



DEPARTMENT OF HEALTH

Management Letter
For the Year Ended June 30, 2011

Report No. 11-11

*Keeping Utah
Financially Strong*

AUSTON G. JOHNSON, CPA
UTAH STATE AUDITOR



Auston G. Johnson, CPA
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MANAGEMENT LETTER NO. 11-11

November 1, 2011

W. David Patton, Ph.D., Executive Director
Utah Department of Health
288 North 1460 West
SLC, Utah 84116

Dear Mr. Patton:

We have completed our audit of the basic financial statements of the State of Utah as of and for the year ended June 30, 2011 in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our report thereon, dated October 28, 2011, is issued under separate cover. We have also completed the Department of Health's portion of the statewide federal compliance audit for the year ended June 30, 2011. Our report on the statewide federal compliance audit for the year ended June 30, 2011 is issued under separate cover. The federal programs tested as major programs at the Department were the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Title XIX Medicaid Cluster, the Children's Health Insurance Program, and the Special Education Grants for Infants and Families.

In planning and performing our audit of the federal programs listed above, we considered the Department's compliance with the applicable types of compliance requirements as described in the OMB Circular A-133 Compliance Supplement for the year ended June 30, 2011. We also considered the Department's internal control over compliance with the requirements previously described that could have a direct and material effect on these programs in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Additionally, we considered the Department's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinions on the basic financial statements but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over compliance or financial reporting.

Our consideration of internal control over compliance and financial reporting was for the limited purposes described in the preceding paragraph and would not necessarily identify all deficiencies in the Department's internal control over compliance or financial reporting that might be significant

deficiencies or material weaknesses and, therefore, there can be no assurance that all such deficiencies have been identified. However, as discussed below, we identified a certain deficiency in internal control that we consider to be a material weakness and other deficiencies that we consider to be significant deficiencies.

A deficiency in internal control over compliance or financial reporting exists when the design or operation of a control over compliance or financial reporting does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct noncompliance with a type of compliance requirement of a federal program or misstatements on a timely basis. A material weakness in internal control over compliance or financial reporting is a deficiency, or combination of deficiencies, in internal control over compliance or financial reporting, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program or a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. We identified a certain deficiency in internal control that we consider to be a material weakness. This deficiency is identified in the accompanying table of contents and is described in the accompanying schedule of findings and recommendations.

A significant deficiency in internal control over compliance or financial reporting is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program or over financial reporting that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We identified certain deficiencies in internal control that we consider to be significant deficiencies. These significant deficiencies are identified in the accompanying table of contents and are described in the accompanying schedule of findings and recommendations.

In addition, we noted other reportable instances of noncompliance which we are submitting for your consideration. These matters are described in the accompanying schedule of findings and recommendations.

The Department's written responses to the findings and recommendations identified in our audit have not been subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

This communication is intended solely for the information and use of the Department's management and is not intended to be and should not be used by anyone other than these specified parties. However, the report is a matter of public record and its distribution is not limited.

We appreciate the courtesy and assistance extended to us by the personnel of the Department during the course of our audit, and we look forward to a continuing professional relationship. If you have any questions, please call Van Christensen, Audit Director, at (801) 538-1394.

Sincerely,



Auston G. Johnson, CPA
Utah State Auditor

cc: Robert Rolfs, MD, MPH, Deputy Director / State Epidemiologist
Michael T. Hales, Deputy Director / Director of Division of Medicaid and Health Financing
Shari A. Watkins, CPA, Director, Office of Fiscal Operations
Marc E. Babitz, MD, MPH, Director, Division of Family Health & Preparedness

DEPARTMENT OF HEALTH
FOR THE FISCAL YEAR ENDED JUNE 30, 2011

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Finding Type:

MW Material Internal Control Weakness
SD Significant Deficiency of Internal Control
MN Material Noncompliance
RN Reportable Noncompliance or Illegal Acts

Applicable To:

s State Financial Statements
f Federal Program

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FINDINGS AND RECOMMENDATIONS FOR THE FISCAL YEAR ENDED JUNE 30, 2011

1. INTERNAL CONTROL WEAKNESSES, NONCOMPLIANCE, AND INADEQUATE DOCUMENTATION

Federal Agency: **DHHS**

CFDA Number and Title: **93.767 Children's Health Insurance Program**

Federal Award Number: **5-1005UT5021**

Questioned Costs: **\$15,772**

Pass-through Entity: N/A

We reviewed the eligibility determination and documentation process for 55 Children's Health Insurance Program (CHIP) cases. We noted internal control weaknesses, noncompliance, and/or inadequate documentation with 13 cases, or 23.6% of the total CHIP cases reviewed as described below. In addition, we tested CHIP service payments for these 55 cases and noted 6 payments (10.9%), totaling \$438 (federal and state portions), which were considered unallowable due to incorrect eligibility decisions. After we brought these errors to the attention of the Department of Workforce Services, they were able to make corrections in their system and eliminate questioned costs for one payment of \$102, reducing the unallowable costs to \$336 (federal and state portions). The 55 CHIP payments tested totaled \$4,406 and were taken from a total population of \$74,394,522 (federal and state portions). During our testwork we noted other incorrect eligibility decisions and noncompliance associated with the 55 CHIP cases that were not included in our sample of CHIP payments but have been included below.

As a result of the incorrect eligibility decisions and other noncompliance issues, we have questioned the federal portion of all costs associated with these cases: \$3,250 for federal fiscal year 2011 and \$12,522 for federal fiscal year 2010. The Department of Health sets CHIP policy and processes all CHIP expenditures. The Department of Workforce Services handles eligibility determination and case file management for CHIP.

a. Incorrect Eligibility Decision

For one case, the caseworker placed the household on CHIP even though the children were eligible for the Newborn Plus Medicaid Program. Per CHIP policy 201, households eligible for Medicaid are not eligible for CHIP. This error resulted in total questioned costs of \$3,748. The cause of this error appears to be that the caseworker did not properly consider Medicaid eligibility during the annual CHIP review.

b. Improper Income Verification

For two cases, proper income verification was not received during the CHIP annual reviews. Per CHIP Policy 705, income verification is required for CHIP eligibility. These errors resulted in total questioned costs of \$7,254. The cause of these errors appears to be a

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misunderstanding by the caseworker concerning the requirement to obtain the proper verification of income.

c. Income and Household Size Changes not Considered

For one case, verification of decreased income and increased household size were received before the CHIP review was processed but were not considered before processing the review, as required by CHIP policy 704. This caused a child eligible for the Newborn Medicaid Program to be placed on CHIP. This error resulted in total questioned costs of \$677. The cause of this error appears to be caseworker misunderstanding of CHIP policy.

d. Income Calculation Error

- 1) For two cases, unearned income was incorrectly calculated. Per CHIP Policy 402-4 and Medicaid Policy 403-4, the additional unemployment compensation provided by the American Recovery and Reinvestment Act of 2009 was required to be excluded from household income. The errors for these cases caused the children that were eligible for the Newborn Plus Medicaid Program to be placed on CHIP. These errors resulted in total questioned costs of \$2,291.
- 2) For one case, the earned income disregard was not applied in accordance with Medicaid Policy 409-3, which resulted in incorrect income calculation. This error caused a child that was eligible for the Newborn Plus Medicaid Program to be placed on CHIP. This error resulted in total questioned costs of \$1,418.
- 3) For one case, the household's income was calculated incorrectly for self-employment income. CHIP Policy 410-2 requires certain documentation to be obtained to determine allowable business deductions to determine CHIP eligibility. This error caused the household to be placed on the incorrect CHIP plan, with a lower quarterly premium than that for which the household was eligible. This error resulted in total questioned costs of \$240.
- 4) For one case, rental income was not considered when calculating the household's income. CHIP Policy 402-9 requires rental income to be included as countable income. This error caused the household to be placed on the incorrect CHIP plan, with a lower quarterly premium than that for which the household was eligible. This error resulted in total questioned costs of \$144.
- 5) For three cases, best estimate of monthly income was calculated incorrectly by not annualizing unemployment income as required by CHIP Policy 415-1. These errors resulted in the household being placed on the incorrect CHIP plan. After we brought

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these cases to the Department of Workforce Services' attention, they made corrections for these errors; therefore, we have not questioned any costs associated with these errors.

The cause of these income calculation errors appears to be caseworker misunderstanding of policies regarding best estimate income calculations, as well as human error. Five of the 55 total cases tested (9%) were eligible for CHIP, but put on the wrong CHIP plan.

e. **Improper Documentation**

For one case, the name used on a paystub was not properly documented as belonging to a member of the household. We have not questioned costs associated with this case because it appears the name on the paystub was an alias for a household member and the household was eligible for CHIP; however, not verifying/documenting an alias could result in improper household eligibility. The cause of this error appears to be caseworker oversight.

Recommendation:

We recommend that the Department of Health work with the Department of Workforce Services to strengthen internal controls, provide employee training, and ensure that eligibility decisions are appropriate by ensuring Department of Workforce Services eligibility specialists:

- a. Properly analyze Medicaid and CHIP eligibility during the CHIP application and/or review process.**
- b. Properly verify household monthly income.**
- c. Properly consider changes to household size and monthly income during the CHIP review.**
- d. Properly calculate household monthly income.**
- e. Properly document pertinent case information.**

Department of Health's Response:

The Utah Department of Health (UDOH) concurs with this finding and recommendation. As the state agency that administers the Children's Health Insurance Program (CHIP), UDOH must ensure that eligibility for the program is accurately determined. UDOH has contracted with the Department of Workforce Services (DWS) for eligibility determination and case management. UDOH works closely with DWS to establish controls and processes for these services.

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The Operating Agreement between UDOH and DWS establishes targets for accuracy on CHIP eligibility determination and establishes bonuses if DWS meets the targets. For FY 2011, the accuracy target was no more than 12.0 percent errors. UDOH performed an in-depth review of DWS' eligibility determinations for CHIP. The findings in the UDOH review coincide with the state audit findings of errors regarding children on the wrong program or the wrong CHIP plan. Because DWS did not meet the accuracy target, UDOH did not pay out funds to DWS for FY 2011 under the accuracy bonus provision of the agreement. UDOH will continue to review DWS' accuracy on CHIP eligibility determinations and use the agreed upon standards to determine if DWS qualifies for any funding under the accuracy bonus in FY 2012. The agreed upon accuracy target for FY 2012 is no more than 10.0 percent errors.

UDOH staff will be participating with DWS in the focused review of CHIP eligibility decisions. Reviews will occur in real time. When a DWS eligibility worker from the CHIP team makes a decision on a case, the case will be sent to a queue before being acted on by the system. The reviewers will pull from the queue and be able to provide immediate feedback to the worker and supervisor if any error is found. By reviewing decisions before they are released, more decisions will go out correctly. In addition, the reviewers will be able to meet with the supervisor and the team and provide them an overview of the types of errors that are occurring most frequently on their teams. At the end of this review, DWS and UDOH will determine what changes need to be made to eligibility policy, procedure, the eREP eligibility determination system, or training to improve the quality of CHIP decisions.

UDOH and DWS have started a CHIP Design group to review areas of concern and find areas where eligibility system enhancements make sense. The workgroup is addressing known defects and issues as well as reported usability problems that may be contributing to inaccurate decisions. The group will be focusing on annualized income and how it is entered into the eligibility determination system, the filter that helps decide between Medicaid and CHIP eligibility (Medicaid Check), CHIP premium collections, and other identified areas of concern found in the CHIP focused review. During this process, we expect to prioritize and fix the identified issues by May 2012.

Contact Person: Emma Chacon, CHIP Director, (801) 538-6577

Anticipated Correction Date: Ongoing through June 2012

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FINDINGS AND RECOMMENDATIONS FOR THE FISCAL YEAR ENDED JUNE 30, 2011

2. **INCORRECT ELIGIBILITY DETERMINATION AND INADEQUATE DOCUMENTATION OF ELIGIBILITY**

Federal Agency: **DHHS, CMS**

CFDA Number and Title: **1) 93.778 Title XIX Medicaid Cluster**
2) 93.778 Title XIX Medicaid Cluster – ARRA

Federal Award Number: **1) 05-1105UT5MAP 2) 05-1105UTARRA**

Questioned Costs: **1) \$3,098 2) \$420 = \$3,518**

Pass-through Entity: N/A

We reviewed the case files for 60 Medicaid service expenditures at the Department of Health. The expenditures for these cases totaled \$3,969,482 and were taken from a total population of \$1,879,169,761. We noted 7 cases (11.7%) with eligibility determination errors, including 1 case (1.7%) with a payment totaling \$14 where household members were considered ineligible due to incorrect eligibility decisions. As a result of the incorrect eligibility decisions, we have questioned the federal portion of costs associated with these cases totaling \$3,518 (\$3,480 for federal fiscal year 2011 and \$38 for federal fiscal year 2010).

Although all Medicaid expenditures are processed at the Department of Health, eligibility and case file management for Medicaid is handled by the Department of Workforce Services. The causes of these errors appear to be that caseworkers did not correctly determine or document eligibility as required by Medicaid policy and did not make corrections when known deviations occurred mainly due to human error or unfamiliarity with policy.

a. Improper Verification of Assets

For one case, the caseworker did not include the household's vehicles as part of the household's assets when determining eligibility, as required by Medicaid Policy Manual 500 and 731-1. Documentation obtained later indicates that these vehicles would have put the household over the asset limit for Medicaid; however, the child in the household would have been eligible for the Newborn Medicaid Program since that program does not have an asset limit. We have questioned costs of \$3,518 for the other household members as a result of this error.

b. Improper Verification of Disability

For one case, the caseworker did not obtain proof of disability, as required by Medicaid Policy Manual 303-2, before approving Disabled Medicaid. After bringing this error to their attention, the Department of Workforce Services applied for and received a retroactive disability determination for this case from the Medical Review Board. Therefore, this error did not result in an incorrect eligibility decision and we did not question costs associated

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with this case. However, not obtaining proof of eligibility could result in improper eligibility decisions and/or payments.

c. Incomplete Verification of Income or Income Calculation Errors

- 1) For one case, the caseworker relied on the client's statement when verifying income at the time of eligibility determination; however, a client's statement cannot be used to verify income, per Medicaid Policy Manual 731-3. After bringing this error to the Department of Workforce Services' attention, verification of income was subsequently obtained and did not result in an incorrect eligibility decision. We did not question any costs associated with this case. However, such errors could result in improper eligibility decisions.
- 2) For two cases, the caseworker calculated the client's income incorrectly when determining eligibility. These errors did not result in improper eligibility decisions, so no costs are questioned. However, such errors could result in improper eligibility decisions.

d. Improper Verification of Pregnancy

For one case, the caseworker did not verify pregnancy as required by Medicaid Policy Manual 731-1. Verification that the client was pregnant and was eligible for Medicaid was subsequently evidenced by the birth of twins; therefore, we did not question any costs associated with this case. However, improper verification of a pregnancy could result in an incorrect eligibility decision.

e. Improper Review Procedure

For one case, the caseworker properly closed a program when the household returned a review after the deadline but improperly reopened the program without requiring the household to submit a new application, as required by Medicaid Policy Manual 721-1 C.8. We did not question costs because other documentation in the case file indicates that the household would likely still be eligible for the same program. However, such errors could result in improper eligibility decisions.

Recommendation:

We recommend that the Department of Health work with the Department of Workforce Services to ensure that they follow established policies and procedures when determining eligibility for Medicaid Programs, including adequate documentation of all eligibility factors and decisions.

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Department of Health's Response:

The Utah Department of Health (UDOH) concurs with this finding and recommendation. As the single state agency for Medicaid, UDOH must ensure that eligibility for the program is accurately determined. UDOH has contracted with the Department of Workforce Services (DWS) for eligibility determination and case management. UDOH works closely with DWS to establish controls and processes for these services.

As required by federal regulation, UDOH conducts regular reviews of DWS' Medicaid eligibility determinations through its Medicaid Eligibility Quality Control (MEQC) reviews. The next cycle of MEQC reviews will include a review of DWS' quality control process. The DWS process is the first line of review on its eligibility determinations. This process must be accurate in order for the reviews to be accurate. UDOH believes that this review will train the reviewers who in turn will be able to train the front line staff in their direct feedback.

In addition, UDOH and DWS have agreed to co-locate key staff related to these processes. UDOH and DWS believe that their staff will benefit from greater exposure to the processes and demands experienced in the other department. To enhance this understanding, some staff from UDOH will work in DWS offices and some staff from DWS will work in UDOH's office. The co-location effort will focus on three key areas where the departments have a high level of interaction: 1) eligibility policy and procedure development, 2) federal quality reviews and performance reviews, and 3) medical disability determinations and disability document preparation. This co-location will facilitate a greater exchange between staff and allow direct training of individuals involved in these critical processes.

UDOH policy specialists work with DWS medical program specialists to clarify eligibility policy questions, review procedure, review DWS-authored training, and develop policy. UDOH will work with DWS to plan and implement regular Medicaid training to help DWS eligibility specialists better understand medical policy and therefore be able to increase the accuracy of their medical determinations. Subjects may include the following: best estimate of income, self-employment income, transitioning between medical programs, proper notice, and spenddown.

As discussed in the response to Finding 1, UDOH and DWS have already agreed to accuracy targets for the Children's Health Insurance Program. UDOH will work with DWS to establish accuracy targets for Medicaid. These targets will be incorporated into the Operating Agreement by amendment. UDOH will use the agreed upon standards to determine if DWS is meeting its accuracy target for FY 2012.

*Contact Person: Jeff Nelson, Director, Bureau of Eligibility Policy, (801) 538-6471
Anticipated Correction Date: Ongoing through June 2012*

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3. THIRD PARTY LIABILITY INFORMATION NOT ADEQUATELY OBTAINED OR UPDATED

Federal Agency: **DHHS, CMS**

CFDA Number and Title: **1) 93.778 Title XIX Medicaid Cluster**
2) 93.778 Title XIX Medicaid Cluster – ARRA

Federal Award Numbers: **1) 05-1105UT5MAP 2) 05-1105UTARRA**

Questioned Costs: **1) \$201,242 2) \$26,156 = \$227,398**

Pass-through Entity: N/A

We reviewed the case files for 60 Medicaid service payments at the Department of Health and noted errors related to Third Party Liability (TPL) with 2 (3.33%) of the cases totaling \$49,575. As a result of these errors, we have questioned the federal portion of costs associated with these cases totaling \$227,398 (\$79,266 for federal fiscal year 2011 and \$148,132 for federal fiscal year 2010).

Although all Medicaid expenditures are processed at the Department of Health, TPL determination and case file management for Medicaid is handled by the Department of Workforce Services. The cause of these errors appears to be that caseworkers did not follow through with TPL policy, either by overlooking TPL and human error or unfamiliarity with TPL policy. The errors noted were as follows:

- a. For one case, the caseworker never notified the Office of Recovery Services (ORS) or the Buy-Out Unit in the Department of Health's Division of Medicaid and Health Financing of TPL coverage reported during the original Medicaid application or of the client's option to enroll in COBRA when TPL coverage ended, as required by Medicaid Policy Manual 225. Given the client's poor health and recent hospitalization and the fact that he was applying for Disabled Medicaid, it is more than likely that the Buy-Out Unit would have approved the Buy-Out (paying COBRA premiums rather than covering costs through Medicaid) as cost-effective. COBRA coverage would have lasted at least 18 months, and Medicaid costs would have been avoided. In addition, TPL should have been charged through the date TPL coverage ended. The federal portion of the amount that may have been recovered from the third party or avoided through payment of COBRA premiums is \$225,612. After we notified ORS of this issue, ORS opened a case and filed a claim with the third party insurer for costs incurred prior to the end of coverage, totaling \$9,637.
- b. For one case, the caseworker obtained TPL information at the time the household applied for Medicaid but did not report this information to ORS as required by Medicaid Policy Manual 225-3 and by federal regulations (42 CFR 433.135 through 433.154). The federal portion of the amount that may have been recovered from a third party is \$1,786.

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Recommendation:

We recommend that the Department of Health work with the Department of Workforce Services to ensure that Medicaid caseworkers follow policies and procedures to report TPL information to the Office of Recovery Services and the Buy-Out Unit (if applicable) in a timely manner.

Department of Health's Response:

The Utah Department of Health (UDOH) concurs with this finding and recommendation. As the single state agency for Medicaid, UDOH must ensure that eligibility for the program is accurately determined and that critical information (like the availability of potential health insurance coverage) is collected on a timely basis. UDOH has contracted with the Department of Workforce Services (DWS) for eligibility determination and case management. UDOH works closely with DWS to establish controls and processes for these services.

As required by federal regulation, UDOH conducts regular reviews of DWS' Medicaid eligibility determinations through its Medicaid Eligibility Quality Control (MEQC) reviews. Once UDOH has completed its currently scheduled reviews, it will propose to the Centers of Medicare and Medicaid Services (CMS) that the next MEQC review will focus on third party liability (TPL). If CMS approves this proposal, UDOH will focus the following MEQC review on this issue. Based on the results of the review, UDOH will work with DWS to implement the appropriate changes in policy, procedures, training, and systems in order to reduce DWS staff errors in this area.

DWS eligibility specialists received training last year on Buyout, TORT and TPL referrals, which helped increase appropriate referrals. In order to continue the progress made from the last training and to address the findings of this audit, UDOH will work with DWS to plan and implement a regular TPL training module for all eligibility specialists. In addition, UDOH will continue to work with DWS to properly enhance the myCase and eREP automated TPL referral systems to send appropriate and correct TPL or Buyout referrals. UDOH will work with DWS to create a worker driven method to pass information to either Buyout or ORS directly as needed.

*Contact Person: Jeff Nelson, Director, Bureau of Eligibility Policy, (801) 538-6471
Anticipated Correction Date: Ongoing through October 2012*

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FINDINGS AND RECOMMENDATIONS FOR THE FISCAL YEAR ENDED JUNE 30, 2011

4. **NONCOMPLIANCE WITH TREASURY-STATE AGREEMENT**

Federal Agency: **USDA and DHHS**

CFDA Numbers and Titles: 1) **10.557 Women, Infants, and Children (WIC)**
2) **93.767 Children's Health Insurance Program (CHIP)**

Federal Award Numbers: 1) **3UT700709** 2) **5-0905UT5021**

Questioned Costs: **\$-0-**

Pass-through Entity: N/A

We tested 29 cash draws made by the Department of Health and noted 4 draws (14%) that did not comply with the clearance patterns specified by the Treasury-State Agreement as follows:

- a. The Treasury-State Agreement allows draws for WIC benefits to be made such that federal funds are received one day after the expenditures are made. However, of the 9 WIC cash draws tested, 1 draw for \$152,426 was two business days late.
- b. The Treasury-State Agreement allows draws for CHIP benefits to be made such that federal funds are received two days after the expenditures are made. However, of the 6 CHIP cash draws tested, 2 draws totaling \$3,676,104 were one business day early and 1 draw totaling \$32,908 was one business day late.

Not complying with the Treasury-State Agreement could result in lost interest to the State or in an interest liability for the State.

Recommendation:

We recommend that the Department of Health comply with the Treasury-State Agreement when drawing federal funds for the WIC and CHIP programs.

Department of Health's Response:

The Utah Department of Health (UDOH) agrees with this finding and recommendation. UDOH will provide additional training for staff performing the federal cash draws and has implemented additional management reviews.

Contact Person: Jerry Edwards, Financial Manager, (801) 538-6647

Anticipated Correction Date: State Fiscal Year 2012

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FINDINGS AND RECOMMENDATIONS FOR THE FISCAL YEAR ENDED JUNE 30, 2011

5. **NONCOMPLIANCE WITH TREASURY-STATE AGREEMENT FOR AMERICA RECOVERY AND REINVESTMENT ACT DRAWS**

Federal Agency: **USDA and DHHS**

CFDA Numbers and Titles: 1) **10.557 Women, Infants, and Children – ARRA**
2) **93.778 Title XIX Medicaid Cluster – ARRA**

Federal Award Numbers: 1) **WICMIS-ARRA-10-UT** 2) **05-1105UTARRA**

Questioned Costs: **\$-0-**

Pass-through Entity: N/A

We tested five American Recovery and Reinvestment Act (ARRA) draws at the Department of Health for compliance with the Treasury-State Agreement. Two of the draws tested (one Medicaid and one WIC) were not made timely. The Treasury-State Agreement requires Medicaid and WIC draws to be made on at least a weekly basis; however, during fiscal year 2011, the Department of Health made only three Medicaid ARRA draws totaling \$126,202,910 and two WIC ARRA draws totaling \$99,865. One of the Medicaid ARRA draws for \$36,673,859 was not received by the Department of Health until several days or even months after the expenditures were made. One of the WIC ARRA draws for \$94,625 was not received by the Department of Health until 45 days after the expenditure was made. Not drawing the funds as they are available results in lost interest to the state.

The Department of Health has made a conscious decision not to implement any changes to make ARRA draws in accordance with the Treasury-State Agreement because the current system is not set up to separate Medicaid ARRA costs on a weekly basis and by the time a new system would have been implemented, the ARRA program would have ended. However, the 2011 Treasury-State Agreement does not specify different draw methods to be used for Medicaid and WIC ARRA draws; therefore, we believe that ARRA draws for these programs should be made using the same methods outlined by the Treasury-State Agreement for non-ARRA draws.

Recommendation:

We recommend that the Department of Health follow the Treasury-State Agreement and draw funds as they are available or that the Department of Health modify the Treasury-State Agreement to specify different draw methods for ARRA and non-ARRA expenditures.

Department of Health's Response:

The extension of ARRA approved by Congress ended 6/30/2011. The Utah Department of Health (UDOH) will no longer be drawing ARRA funds except in the case of settlements that apply to those years where ARRA was available. With settlements, we will be able to draw

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ARRA in compliance with the Treasury agreement. Implementing this recommendation earlier in the year was very problematic. Per our response to the SFY10 audit finding #5, UDOH tried to coordinate with State Finance a modification of the Treasury agreement. It was determined that any changes would not have been approved and in place before 6/30/2011 when the ARRA extension ended. As stated in our response to the SFY10 audit finding: The Medicaid ARRA draw process by necessity is different than what was included in the Treasury agreement. The enhanced FMAP is not available for expenditures already receiving an enhanced reimbursement such as Disproportionate Share Hospital payments, Indian Health Services, Breast and Cervical Cancer, Family Planning services, Sterilization, QI 1's, and PASSAR. These expenditures must be deducted from total expenditures to arrive at the allowable draw. The reports used for these exclusions do not pull the information from FINET, but from the Medicaid Management Information System (MMIS). The MMIS reports were developed for quarterly Center for Medicare and Medicaid Services (CMS) 64 reporting, not for weekly processes. In order to comply with the Auditor's recommendation, UDOH would have had to redirect staff to redesign these reports and use our limited resources in reconciling to the CMS 64. The individual with the skills needed for this redesign was and is currently working on the CMS 64 reporting itself and other issues critical to UDOH and CMS. By the time the recommended reports would have been designed and a reconciliation process developed and tested, the ARRA draws would have been nearly at the end of the extension approved by Congress. If UDOH would have used the last known exclusion amount rather than redesigning the reports, we would have been in an overdraw position. The needed information was not readily available with our current reporting.

Contact Person: Steven Phillips Financial Manager, (801) 538-6602

Anticipated Correction Date: July, 2011

6. INADEQUATE CONTROLS OVER WIC VOUCHERS

Federal Agency: **USDA**

CFDA Number and Title: **10.557 Women, Infants, and Children (WIC)**

Federal Award Number: **3UT700709**

Questioned Costs: N/A

Pass-through Entity: N/A

The Department of Health does not have a control to ensure that the amount requested for reimbursement and paid to the WIC voucher processing bank for WIC vouchers is correct. Currently, the Department identifies the ultimate disposition of each voucher and reconciles the WIC vouchers processed by the voucher processing bank to the voucher system on a monthly basis; however, we noted monthly differences of up to \$1.6 million between WIC vouchers processed and what the WIC voucher processing bank requested for reimbursement. Differences

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throughout the year were both positive and negative with the total net amount for the year being \$368,763 more requested than vouchers processed.

Small differences are expected due to timing and possibly other factors; however, without a review or reconciliation of the vouchers processed to the amount requested and paid to the voucher processing bank, errors could occur and not be detected by the Department.

Recommendation:

We recommend that the Department of Health implement controls to ensure that the amounts paid to the WIC voucher processing bank reconcile to the vouchers processed through the WIC voucher system.

Department of Health's Response:

The Utah Department of Health (UDOH) agrees with this finding and recommendation. UDOH is now performing a monthly reconciliation of the WIC food electronic fund transfers to the WIC food vouchers.

*Contact Person: Jerry Edwards, Financial Manager, (801) 538-6647
Anticipated Correction Date: State Fiscal Year 2012*

7. INTERNAL CONTROL WEAKNESS and NONCOMPLIANCE WITH MAINTENANCE OF EFFORT

Federal Agency: **DHHS**

CFDA Number and Title: **84.181 Infants and Toddlers with Disabilities**

Federal Award Number: **H181A100111**

Questioned Costs: N/A

Pass-through Entity: N/A

The Department of Health is not in compliance with supplement not supplant/maintenance of effort requirements for the Infants and Toddlers with Disabilities program. Federal regulations (34 CFR 303.124) require that the State and local funds budgeted for expenditures in the current fiscal year for early intervention services must be at least equal to the total amount of State and local funds actually expended for these same services in the preceding fiscal year. Per our testwork, the Department's current year budget for expenditures was less than the previous year's expenditures by \$135,700. We also noted that the Department's current year expenditures were \$99,612 less than the previous year's expenditures. This noncompliance with 34 CFR 303.124 was likely caused by State budget cuts.

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Recommendations:

We recommend that the Department of Health implement internal controls to ensure compliance with federal regulations.

Department of Health's Response:

The Utah Department of Health (UDOH) agrees with this finding and recommendation. UDOH will continue to spend all funding appropriated by the Legislature for the Baby Watch/Early Intervention program. UDOH will monitor compliance with 34 CFR 303.124.

*Contact Persons: Kim Romero, Bureau Director, Division of Family Health Preparedness,
(801) 538-6911*

Jerry Edwards, Financial Manager, (801) 538-6647

Anticipated Correction Date: State Fiscal Year 2012

8. **NONCOMPLIANCE WITH TRANSPARENCY ACT REPORTING REQUIREMENTS**

Federal Agency: **USDA**

CFDA Number and Title: **10.557 Women, Infant and Children (WIC)**

Federal Award Number: **3UT700709**

Questioned Costs: **\$-0-**

Pass-through Entity: N/A

We reviewed two subawards from the WIC program for compliance with the Transparency Act reporting requirements. All subawards subject to the Transparency Act must be reported in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS) no later than the last day of the month following the month in which the award was signed. For both of our sample items, the subawards were reported in the FSRS more than 6 months past their required dates. The Department of Health stated that they did not have timely access to the reporting system and, once access was obtained, the new reporting process was complicated, requiring multiple requests for help from the federal agency. Untimely submission of subawards could result in inaccurate information on the FSRS website.

Recommendation:

We recommend that the Department of Health report those subawards subject to the Transparency Act in the FSRS in a timely manner.

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Department of Health's Response:

The Utah Department of Health (UDOH) agrees with this finding and recommendation. UDOH reviewed the FSRS process and developed procedures to ensure compliance with the Transparency Act. Each month the FSRS grant listing is reviewed to determine if reports need to be completed and/or new grants added. The personnel responsible for reporting in the FSRS are now familiar with the system and the reporting requirements.

*Contact Person: Jerry Edwards, Financial Manager, (801) 538-6647
Anticipated Correction Date: State Fiscal Year 2012*

9. LACK OF CONTROLS OVER OVERPAYMENTS AND RECEIPTS

Federal Agency: **DHHS, CMS**

CFDA Numbers and Titles: **1) 93.778 Title XIX Medicaid Cluster
2) 93.778 Title XIX Medicaid Cluster – ARRA**

Federal Award Numbers: **1) 05-1105UT5MAP 2) 05-1105UTARRA**

Questioned Costs: N/A

Pass-through Entity: N/A

The Program Integrity Unit does not have adequate internal controls to properly record and track identified overpayments and the associated cash receipts (checks received as payment or deductions of future claims recorded). Controls should ensure that duties are properly separated, that overpayments cannot be modified or deleted without detection, and that cash receipts are properly recorded and deposited. The inadequate internal controls appear to be caused by inadequate management oversight. If controls over identified overpayments and cash receipts are not properly established, management cannot conclude whether cash receipts have been properly recorded or overpayments collected, or whether cash receipts could have been lost or misappropriated. We have not identified any questioned costs or noncompliance; however, an investigation that was requested by new management is ongoing and any noncompliance or questioned costs will be reported in subsequent reports.

Recommendation:

We recommend that management implement adequate internal controls to properly record and track overpayments and associated receipts.

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Department of Health's Response:

The Program Integrity Unit is now located within the newly created Office of the Inspector General (OIG). The OIG is an agency within the Governor's Office of Planning and Budget beginning July 1, 2011. The new Medicaid Inspector General (OIG) immediately identified internal control deficiencies related to provider overpayments and has taken steps to ensure segregation of duties over cash receipts and deposits. The OIG has made personnel changes to ensure better oversight of the recovery process. The OIG has also enhanced data mining procedures, increasing the effectiveness of overpayment identification.

*Contact Person: Lee Wyckoff, CPA, CISA, CFE, Inspector General, (801) 538-6856
Anticipated Correction Date: January 2012*