for the previous calendar year. The report shall utilize filing instructions from the National Association of Insurance Commissioners or the Washington State Office of the Insurance Commissioner and shall adhere to generally accepted accounting principles or, statutory accounting principles and generally accepted auditing standards."

Per review of the contract, we found all applicable language to be present, but noted the timing of the report collection. Because the amendment requires contractors to submit audited annual financial reports via MC-Track by June 5 each year starting June 2023, we asked Mike and Ming to confirm that there had not been any reports collected during SFY22 and they said that this statement was accurate (**Control Weakness**). They mentioned that they were able to make contract amendments in time with their updated financial reporting policy, which became effective for contract amendment #13 in July 2022 (see: [FIMC Contract Template](#)). They explained that the contract requirement is based on similar requirements by the Office of the Insurance Commissioner (OIC), as adjusted by the specific language of the CFR, and that once HCA receives the audited financial reports, they will be sent to CMS for their review. Although they were unable to implement the control changes for the SFY22 audit period (**Control Weakness**), and therefore did not obtain any audited financial reports for SFY22, the amendment requires contractors to submit audited annual financial reports via MC-Track by June 5 each year starting June 5, 2023, so HCA expects that they should be in compliance in the next audit period. We asked if there were concerns with the MCOs meeting this timely since it was only just recently added to the contract and Mike clarified that because the MCOs are essentially doing this work already in order to meet requirements of the OIC, HCA is confident that they'll be received timely and if not, corrective actions would be taken.

After the conclusion of our discussion, we indicated that there will be an exception for noncompliance as well as a lack of internal controls in this area, and HCA agreed.

### Periodic Audits

Per 42 CFR § 438.600(c) and section 438.602, periodic audits of financial and encounter data are required for all MCOs for rating periods on contracts starting on or after July 1, 2017, at least every three years.

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### *Encounter Data Audits*

First, we inquired on the status of the encounter data audits. HCA informed us that they had substantially completed their first required encounter data audits over each of the MCOs during SFY21. Per review of their [website](#), these reviews were completed in July 2021 and per further inquiry with Mike and Ming, we confirmed the results were posted publicly in February 2022. During the prior audit, the Authority provided us with the following timeline of these audits:

- June 2019 - Random Sample of 120 encounters selected from universe of claims from 01/1/2018-12/31/2018. Notice of Intent to Audit sent to each plan with instructions, the random sample and date for onsite visit.
- July 2019 - Onsite visits began.
- August 2019 - Documentation analysis began.
- August 2020 - Result of HCA analysis documented and provided to plans in a Preliminary Audit Report.
- September 2020 - Plans responded to audit report and submitted additional documentation.
- October 2020 - Meetings with MCOs that requested one to go over the Preliminary Audit Report.
- April 2021 - Final Notices and Imposition of Sanctions sent to MCOs.
- May 2021 - MCOs requested Dispute Resolution of the EDV Final Notices and Sanctions.
- June 2021 - EDV Dispute Resolution meetings with the MCOs began.
- October 2021 - Dispute Resolution concluded and Revised Final Report and Imposition of Sanctions sent to MCOs.

We were told that the Authority had experienced several delays in trying to complete these encounter data audits. Firstly, during the process of starting the encounter data audits, organizational changes within the leadership of the Division occurred, which pushed back the audit schedule and, during this transition, very little progress was made. Ming mentioned that the audits were nearing completion when Mike came onboard, but Mike made changes to the format to make the structure different, which even further delayed the work to get these completed. At around this point, the audits were mostly complete, but they were needing to conclude and issue sanctions, as they did have some findings on their assessment of the encounter data.

We asked them to elaborate on their audit methodology for the encounter data audits and they said that each state is left to determine how to conduct the audit and review the data, so they chose to take a broad approach. Ming explained that the first years' audit process involved taking the encounter data from calendar year 2018, that is used for rate setting, and taking a small sample size of around five to ten claims per claim type. This resulted in a review of about 120 out of universe of millions of claims. They took careful consideration to ensure they hit all types of claims, such as nursing, outpatient, therapies, etc., to get good coverage. Mike mentioned that in future periods, they could choose to take a more narrow focus, such as a specific emphasis on hospice, pharmacy, or inpatient, services and then check to see about the accuracy and completeness of the

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data by means of revalidation.

HCA intends to perform audits at least every three years, but has not established a specific schedule, but plans for them to occur in a "semi-regular routine fashion" (**Control Weakness**). They then explained that the next round of audits are scheduled to begin January 2023 and conclude review by June 30, 2023, with an audit scope of specific dates of service in calendar year 2020. The notices of intent to audit will be provided to the MCOs in January 2023, which will kick-off their ability to begin field work. Their planned scope will also be larger with around 20 samples per claim type selected for review, which should result in approximately 240 claims in total. Some changes that they're implementing in this next upcoming round of encounter data audits, which were lessons learned from the first set, was to specifically ask for the MCOs to submit raw data, otherwise known as the 837 files. This will better allow the Authority to more efficiently verify the completeness and accuracy of the data.

Another lesson learned from their first encounter data audit, that Mike and Ming shared with us, was regarding the audit results, finding, conclusions, and sanctions processes. They mentioned that unfortunately, MCOs were less than adequate on their responsiveness to the initial results over their first audit and they had also disputed the audit findings, and so the Authority re-reviewed and modified the findings. Once these were resolved and finalized, the MCO sanctions were needing to be finalized before sending to the Centers for Medicare & Medicaid Services (CMS) and posting the reports on their website. The Office of the Attorney General (AGO) worked on the sanctions to ensure they were legally defensible, which took some additional time. This resulted in adjusted final audit findings being released in SFY22. In April 2021 final notices and imposition of sanctions were sent to MCOs. Mike said that this first set of audits helped to let MCOs understand that these reviews are taken seriously and that consequences can result from the audit conclusions. Therefore, the Authority is making an increased effort towards lessening the back and forth and finalizing results earlier on, which should drastically decrease the timeline of the next audit cycle, which they now expect to take approximately six months to complete. They are hopeful that the audits will not be as rough, as they have fine-tuned and strengthened this portion of the process to be more efficient for the next go-around. Both parties are more familiarized with the structure and framework for how sanctions and breaches of contract are processed.

### *Financial Data Audits*

Next, we inquired on the status of the financial data audits, since at the conclusion of the last audit, HCA did not yet have a solidified plan of direction for conducting these reviews. Similarly to the encounter data audits, HCA intends to perform the financial data audits at least every three years, but has not established a specific schedule. They also plan for these to occur in a "semi-regular routine fashion", yet they also anticipate they will likely occur less frequently than the encounter data audits (**Control Weakness**). They confirmed that during SFY22, they had not completed the MCO financial data audits and that they do not currently have the full expertise needed for performing all functions and duties of the financial data audit process (**Control Weakness**).

Kathy is the lead auditor in charge of the financial data audit project and she mentioned that the group of lead auditors assigned to these audits



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are different from those who conduct the encounter data audits, as these have a very different focus. The Authority is currently in discussions on how or whether to on-board a forensic accountant and/or hire a contractor. They did select a forensic accounting firm to contract with some time ago, but have not yet received a contract proposal from them. It was explained that the contractor would be utilized to help during the dispute phase as well as additional financial services in regards to the financial data. HCA is currently still waiting on this official contract proposal.

Alternatively, Kathy has been proactively seeking input from other states who've conducted these audits, in order to learn of some best practices that they could hopefully integrate into the process, primarily if they were to do the work in lieu of the forensic accountant. She stated that the guidance received thus far has been beneficial and is easing some concerns on the possibility of filling the knowledge gap that they felt would be required of a contractor. Additionally, in the meantime while determining the contractor's involvement, the Authority is able to make forward progress in the review over the areas of HCA's expertise.

They began their first financial data audit of MCOs, which has been underway since early July 2022. Kathy mentioned that her scope includes dates of service from within the 2021 calendar year universe and has so far received all the supporting documentation from the MCOs. Because the Authority has never done these audits before, there is still a lot of uncertainty over the timing, scope, extent of involvement, ability, and manner that they will perform this review (**Control Weakness**). However, they did explain that they do expect that findings are likely, and that sanctions could be written in this scenario, but since it's still at the early stages of the audit, Kathy couldn't pinpoint any particular areas of known concerns. We were provided a copy of their Audit Plan for the SFY23 detailing their scope and timelines for upcoming audits (see: [PIMCO Audit Plan FINAL SFY23](#)), but they do not apply to the period under audit (**Control Weakness**). Kathy mentioned that, with the assumption of bringing in a forensic accountant, the audit is due to conclude by the end of March 2023, or even as early as December 2022 if there are no major hold-ups. Unfortunately, Kathy stated they have ran into some roadblocks, due to them still finalizing the audit process and the uncertainty as to whether a contractor will be utilized, so these issues could cause delays in their completion.

### Summary of Key Controls

No controls were identified or present over managed care financial audit requirements. A control deficiency is present. The following summarizes the control weaknesses identified:

- The Authority did not include the annual MCO audited financial report requirement in its MCO contracts until July 2022, after SFY22.
- The Authority did not implement a system for obtaining any audited financial reports during SFY22 and did not obtain any of the MCO's annual audited financial reports. They have an audit plan for SFY23 which includes a plan to obtain audited financial reports from MCOs by June 2023.
- The Authority has not yet implemented a system to ensure MCO audits of both the encounter and financial data is completed at least once every three years and they did not timely perform all periodic audit functions.

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- The Authority has not implemented sufficient policies or procedures over how the Managed Care Financial Audit requirements are to be met.

### **Evaluation of Results:**

We identified the following control deficiencies over Managed Care Financial Care requirements:

- Audited Financial Reports: The contract with each MCO's must require them to submit to the state an audited financial report specific to the Medicaid contract on an annual basis. The Authority did not include this requirement in their contract and has not obtained any audited financial reports from any of the MCOs. The Authority did not establish a process to ensure reports are collected annually until SFY23.
- Periodic Audits: The Authority has not yet performed any audits over the MCO's financial data. They are currently in the process of conducting these reviews for SFY23. The Authority has completed an audit of the encounter data in July 2021, but has not established a process to conduct audits of encounter and financial data no less frequently than once every three years.

We consulted the Decision Matrix for Single Audit Internal Control Deficiencies and determined the likelihood of noncompliance is more than remote and the magnitude of potential noncompliance is material, therefore we assess preliminary control risk at high. The Authority has not implemented any controls to prevent or detect noncompliance with grant requirements, therefore, we will report a finding for a material weakness at FI S1Washington SA22 HCA-M01 Medicaid/CHIP Special Test 10 Managed Care Financial Audits. No internal control testing is necessary in this instance.

### **Preliminary Control Risk Assessment**

#### **Step 4**

HIGH - Internal control design is not likely to be effective to prevent or detect non-compliance with grant requirements. We will report a material weakness in accordance with 2 CFR §200.516(1).

### **R.1.PR.G - ST11 External Quality Review Organization (EQRO)**

*Procedure Step:* Special Test 11 - External Quality Review Organization (EQRO) - Identification of Key Internal Controls

*Prepared By:* LS, 10/27/2022

*Reviewed By:* RJC, 10/31/2022

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Purpose/Conclusion.\*

### **Purpose:**

To gain an understanding of the internal controls the agency has established that provide reasonable assurance of compliance with the Special Test 11 - External Quality Review Organization (EQRO).  
To identify the key internal controls and provide a preliminary control risk assessment based upon our understanding of the internal controls for Special Test 11 - External Quality Review Organization (EQRO).

### **Source:**

Penny Bichler, MCO TEAMonitor Coordinator  
Dianne Baum, Section Supervisor  
Carey Wallace, RN, EQRO Program Manager  
Karen Buchanan, Occupational Nursing Consultant  
William Sogge, External Audit Liaison  
Kari Summerour, External Audit Liaison

### **Conclusion:**

Based on our understanding of internal controls over Special Test 11 - External Quality Review Organization (EQRO), we assessed preliminary control risk as low.

Testing Strategy.\*

### **Step 1: Assess Inherent Risk (IR)**

#### **Inherent Risk of Noncompliance**

See steps to assess risk and risk factor considerations are listed in the ***Inherent and Internal Control Risk***

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**Guidance** that could apply to the compliance requirement you are reviewing. For any inherent risks you identify, determine whether the agency has established internal controls to mitigate the risk. Document this analysis in the Record of Work Done.

### Step 2: Gather Information

**Compliance Requirements:** The SMA must ensure that each managed care organization is evaluated annually on quality, timeliness, and access to the health care services by an EQRO. The state must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438 Subpart E, 42 CFR 438.354).

Review the following that apply to the audit period:

- Medicaid State Plan
- Part 4 of the Compliance Supplement
- the grant agreement or contract, and
- any available program guidelines or handbooks.

### Step 3: Gain an Understanding of Internal Controls

*Obtaining an understanding of internal control involves evaluating the design of a control and determining whether it has been implemented. Implementation means the control exists and the grantee is using it. The key controls you identify should be those that are **effective** in providing reasonable assurance that material noncompliance will be prevented or detected and corrected timely. The identification of key controls should include reviewing all of the Department's written policies and procedures related to the compliance area. If there is not a key control designed to address the compliance requirement, a significant deficiency or material weakness likely exists. When identifying key controls, consider whether inherent risks identified above are reasonably addressed and if automated controls affect the manner in which grant related transactions are initiated, authorized, recorded, processed and reported.*

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Gain an understanding of the grantee's internal controls and identify the key controls to ensure compliance requirements are met.

**Evaluation of Results:** Did you identify any control deficiencies? If yes, **you must:**

1. Use the decision matrix to determine and document the likelihood of noncompliance and the magnitude of potential noncompliance on the program as a whole. (Include this wording) We consulted the *Decision Matrix for Single Audit Internal Control Deficiencies* located in the SWSA Major Program attachment. The likelihood of noncompliance is **<remote/more than remote>** and the magnitude of potential noncompliance is **<less than material/material>**.
2. Document the rationale for a LOW or HIGH risk assessment.]

### **Step 4: Assess Preliminary Control Risk (CR)**

Based on your understanding of key internal controls, assess preliminary control risk. This assessment must be either low or high. Control Risk should be assessed as “**LOW**” when:

1. There is only a remote likelihood that noncompliance that is material could occur and not be prevented or detected on a timely basis, or
2. The auditee’s internal controls are considered sufficient to limit noncompliance to amounts that are less than material and would not merit the attention of the grantor or those charged with governance.

Otherwise, assess control risk as "high." **If preliminary control risk is "HIGH" a finding must be issued.**

***Once you've signed off on this procedure step, wait for supervisor review before proceeding with control/compliance testing. If necessary, schedule a meeting with supervisor to discuss the identified internal controls, and ask questions about how to conduct testing including necessary data, sampling methodology, and coordination with IT Audit. If work from IT audit is expected, please inform the Medicaid supervisor or AIC.***

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Guidance/Criteria:

Record of Work Done:

### **Special Test 11 - External Quality Review Organization (EQRO) - Identification of Key Internal Controls**

#### **Inherent Risk of Noncompliance**

##### **Step 1**

We believe the following inherent risks increase the risk of material noncompliance with the compliance requirement. We will determine whether the agency has implemented internal controls to address these risks and we will also consider these risks when designing our tests of compliance.

- CMS completed a review and provided feedback to the State's External Quality Review for the 2020-2021 reporting cycle and found some components to have been partially met or that they fell below acceptable thresholds (see: [EQRO Feedback Letter WA 2021](#)).

In accordance with AU-C Sec. 935, we have considered inherent risk factors that apply to this compliance requirement and assess the inherent risk of noncompliance at HIGH.

#### **Gather Information**

##### **Step 2**

##### **Review scope of work**

We reviewed the scope of work per the Medicaid State Plan, Part 4 of the Compliance Supplement (if applicable), and any available program guidelines to determine External Quality Review Organization (EQRO) requirements. We identified that the State Medicaid Agency must ensure that each managed care organization is evaluated annually on quality, timeliness, and access to the health care services by an EQRO. The state must ensure that the EQRO conducting such reviews is competent and independent (42 CFR 438 Subpart E, 42 CFR section 438.354).

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### **Understanding of Internal Controls**

#### **Step 3**

In obtaining our understanding of internal controls over compliance, we considered the five components of internal control per AU-C sec. 315 (control environment, risk assessment, control activities, information and communication, and monitoring) as documented in our Overall COSO Evaluation step. Prior to our initial understanding, we requested to receive all applicable guidance including any written policies and procedures of the Authority which relate to the compliance area as part of gaining an understanding of internal controls. The results of this inquiry are summarized at Overview R.1 ST11 Id of IC. Additionally, during planning, staff provided us with a copy of the 1915b Waiver which provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewide-ness, and freedom of choice.

On October 6, 2022, we met with the following staff at the Health Care Authority to gain an understanding of how the Authority ensures that each managed care organization is evaluated annually on quality, timeliness, and access to the health care services by an EQRO, and that the EQRO conducting such reviews is competent and independent:

- Penny Bichler, MCO TEAMonitor Coordinator
- Dianne Baum, Section Supervisor
- Carey Wallace, RN, EQRO Program Manager
- Karen Buchanan, Occupational Nursing Consultant
- William Sogge, External Audit Liaison
- Kari Summerour, External Audit Liaison

The EQRO is a federally mandated contractor and is required to be objective to ensure quality of care is met. To be objective, they must not be connected with any managed care plans. Each year, the EQRO is required to prepare an

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annual technical report over comprehensive, quality, timeliness, appropriateness of care for clients on all contracts with Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepared Ambulatory Health Plans (PAHPs). Federal regulations require certain and optional reports, but they can change each year. The EQRO contract requires evaluation of each MCO annually on quality, timeliness, and access to the health care services within the EQR Technical Report deliverable. The report is received from the EQRO by December or January each year for review and then the report is sent to CMS each April. Comagine Health (DBA Comagine) is the contractor selected by the Authority to perform these duties. Comagine is a national company in multiple states, including Oregon, and many mid-west states, also utilize Comagine. States may also contract with an EQRO to conduct one or more EQR-related activities.

Comagine is a multi-year contract that will end in December 2023. The process of selecting the EQRO for contract includes soliciting potential contractors to perform the work. Comagine was merged, but Washington has used the same contractor since 2015 and has continued to select them each cycle until it goes back up for procurement. Staff mentioned that while they did have multiple bidders in the last couple RFP cycles, Comagine has consistently been the clear choice each time. When they do solicit offers for the work, they review competence and independence as part of the Request for Proposals (RFP) process and evaluation. During the EQRO request for proposal (RFP) process, the Authority utilizes selection criteria to evaluate the competence and independence of potential contractors to ensure they meet the requirements for contract (**Key Control #1- Control Activities**). Staff involved with EQRO requirements work with contracts staff to develop the RFP criteria for evaluation and selection mechanisms.

As a part of the RFP process, bidders must fill out an Exhibit A document (see: [Exhibit-A Min-Quals-Certification](#)). The exhibit includes questions that help ensure the bidder meets the requirements of being an EQRO. These include documenting leadership, independence, and experience. Additionally, the exhibit outlines that the bidder must have five years of experience as an EQRO and five years experience working with governmental organizations. If the exhibit is not fully completed, the bid will not be considered to move further in the selection process. The contracts



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unit screens bid applications for minimum qualifications prior to providing the potential contractors bid submissions to the RFP Review Team.

After the bidders have submitted their completed documents (including Exhibit A) they move on to the selection process. As part of the evaluation, staff bios, background experience, data analysis, and skills are all considered. A team of specialty experts assist with selecting the EQRO. Each question on the exhibit will be scored and evaluated by the team of different reviewers that are assigned to that portion of the exhibit based upon their area of expertise. An odd number of reviewers are assigned to this task to eliminate the risk of any decisions resulting in a tie. Once the reviewers have completed their scoring, the bidders are "graded" based upon their final score. After the completion of this process, the contractor with the highest score is selected, which has been Comagine. If any changes were to occur to the contractor's competence or independence during the contract period, the contract language requires the contractor to notify the Department right away.

The Technical Report is required to follow the applicable CFR and CMS EQR Protocol for Technical Reports. There are three mandatory activities which must be conducted on each managed care plan, and a fourth which will be mandatory once the protocol is created (listed below). For PCCM entities, only the performance measurement validation and a review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D must be conducted.

1. Performance Measurement Validation
2. Performance Improvement Project (PIP) Validation
3. A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D
4. Network Adequacy Validation. A protocol must be created to support this activity. Once the protocol is created, states will have one year to begin implementation.

There are six optional activities. The state has discretion to determine which optional EQR-related activities, if any,

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it wishes to conduct and include in the annual EQR. EQR-related activities are intended to improve states' ability to oversee and manage the managed care plans they contract with for services and to help managed care plans improve their performance with respect to quality, timeliness, and access to care. The optional activities are:R.1 ST11  
Id of IC

5. Encounter data validation
6. Administration or validation of consumer or provider surveys of quality of care
7. Calculation of performance measures
8. Implementation of performance improvement projects
9. Focus studies on quality of care
10. Rating of managed care plans. CMS must first create the Quality Rating System (QRS) and create a protocol before this activity can be utilized by states

Per their 2021 Annual Technical Report, Comagine conducted the following required and optional activities:

- Quality Strategy Effectiveness Analysis
- Compliance Review
- Performance Improvement Project (PIP) Validation
- Performance Measure Validation
- Value-Based Purchasing (VBP) Performance Measure Recommendation and Evaluation
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Wraparound with Intensive Services (WISe) Program Review
- Behavioral Health Performance Measure Focus Study
- Evaluation of Quality, Access and Timeliness of Health Care and Services

The EQRO Program Manager is trained to monitor the CFR adherence for all EQR work, including the EQR Protocols. The EQRO Program Manager cohesively reviews the template, the draft, and the final document and coordinates with HCA subject matter expert reviewers on details or concerns that arise during these reviews (**Key Control #2- Control Activities/Monitoring**). A draft version is then reviewed where SMEs reflect on the

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outcome. Once it is finalized, it is sent to each managed care plan group and leadership to review for recommendations. States are given recommendations for improvement.

The template of the next year's deliverable is built from the prior year's final accepted document to ensure the structure remains the same, addressing all required elements, and then is updated to address any changing expectations. The EQRO Program Manager coordinates discussion internally and with the EQRO contractor at the monthly contractor meeting to address any feedback received and ensure continuous improvement year over year. The Authority has a very close working relationship with the EQRO and they engage in constant communication. The performance of the EQRO is monitored monthly. Each month, an invoice is prepared that shows a summary of the EQRO's activities. If the Authority has questions regarding this invoice, they will have a discussion with the EQRO to go over any items that require clarification.

All year round, meetings are held throughout the review cycle for activities that occurred during the year. Each month, an update meeting is held between the EQRO and the Authority to discuss progress and alignment with contracts, project focus, and plans. They stated that the agendas for these meetings are retained (**Key Control #3-Monitoring**). Each activity is focused at the activities level and Penny Bichler, MCO TEAMonitor Coordinator, ensures each MCO meets compliance. Multiple processes exist to address how the Authority ensures that the EQRO captures all MCOs:

- Monthly meetings are held with the EQRO to update them on the status of the agency's compliance review and discussing timeliness and planning for upcoming EQRO deliverables
- Required review and approval by HCA of EQRO's draft Technical Report to ensure it complies with CFR, addressing all MCOs. Contract manager tracks status of deliverables and ensuring EQRO meets expectations.

Once the technical report is completed, it is sent to CMS. There was a CMS completed External Quality Review for the 2020-2021 reporting cycle. The technical report review and feedback located at [EQR Feedback Letter WA 2021](#)

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was provided to the Department on November 2, 2021. In summary, CMS' review of Washington's EQR technical reports showed that it partially met the condition to include all the required elements in the report. This requires that the technical report include an assessment of the degree to which each MCO, PIHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. CMS found that while the January 2021 report included the state's response to the previous year's EQR recommendations, it did not provide plan-level assessments. CMS recommended that in future reports, the state could dedicate a section of the report to the recommendation made in the previous year's report and outline the degree to which each plan addressed those recommendations. In addition to CMS' findings related to the completeness of EQR technical report submissions, Comagine Health identified that plan performance on 42 CFR 438 Subpart D and QAPI standards fall below acceptable thresholds. Washington's reports addressed all 11 Part 438 Subpart D and QAPI standards but did not provide plan compliance scores specific to each Subpart D and QAPI standard, as described in the Coverage and Authorization of Services standard. CMS recommended that scores specific to each federal standard are provided in future reports. However, the Department fully met the following remaining EQR conditions:

- The state submitted and posted its EQR technical report by April 30th
- All eligible Medicaid and CHIP plans are included in the report
- Validation of performance improvement projects (PIPs)
- Validation of performance measures
- A review for compliance with 42 CFR Subpart D and quality assessment and performance improvement (QAPI) standards within the previous three years, cross-referenced in CHIP regulations at 42 CFR 457.1250(a)

Because of the timing of the CMS External Quality Review, the review has not yet been completed for the 2021-2022 reporting cycle.

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### Summary of Key Controls

We identified the following key controls over EQROs:

- **Key Control 1 - Control Activities:** During the EQRO request for proposal (RFP) process, the Authority utilizes selection criteria to evaluate the competence and independence of potential contractors to ensure they meet the contract requirements.
- **Key Control 2 - Control Activities/Monitoring:** To ensure the draft technical report complies with CFR by adequately addressing all MCOs and items of annual evaluation, the EQRO Program Manager reviews the technical report template, draft, and final document and coordinates concerns with HCA subject matter experts.
- **Key Control 3 - Monitoring:** Each month, staff from the EQRO meet with the Authority to discuss progress and alignment with contracts, project focus, and plans.

### **Evaluation of Results:**

Based on our understanding of the key controls over EQROs, we did not identify any control deficiencies. If processes are performed as intended, we believe controls in place are sufficient to prevent and detect potential noncompliance with this requirement.

### Preliminary Control Risk Assessment

#### **Step 4**

LOW - Internal control design is likely to be effective to prevent or detect non-compliance with grant requirements. We will perform testing to determine if we can place reliance on the controls.