

AUDIT RESPONSE REPORT

1. DHS: Safe Drinking Water Revolving Loan Fund FY 6-30-06, audit # 2007-30, (dated 12/19/07)

- Recommend the department comply with GAAP and ensure that balances reported on the financial statements are adequately supported and agree to the state's accounting system; any differences should be readily explained. Also department management should review the department's year-end accrual methodology and ensure it is reasonable for federal programs of all sizes and ensure transactions impacting prior fiscal years are recorded as prior period adjustments.

The department reconciles the drinking water loan fund and set-asides reporting statements to the state's accounting system with any differences explained in notes to the statements. The department utilized system control reports for this purpose while the auditors used queries of the statewide financial management system. The department will continue to refine the year-end accrual methodology and make appropriate adjustments to the methodology, so that accruals reflect better the year-end loan fund and set-aside financial position. At the request of EPA, on September 30, 2008, SOS determined the balance sheet and operating statement were mathematically accurate and prepared in a format required by GAAP.

- Recommend the department prepare the set-aside funds cash flow statement in accordance with GAAP.

The department will implement the recommendation by using a standard cash flow statement format that is in accordance with GAAP. At the request of EPA, on September 30, 2008, SOS determined the statement of cash flows was mathematically accurate and prepared in the format required by GAAP. While SOS did not review the details of the line items, SOS found that the statement was mathematically correct and prepared in the format required by GAAP.

- Recommend the department ensure the amounts reported in the financial statements (consolidated) of DEQ agree to the state's accounting system.

The department is not responsible for the information reported by DEQ. DEQ was notified of the recommendation.

- Recommend the department ensure adequate cash monitoring processes are in place over the department's set-aside funds.

The department will work with program staff to establish procedures to manage expenditures and cash by fiscal year within the federal budget period for the Drinking Water set-aside funds. At the request of EPA, on September 30, 2008, SOS verified that the account balances on the balance sheet and operating statement were corrected in accordance with their prior report recommendations. SOS found the department had made corrections to the account balances to report the balances in accordance with GAAP.

2. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2007, audit # 2008-03, (dated 3/20/08 revised 07/24/08)

- We recommend department management review their accrual methodology, and compare estimated accruals with actual accrual period results. This will allow management to make any necessary adjustment to their methodology to ensure it is fundamentally sound and results in accruals that are reasonably accurate.

Corrective action was taken. The department made changes to Medicaid accruals and revised financial statement procedures for estimated expenditures to account for the differences between financial statement and budgetary accruals and to produce better accrual estimates. A new procedure was implemented for the 2007-2008 financial statement accruals including a review to determine if the methodology is reasonably accurate. (See previous year's Statewide Single Audit finding 06-1).

- We recommend department management ensure future contracts with service providers require the service providers to have periodic independent internal control reviews performed. Further, we recommend department management ensure adequate supporting documentation is obtained for all transactions posted to the accounting system. Management should provide training as necessary to help ensure staff and supervisors post all transactions in accordance with the revenue recognition principles identified by GAAP.

Corrective action was taken. The department corrected the methodology for recording Drug Rebate and the Drug Rebate Allowance for Doubtful Accounts and made the appropriate adjustments to the accounting records. The department implemented new contract language for selected private industry service provider contractors who also act as fiscal agents. Managers understand their role in reviewing transactions for proper documentation as part of their approval process.

As part of the department's Transformation Initiative, individual divisions conducted events to focus on improving documentation to support eligibility determination and supporting financial transactions. The department is continuing its efforts to improve program integrity through Transformation Initiative #OX7.

For the 2009 reporting period, DHS changed Drug Rebate service providers. The contract with the department's current provider of Drug Rebate services was amended to include SAS-70 requirements. This amendment required a SAS-70 Audit Report Level 1, performed by a mutually approved independent auditor, for the period December 6, 2008 through September 30, 2009. A copy of this report has been provided to the department. A SAS-70 Audit Report Level 2 was also provided for the period October 1, 2009 to June 30, 2010. An additional SAS-70 Report Level 2 will be provided by October 30, 2012 for the period ending June 30, 2012.

- We recommend department management ensure appropriate query limits are used and communicate the importance of management reviews to ensure other revenue is properly accrued at fiscal year end.

The department included documentation of query limits in the focused efforts to improve documentation described in the response to the prior finding. The department has revised our accrual procedures. Other fund revenue accruals were part of the revisions made to the procedures. In our new accrual methodology, we have included extensive review of the process in part and as a whole. The written procedures are reviewed and updated as needed.

- We recommend department management ensure all costs incurred for vocational rehabilitation services are reasonable, necessary and adequately supported. Further, department management should ensure client files include adequate documentation of decisions made regarding the allowability of expenditures.

The Office of Vocational Rehabilitation Services provided staff training as a part of the ORCA 5 system roll out. Every staff person in the state was trained and provided a new ORCA users manual which includes clarified instructions regarding vehicle modification documentation and purchase documentation. Training began in June 2008 and was completed in September 2008.

- We recommend department management ensure the equipment tracking database includes adequate information to comply with OMB Circular A-133 requirements. At a minimum, the department should ensure the database includes all qualifying equipment, purchase and disposal dates, temporary or permanent assignments to clients, and whether equipment is for client or department use. We also recommend department management perform a periodic inventory of vocational rehabilitation equipment.

The Office of Vocational Rehabilitation Services (OVRs) initiated a new internal policy in February 2010. The key change is that the program is no longer storing any client property. This is due to the cost of storage being greater than the value of the items. The program is now disposing property as quickly as possible by either assigning it to the client, reassigning it to another client, or donating it to a not-for-profit agency. This makes having an annual inventory unnecessary. Property tracking is done in each client's file and reviewed when files are reviewed either by the branch manager or the OVRs Quality Assurance unit.

- We recommend department management ensure employees are aware of the policy related to transportation provisions and that adequate documentation is maintained, including mileage logs.

The department emphasizes the importance of following policy related to documentation of client transportation costs in the counselor training conducted quarterly and in quality assurance reviews. The department requires Office of Vocational Rehabilitation Services branch managers to periodically review counselor transportation purchases to assure compliance with policy.

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- We recommend department management ensure eligibility is determined or eligibility extensions are filed within 60 days of a client's application. We also recommend the department retain sufficient documentation to support eligibility determinations.

A statewide branch manager meeting was held on June 11, 2008 and included a review of the Secretary of State Audit responses. Branch managers emphasize that compliance of eligibility or eligibility extensions are completed within 60 days of a client's application. The OVRS quality assurance staff review vocational rehabilitation counselor case loads to monitor eligibility determinations and the required time frame.

- We recommend department management work with the designated federal agency to determine the allowability of providing emergency assistance after the 365 day period, whether Adoption Assistance subsidy payments are allowable under the state's plan, and if the department can determine eligibility based on when the client was initially removed from the home rather than six months from determining emergency assistance. We also recommend department management implement controls to ensure assistance payments are only made to clients who meet the age requirement and are within the yearly assistance limit of \$25,350.

A monthly report is provided to all Federal Revenue Specialists in the field offices via email to notify them when an annual redetermination is due. The monthly email reminds the Federal Revenue Specialists of timelines and redetermination procedures. This report also contains the date of birth for each child 18 years of age or older. Central Office continues to monitor this report and provide training as deemed necessary.

The existing report to identify all cases that reach the \$25,350 assistance limit within 365 days was determined to be inaccurate. To satisfy the necessary corrective action a new report was created in June 2009, by querying SFMA to more accurately report all cases that exceed the \$25,350 assistance limit. In October 2010, Central Office modified the \$25,350 report to include a break down per case, per monthly payment. This ensures a more timely and accurate determination of ineligibility when a client exceeds the \$25,350 limit.

- We recommend department management consult with the designated federal agency to ensure the department's method for allocating these costs to TANF is allowable or whether the department is required to identify the specific client whose services are charged to TANF and maintain adequate eligibility documentation.

System modifications completed on September 1, 2008 allowed Child Welfare to complete eligibility redeterminations and to appropriately code a child as eligible for both TANF and Title IV-E. In September 2008, Child Welfare completed the past period redeterminations retroactively beginning with February 2008. The redeterminations were then completed monthly with the redeterminations becoming up to date in March 2009. Beginning March 2009, the financial system is claiming appropriately based on the child's eligibility.

- We recommend department management take steps to ensure employees are adequately trained to understand the coding that needs to be entered in the child welfare system.

The department provided refresher training to Child Welfare eligibility specialists in September 2008, reminding them of the requirement to document income verification in the narrative section of the eligibility form. The department has implemented an internal quality assurance process including a monthly report indicating when a Child Welfare TANF-EA eligibility determination has been completed without the required narrative effective March 2009. Central Office will also occasionally monitor the narratives to ensure appropriateness and to provide continued training as deemed necessary.

Child Welfare's current system FACIS was modified in 2009 to require a narrative be input when the Federal Revenue Specialist completes a TANF-EA eligibility determination. Central Office occasionally monitors the content of narratives to ensure completeness. A monthly report is provided to all Federal Revenue Specialists in the field offices via email to notify them when annual redetermination is due. The monthly email reminds the Federal Revenue Specialists of timelines and redetermination procedures.

- We recommend department management ensure income verification used for eligibility determinations is retained in accordance with department and federal requirements.

The department provided refresher training to Child Welfare eligibility specialists in September 2008 reminding them of the requirement to document income verification in the narrative section of the eligibility form. Child Welfare procedures were updated to require that a narrative is written on every case determination and redetermination. In addition, the Child Welfare system was modified to require a narrative prior to completion of the TANF determination.

The department has implemented an internal quality assurance process including a monthly report indicating when a Child Welfare TANF-EA eligibility determination has been completed without the required narrative effective March 2009. Central Office will also occasionally monitor the narratives to ensure appropriateness and to provide continued training as deemed necessary.

Child Welfare's current system FACIS was modified in 2009 to require a narrative be input when the Federal Revenue Specialist completes a TANF-EA eligibility determination. Central Office occasionally monitors the content of narratives to ensure completeness. A monthly report is provided to all Federal Revenue Specialists in the field offices via email to notify them when annual redetermination is due. The monthly email reminds the Federal Revenue Specialists of timelines and redetermination procedures.

In addition, this eligibility criteria will be a required field on the new OR-Kids system.

- We recommend department management strengthen controls over the eligibility process to ensure that applications are complete and that income determinations are accurate and adequately supported. Further, department management should periodically remind staff of the importance of obtaining independent third party information, or questioning the applicant to verify information reported on client applications.

Children, Adults and Families (CAF) Self Sufficiency Programs (SSP) continues to proactively strengthen controls over the eligibility process. Income budgeting, signatures and documentation issues are being addressed.

Streamlining eligibility:

In October 2009, the department streamlined the Children's Health Insurance Program (CHIP) eligibility process.

- *The CHIP countable income calculation used for the initial eligibility decision was reduced from a three-month income average to a two-month average. CAF is working with DMAP in looking at "budget month" income.*
- *The uninsurance requirement was modified to make it less restrictive and easier to verify.*
- *The CHIP resource limit was eliminated.*

In May 2010, the department revised OAR 461-115-0705 (Required Verification) stating what income should be verified when an application is processed. Now verification is required for any income a client has received as of the date of request. All other income is anticipated unless questionable.

SSPAT CHIP reviews:

The Self Sufficiency Program Accuracy Team (SSPAT) completed a special project of CHIP reviews at ten branches in April through June 2009. The SSPAT CHIP review project emphasized budgeting, available third party resources, effective dates and correct program decisions. Trend information was shared with managers and staff at the ten branches, Program Managers and with the medical training team. Following the project, SSPAT staff developed a CHIP training Power Point which was distributed statewide for local and district use starting in February 2010.

MEQC CHIP reviews:

CAF SSP Medical Quality Control (MEQC) completed a review of CHIP cases as part of the federal Payment Error Rate Measurement (PERM) and Quality Control (QC) process.

- Each QC CHIP error was reported to field offices. Eligibility workers and branches were required to take appropriate action to correct errors.*
- QC CHIP errors are discussed at the monthly statewide Quality Assurance (QA) Panel meetings. This is a statewide discussion of root causes of errors with a focus on prevention. Participants include field staff, Program Integrity, policy, and training.*

In 2010, QC conducted a CHIP review project in collaboration with SSPAT. Cases were sampled from offices with the highest number of CHIP cases. The review focused on error prone eligibility elements identified through the PERM and QC reviews: Earned income and private health insurance.

- A total of 300 cases were sampled for the project.*
- Error findings were reported to branch offices as they were identified. Corrective action was required for all discrepancies.*
- Review project concluded in June 2010.*

- *A Statewide error summary will be provided to field leadership.*

Application form changes:

The department implemented a significantly shorter version of the OHP 7210 Oregon Health Plan Application for April, 2008.

- *The revision is several pages shorter than the prior version and emphasizes income and resource related questions by removing many other questions to separate forms.*
- *The revision further emphasizes self-employment income by specifically asking if an applicant is self-employed rather than relying on completion of a companion form to indicate self-employment.*
- *Training for the new OHP 7210 reminded eligibility workers to review for the applicant's signature. (CAF SSP received clarification from CMS that only one signature is required per application. CAF SSP is working with other program areas to make sure one signature is sufficient when applicants are using one application and apply for multiple programs). It also reminded eligibility workers to compare the information on the form to the prior application (if available) and to compare it against any other available income resources, including the Employment Department and Work Number screens.*
- *In addition, a new Oregon Health Plan On-line Application (OHP 7210W) was implemented July 2010. The on-line application is submitted electronically into the imaging system and has an electronic signature.*

Oregon Health Authority has hired a consulting firm to review the OHP 7210. The purpose is to have the application be more user friendly.

SSP trainings:

- *CAF SSP provided statewide narrative training completed in April 2009. The training emphasized the need to document eligibility and verification items thoroughly but succinctly in the case record.*
- *Eligibility worker training includes the requirement the client have a signed application. The CAF SSP training material was revised in April 2009, to emphasize the signature policy. Signature requirements were included in the March 2008 Skill Maintenance Challenge.*

- *In May 2008, a Skill Maintenance Challenge specific to income and resource verification was distributed. Income and resource issues were revisited for the October 2009 CHIP policy changes and are currently being trained again as part of a statewide January policy training.*
- *Eight Accuracy Summits were conducted across the state the summer of 2008. The 2008 Accuracy Summits addressed program accuracy needs identified from field staff and managers, as well as program and program integrity staff. The sessions included eligibility reminders, including income and resource verification requirements.*
- *SSP training staff developed and delivered Healthy KidsConnect training, practice opportunities and learning assessments for SSP and Seniors and People with Disabilities (SPD) eligibility and support staff. Training for SSP and SPD staff who determine eligibility focused on new eligibility requirements; case coding; and the role of the Office of Private Health Partnerships (OPHP). SSP trainers provided Healthy KidsConnect classroom training for approximately 950 eligibility staff in 55 sessions delivered across the state. Also, approximately 425 eligibility staff participated in one of the 17 Healthy KidsConnect NetLink sessions on-line. SSP trainers developed presentation, talking points, pre- and post-testing materials to support local Healthy KidsConnect training for SSP and SPD reception and support staff. Two Healthy KidsConnect focused skill challenges also helped SSP managers assess and support policy knowledge in local unit meetings.*

Self Sufficiency Modernization (SSM) efforts:

CAF SSP program staff are working in partnership with Office of Information System staff to modernize CAF SSP eligibility systems. CAF SSM continues to move forward with a stage rollout. Supplemental Nutrition Assistance Program (SNAP) just rolled out Release II of the on-line application. With this processing being rolled out across the state, workers will be familiar with the application once medical is phased in.

- *The first phase of the new web-based application is the on-line OHP 7210W. The 7210W is a version of the OHP 7210 submitted electronically by the user into the SSP imaging system. A later version of an interview style on-line medical application is being developed for expected implementation in 2011.*

- *The 'Medical Decision' training tool is currently used to assist staff in determining medical program eligibility. The department plans to automate the medical program eligibility decision process using a web-based computer system.*
- *In addition to updating some legacy computer systems, a more intuitive user interface will be implemented. Applicant information will be entered on a common data interface screen and the data will be used to populate other screens or systems, reducing data entry errors and improving the accuracy of the client data.*
- *The new application will act as a medical benefit calculator for eligibility workers. Eligibility workers will enter client information for each applicant, including income, household composition and other eligibility factors. The new application will review the eligibility factors for each medical category, including countable income, and assist the eligibility worker in making an eligibility determination. Income calculations will be automated. The new income calculation functionality will improve the accuracy of earned income calculations. New imaging technology will streamline the eligibility determination process and allow workers instant access to documents, including income documentation.*
- *Use of imaging technology will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility. The modernization efforts will be implemented in phases, beginning in 2009 and continuing throughout 2011, and with all programs being implemented by 2017.*

The three cases noted in the audit finding have been researched and all ineligible charges for these clients during the affected eligibility period have been reversed as originally charged and re-charged as state only funds. (Please also see Statewide Single Audit findings 09-14 and 10-12.)

- We recommend department management create and implement policies and procedures for the timely and adequate review of Adoption Assistance entries into the child welfare information system. We further recommend that department management consider reviewing Adoption Assistance cases entered into the child welfare information system, during the budget reduction period, to ensure payment amounts were entered correctly. Finally, we recommend the department ensure all overpayments are collected.

An eligibility coding exception report was developed and implemented by the Adoption Program in April, 2008, to identify coding errors. The report is a comparison of Title IV-E eligibility in ARMS and IIS that quickly shows coding discrepancies. The monthly report is received by the Management Assistant in the Adoptions Unit, who reviews the report and highlights apparent errors. The report is forwarded to Adoption Unit support staff that correct the errors, annotate on the report that corrections were entered on ARMS or IIS, respectively, and then return it to the Office Manager to retain.

As staff developed the report and protocol described above, an additional quality control step was identified that initially involved a manual review step. This quality control step has subsequently been developed as an automated process in collaboration with DHS Information Services programming staff. Adoption Assistance support staff use the new protocol and system to do a quality assurance check of eligibility. The automated system is supported by written requirements documentation for security procedures related to issuing and approving payments for new cases.

A payment coding exception report that is separate from the one described in the section above, was developed and implemented to identify Adoption Assistance payments entered in ARMS and IIS that do not match. The report is received by the Adoptions Program Management Assistant, who reviews the report and forwards it to Adoption Assistance Coordinators and support staff to review and correct. The over/underpayments are corrected in ARMS/IIS. In overpayment situations, families are contacted and a repayment schedule is established; in underpayment cases the errors are corrected and families are paid according to the adjustment. Corrections are noted on the report and it is returned to the Office Manager for retention.

All of the above actions were completed as of November 30, 2009. (Please also see Statewide Single Audit findings 08-28 and 09-19).

A protocol has also been designed to ensure that support staff entering information into the system have the information reviewed by the Adoption Assistance Coordinator for sign off. The program is requesting that a monthly report be provided prior to release of new adoption assistance payments to ensure that funds being released match payments authorized by the coordinators.

- We recommend department management ensure child care expenditures, submitted to the Oregon Employment Department for reimbursement, are allowable under the interagency agreement and are supported in the accounting records. Furthermore, if indirect costs are allocated to this federal program, department management should ensure the allocation is done in accordance with OMB Circular A-87.

The department has revised its cost allocation procedure to allocate sufficient costs to the Oregon Council on Developmental Disabilities (OCDD) funding sources. Financial Services has updated the grant profile to ensure that it contains the CFDA number and DHS is recognized as a recipient of the federal funds as other funds. Cost allocation has been turned on for this grant and indirect cost is currently being allocated in accordance with OMB Circular A-87.

- We recommend the department document the approved site visit protocol. This protocol should be available for review by program employees so that proper monitoring procedures are performed.

The 2002 VFC Operations Guide (in effect during the audit time period) stated that grantees should, rather than must, develop written policies and procedures for site visit protocol. The Immunization Program had frequent communication with both the CDC Program Officer and VFC Specialist, ensuring that CDC approved of the Oregon Immunization Program's methodology.

The Immunization Program's protocol was to require that an experienced health educator accompany a new VFC health educator to all site visits until fully trained. On-site training ensured that expectations were communicated in an immediate and practical manner. Feedback to the new health educator is current and directly reflects the situation at hand. As previously mentioned, CDC staff approved this methodology.

In response to this finding and updated CDC requirements in the September 2007 VFC Operations Guide, the Immunization Program has developed a timeline documenting due dates and identifying responsible staff for policies and procedures to formally define site visit protocols (VFC operations Guide - Requirements, Policies and Procedures).

A Site Visit Protocol, Site Visit Guide “High Risk Questions” Answer Key, and VFC Health Educator Training Manual have all been developed. The Protocol was implemented as a pilot in February and officially implemented in final form August 1, 2008. All staff who conduct VFC site visits receive training on the policy at hire, and with every publication update. (Please also see Statewide Single Audit finding 08-33).

- We recommend the department implement procedures to ensure all reports that are submitted to regulatory agencies are reviewed and approved by applicable supervisors prior to submission.

Public Health Division, Financial Services, has developed and implemented a policy to address this finding: Procedures for preparing the quarterly 272 report (Federal Cash Transaction Report).

- We recommend department management ensure that the ADP risk analysis and system security reviews are conducted at least every two years, as required.

The replacement Medicaid Management Information System (MMIS) began operation in December 2008. The former legacy MMIS system originally addressed in this finding is no longer operational. The new MMIS system on-site certification review began January 24, 2011.

The Information Security Office (ISO) ran a successful application assessment of the MMIS on May 06, 2009, and the processing contractor made corrections based on the findings. This assessment was run and the results were verified by ISO personnel. An application assessment process is being built into the System Development Life Cycle (SDLC).

The DHS/OHA Information Security Office began the MMIS network and server vulnerability scan using the MMIS Test environment. ISO began with the test environment due to the limited number of servers, impact to the business, and ISO developed the network and server testing processes using a newly purchased software solution.

ISO ran a successful assessment of the MMIS test environment on December 9, 2010, resulting in no network and server vulnerabilities. This assessment was run and the results were verified by ISO personnel.

The ISO completed the MMIS production network and server vulnerability scan utilizing the knowledge gained from the test environment assessment. The initial start date for the production assessment occurred on January 31, 2011. This assessment period covered multiple days due to the large number of servers and the use of multiple software solutions. ISO is compiling the Risk Assessment Report, focusing on MMIS at this time.

Using previous assessments like the Department of Human Services Information Security Business Risk Assessment (ISBRA) and Acumentra Assessment, incident analysis, and compliance mapping; the department's Information Security Office has developed a framework to support an Information Security Management Plan (iSMP). Our information security assessment plans include key iSMP elements identified below. These efforts were active during the July 2008-June 2009 time period:

- In 2008, ISO purchased a product and began developing processes to collect and identify information content types.*
- Using this product ISO began mapping information security regulatory requirements and contractual obligations. Controls were linked to regulatory requirements, contractual obligations, and information content types.*
- This product allows DHS to develop and document a baseline of information security controls, and to identify exceptions with their respective controls.*

- *The product also enhanced ISO's incident management activities. These activities include risk analysis, notification, and development of correction action plans. This product will also be used to manage our assessment plans and risks.*
- *The product purchased in 2008 also allowed ISO to begin developing processes to enhance our management of information exchanges.*
- *In 2008, ISO hired an Awareness and Education Program Manager. This individual has assessed compliance requirements and incidents. This information is being used to update ongoing Awareness and Education activities.*
- *In 2009, ISO purchased an additional product that will assist us in better defining individual access and responsibilities.*
- *Using this product, DHS will manage roles through the use of the Roles Steering Committee (RSC). This product will allow managers to assign defined roles to staff and will help DHS analyze and manage system access privileges of DHS systems and associated network devices.*
- *In 2008-2009, ISO developed Application and System Information Security Requirements; Vendor Hosting Requirements; and a Project Deliverable Security Plan.*
- *In 2009, ISO began working with the State Data Center (SDC) to provide tape encryption capabilities.*
- *In 2009, ISO purchased and implemented a product as part of DHS' Code Review process. Systems like MMIS, OR-Kids, and CAF Self-Sufficiency Modernization have had their code reviewed and corrective actions taken to mitigate identified vulnerabilities.*
- *ISO was involved in a number of assessments during 2008 and 2009. These include but are not limited to DHS ISBRA and Acumentra.*
- *DHS has determined that an ADP assessment will be conducted biennial for all systems with information classified with a sensitivity level of 3 (RESTRICTED) or 4 (CRITICAL).*

In addition, the Information Security Office is actively working with the Office of Information Services to identify and log all the department's computer systems. ADP risk analysis and security reviews will then be scheduled and completed for the documented computer systems.

The Information Security and Privacy Office (ISPO) completed an initial application vulnerability assessment for the Medicaid Management Information System (MMIS) web application during May 2011. As part of the MMIS web application Release Management process, ISPO performs an application vulnerability assessment. The last MMIS web application vulnerability assessment was completed during August 2011.

ISPO is also scheduling an annual MMIS network vulnerability assessment. (Please see Statewide Single Audit 10-11.)

- We recommend department management apply the check clearance pattern to all applicable Medicaid expenditures. Additionally, the department should work with the federal government to determine the amount of interest owed for state fiscal year 2007.

The problem has been corrected. The department coordinated interest payment with Department of Administrative Services.

- We recommend department management implement procedures to ensure current licenses are maintained for all providers receiving Medicaid payments.

The situation has been corrected. Beginning in November 2007, the department manually sent letters to new providers whose licenses would expire within 60 days. New providers who did not respond by sending a copy of their renewed license were business terminated as a DHS provider. These providers could be reactivated back to their license renewal effective date once a copy of the renewed license is received.

Beginning December 2008, the department's replacement MMIS tracks current license expiration dates and automatically generates demand letters to providers 90 days (and 30 days if necessary) in advance of the expiration date. Providers who do not maintain a required license and/or provide a copy of their renewed license are business terminated as a DHS provider.

For providers licensed by the Oregon Medical Board, the Oregon Board of Nursing, and the Oregon Board of Pharmacy, the new MMIS also has a direct interface with databases maintained by those boards. The Oregon Board of Pharmacy interface runs monthly, while the Oregon Medical Board and Oregon Board of Nursing interfaces run weekly. These interfaces are run to match the boards' license expiration date information with the provider enrollment files in MMIS. If the board has updated a license, the provider's file will be revised to reflect the new expiration date. If a board interface returns an expired license date, the system will automatically business terminate the provider.

- We recommend department management ensure that contracting procedures are adhered to and the review for suspension and debarment is documented in accordance with department policy.

The Office of Contracts and Procurement manager facilitated a workgroup regarding these issues. The work group recommended updates to Procedure 31 Federal Debarment and Suspension.

The debarment procedure was updated August 1, 2008, to include printing the debarment check and placing this documentation in the contract file. An email was sent to all OCP staff explaining the change required for debarment checking with the updated procedure attached.

Unfortunately, the revised debarment procedure was not consistently complied with. An additional notification was sent to all contracting staff reinforcing the importance of the debarment check process. Effective February 23, 2010, a check box was added to the Contract Route Sheet for the EPLS Debarment review and screen print as an interim step. Effective April 2010, a contract check list was created and is now included in every contract request (original and amendment documents). The File Check List completion is now required for every contract action. The check list includes the debarment requirements.

- We recommend department management design and implement internal control procedures over the cost allocation process to ensure that indirect costs are allocated in accordance with the department's federally

approved cost allocation plan. We recommend department management determine the effect of the errors identified above and make appropriate corrections to the cost allocation plan.

Corrective action was taken. Appropriate corrections were made to the spreadsheet used in the cost allocation process to ensure that indirect costs are allocated in accordance with the department's federally approved cost allocation plan. The effect of the errors was identified and appropriate actions were taken. The department is continuing its efforts to improve program integrity through the Transformation Initiative.

- Department management evaluate their review process over eligibility determinations and subsidy payment calculations to ensure the process is working as intended and payments are made only for eligible individuals. We also recommend the department strengthen its payment review process to ensure all coding changes have documented support and are appropriately approved. Further, we recommend the department recover overpayments made.

Subsidy payments were made after the 12-month eligibility period for four of the case files reviewed. Errors were made as a direct result of caseload issues. Since that time, program management implemented a process change for prioritizing redetermination applications to mitigate the risk of subsidies paid beyond 12 months. The prior period adjustment has been calculated and made.

Subsidy payments were made toward a plan that did not meet the federal benchmark. The department's information system correctly coded the subsidy to be paid with state funds. However, the department manually changed the transaction coding without management review, causing the subsidy to be funded with SCHIP funding. To resolve, the agency created an electronic change log so that changes can be tracked, reviewed and corrected. The prior period adjustment has been calculated and made.

Subsidy payments for one of the case files reviewed inappropriately covered the 2 percent administrative fee for insurance coverage through COBRA.

The agency agrees that an error was made on this file based on the procedure in place at the time. Since the audit; however, agency management has reconsidered this unwritten policy and decided to discontinue the practice of deducting these fees from COBRA subsidies. All health insurance premiums contain these costs, yet we don't deduct this portion of the premium prior to subsidy payment for other members. Changing this for COBRA allows the agency to maintain consistency with other premium subsidy payments.

An incorrect family size was entered into the department's information system. Corrective action was taken. The prior period adjustment has been calculated and made. Program management implemented an enhanced audit process for application processing.

An applicant's subsidy level was calculated by the department based on wage information obtained from a state database rather than the pay stubs supplied by the applicant for the time period. Program management implemented an enhanced audit process for application processing. The prior period adjustment has been calculated and made.

An applicant's case file was not complete and did not include sufficient documentation to verify eligibility. The agency disagrees with this finding. It has not been the policy or procedure to regularly request bank statements except for self-employment files. Asset information is self-reported.

- Department management consult with the Center for Medicare and Medicaid Services to determine whether it was appropriate to prepay subsidy payments to meet the maintenance of effort requirements and regarding the allowability of advance insurance premium subsidies funded with SCHIP for ineligible adults.

Advance premium payment (monthly, quarterly, and semi-annually) is common practice in the commercial insurance market. FHIAP bills members in advance of carrier due dates. Payments made to carriers are for future coverage months. OPHP first consulted with the Department of Human Services (DHS) and the Department of Administrative Services (DAS) prior to making the decision to pre-pay subsidies. The agency

thoughtfully considered where to apply these payments to ensure that payments were applied only to active and eligible accounts:

- *OPHP's fiscal unit requested a data pull through a database query on current enrollees in our three largest carriers (Regence BlueCross BlueShield, Oregon Medical Insurance Pool OMIP, and Kaiser) for future invoices to be paid through February 2008. Information was downloaded into an excel spreadsheet for review.*
- *Fiscal staff reviewed each individual account to verify each member's eligibility period, subsidy level, payment history and accounts receivable status to ensure member payments were current.*
- *We removed potential invoice prepayment on any accounts where the:*
 - *Member account was past due;*
 - *Member payment history was not consistently timely or had delinquencies;*
 - *Member eligibility ended prior to coverage period; and*
 - *Coverage period had already been paid.*

Once the accounts had been reviewed, the excel spreadsheet was used to upload the "prepay invoices" into the database for payment to carrier.

The funding script in effect on October 30, 2007, was used for distribution of the payments.

Carriers received the payments, and as the carrier invoiced for the periods, the Fiscal unit reduced the amount of payment by the amount paid in the prepay funds transfer.

Once all prepay funds had been allocated, the fiscal unit reviewed each and every MOE prepay account for verification, and reconciled all prepay amounts.

While the agency believes it operated within its understanding of its contractual obligation with the Centers for Medicare and Medicaid Services (CMS) at the time the expenditures were incurred, a prior period adjustment has been made to adjust expenditures from SCHIP to Medicaid. An increased state fund share

was required to pay for these services due to the lower match rate of the Medicaid program at the time. (Please see Statewide Single Audit finding 08-24.)

3. DHS: Interpretive Services, audit # 2008-22, (dated 07/21/08)

- Recommend the department management develop and implement policies and procedures to ensure that invoices and supporting documentation are adequately reviewed prior to payment approval or within a reasonable period of time if prior approval is not feasible.

Children, Adults and Families (CAF) has instituted a new process which compares the vendor's invoice numbers to previously assigned vouchers to help assure they have not been submitted for payment on another payment voucher.

Seniors and People with Disabilities (SPD) held meetings with their Operations Committee and managers. These meetings helped develop a communication and training plan to outline procedural expectations for quality control and consistency in documenting the need for and providing appropriate interpretive services.

Within the Governor's Advocacy Office, random telephone calls were made to clients identified from contractor invoices as having received alternate format communication. Clients were asked if they had received the identified communication listed on the invoice. Even though clients were instructed that the scope of telephone calls was limited to alternate format verification, many clients wanted to speak about their benefits and when instructed to telephone their worker, many clients were frustrated at not having immediate access to the information they sought.

The invoices that clients were selected from did not contain the client's telephone number, so an inquiry had to be made on the appropriate client screen to obtain a telephone number. Clients were asked three questions:

1. *Your case record reflects that you have requested to receive communication converted into alternate format, do you still want your communication converted into (Braille, Audio tape, Computer Disk?)*
2. *During the past two weeks have you recently received a client notice or application packet that was converted into alternate format?*
3. *How would you evaluate the readability and accessibility of the alternate format material?*

The responses obtained from clients were overwhelmingly positive. Only two clients contacted indicated that they no longer needed alternate format communication. This office contacted the client's caseworker to request that the coding for alternate format be removed from the client's profile. Over a six month period of time, at least a hundred clients were contacted by this office to confirm that they had received correspondence converted in an alternate format, and there was total reconciliation between the invoices and the confirmation from the client. Conducting these "spot checks" also resulted in affirming how appreciative clients were with receiving the alternate format correspondence and how complementary clients were with the accessibility of the converted document.

The Division of Medical Assistance Programs (DMAP) has recently developed a form that interpreters must bring to client appointments for signature by the provider to confirm that these services were rendered. The interpreter service form includes the client name, medical I.D., provider name and provider number, date of service, and time and location. This form, effective since June 16, 2008, must be submitted with the interpreter invoice in order to receive payment. Since March 2008, each invoice received by the DMAP Provider unit has a manager review it to verify client eligibility for the service prior to payment.

Although the Office of Vocational Rehabilitation Services (OVRs) has current policies in place that require supportive documentation prior to payment of invoices; in response to noted payment errors, OVRs communicated procedural expectations to all field staff. The presence of an interpreter at a client meeting must be noted in meeting documentation to certify that interpretive services were provided. This was presented in a recent training rollout of the upgraded OVRs client information system, which began in June and continued through September 2008.

The Office of Human Resources (OHR) reviewed the DHS "Employees As Contractors" policy, DHS-060-003; however, no changes were required. OHR will continue to provide communication and training around the DHS Conflict of Interest policy, DHS-060-002.

- Recommends department management should research all identified payments with inadequate support and initiate measures to collect or withhold from future vendor payments any inappropriate charges.

Connection time reports were requested and received from contractor effective December 15, 2007. A credit was provided to the department. Additionally, random calls were made by DHS employees on the invoice list, approximately two per month, to determine if the services were actually received. In all follow-up calls, the translation service was requested and received.

The audit report referenced an individual being paid for services provided while on paid sick leave. At that time, the department did not have specific knowledge that the employee was also a vendor as the individual did not complete the required notification information for approval. OHR completed its investigation with this employee, and corrective action has taken place. For the previously mentioned situation and other instances identified in the audit, OHR has researched all questioned charges and has initiated measures to collect recoverable payments.

- Recommend department management should work with the vendor that omitted connection times to determine any discounts owed the department.

Beginning with the December 2007 invoice, the vendor has included the connect time for every call as required in the contract. DHS reviews the connect time log with the monthly invoice to determine which calls exceed the provisional connect time and reduces the invoice accordingly.

As mentioned previously, the department worked with the vendor to estimate and collect connect time discounts prior to December 2007, as referenced in the audit report. Changes have been implemented to monitor all invoices for services after December 31, 2007, for accuracy and connect time credit from the vendor as per the contract agreement.

- Recommend department management should initiate procedures to ensure staff responsible for coding payment transactions do so accurately and use codes that best describe the services provided.

DMAP implemented a new coding matrix in March 2008, to ensure accurate and consistent accounting codes were used. OVRS modified their coding and provided it to appropriate staff. CAF requested new coding to better track and report these costs. Appropriate staff were trained on the coding revisions.

Financial Services convened a meeting with department financial and program staff to make certain that the needs of both were met. Financial Services set up any additional codes that were required. Training followed with the correct coding distributed to those responsible for coding invoices for interpreter services and to Financial Services staff.

In response to the vendor payment to an employee that was almost three times what the individual earned while performing similar work as a DHS employee, OHR agrees that employees should not be used as vendors. The work performed by the employee as a vendor was not provided concurrently with work performed as an employee. Because the services were provided by the individual, this payment is not recoverable. The manager in this instance was counseled and now understands the importance of working with OHR for direction prior to making any hiring requests in the future. Since then, the manager attended the DHS Conflict of Interest training and was provided with the new policy.

- Department management should review and clarify contracting requirements with staff, and monitor compliance with those requirements.

The Office of Contracts and Procurement (OCP) offers training to DHS program staff that have contract responsibilities. Since July 2005, hundreds of department staff have been trained in one or more of the following contract related modules: Contract Administration, Contract Overview, Statement of Work, RFP/Solicitation, and the Contract Super Module (all of the above components).

The contract specialist assigned to OVRs (area responsible for issue cited in the audit) has presented twice at OVRs management meetings on contract practices and requirements including appropriate source selection requirements. In addition, OVRs branch managers received Contract Administration training in October 2008.

OCP will continue to scrutinize all contract request forms for compliance with contract rules and statutes.

- Recommend department management should review all payments made to identified employees who were paid as vendors, and collect any inappropriate payments.

With regard to the specific vendor payment that was almost three times what the employee earned while performing similar work, OHR agrees that the person should not have been used as a vendor. The work performed by the employee as a vendor was not provided concurrently with the work performed as an employee. Because the services were provided by the individual, this payment is not recoverable. For the instance involving sick leave, the overpayment was collected in full in July 2008. We have also implemented a monthly review of interpretive services for all DHS employees.

- Recommend department management should develop and implement procedures to identify employees who are also paid as vendors, and review those arrangements and associated payments for appropriateness.

OHR reviewed the DHS “Employees As Contractors” policy, DHS-060-003 and no changes were implemented. This review was completed in August 2008. OHR will also continue to provide training around the department’s Conflict of Interest policy, DHS-060-002.

In 2007, OHR began working with the DHS Training and Development unit to create “train the trainer” Conflict of Interest training. Human Resource Analysts now provide this training to their area managers. In addition, DHS Training and Development has created an on-line Core Values training, available to all department employees, that presents specific conflict of interest scenarios for added learning emphasis. This on-line training was activated in May 2008.

The department has begun reviewing a cross reference check report between the payroll system and the vendor accounts payable systems for name and address matches, to help ensure all payments are appropriate. The department implemented this report in August 2008.

4. DHS: Integrated Information System Applications Controls Review, audit # 2008-24, (dated 08/08/08)

- Department management design and/or implement controls to independently validate Adoption Assistance payment parameters after they are manually entered into the system.

In May 2007, the department initiated the automation of a monthly report allowing for a match comparison of data entered into the two databases, Adoption Recruitment Management System (ARMS) and Integrated Information System (IIS). The intent of these data check runs was to ensure that errors are identified and addressed in a timely manner. However, the focus was to identify any miscoding errors related to Title IV-E eligibility. Upon awareness that incorrect entries were occurring beyond the Title IV-E coding, the monthly report runs were modified to include newly negotiated agreement amounts.

The most recent error identified since the implementation of the monthly report through the audit involved a renegotiated agreement rather than a newly negotiated agreement. The matter was immediately addressed and has been resolved.

DHS, as of April 2008, has initiated a monthly comparison report (ARMS-IIS-Amounts) that compares all new agreements and renegotiated agreements entered into ARMS and IIS to identify discrepancies of payment amounts and Title IV-E eligibility entries. This report is reviewed by department management of the Adoptions Unit and any discrepancies are corrected.

- Department management design and/or implement controls to ensure monthly reconciliations of system payments are timely and effectively performed.

This is a large system with a complex reconciliation. We found that review of the reconciliation report for the sample month (September 2007) was completed on November 28, 2007 or within 45 days of the September SFMA cutoff in mid-October. This meets our timeliness standards. This reconciliation report was completed on a current basis during the first ten months of 2007-2008. The report was submitted for approval and review within 45 days. We continue to look at ways to improve the effectiveness of the report by including comparisons with SFMA, IIS, and Treasury data. The Office of Financial Services continues to meet its timelines. The Office of Financial Services also continues to work with the Office of Information Services to get better reports to assist with the reconciliation process. We anticipate further efficiencies in the reconciliation with the implementation of OR-Kids, the replacement system.

- Department management design and/or implement controls to properly record the issuance and payment of replacement checks.

The prior 'replacement' check process is no longer being used. The Office of Financial Services developed a new process to properly record reissuing replacement checks.

- Department management design and/or implement controls to separate duties for establishing Adoption Assistance clients in the system and setting up their associated automatic payments.

A protocol has been designed to ensure that support staff entering information into the system have the information reviewed by the adoption assistance coordinator for sign off. The program is requesting that a monthly report be provided prior to release of new adoption assistance payments to ensure that funds being released match payments authorized by the coordinators.

- Department management design and/or implement controls to ensure adjusting entries to correct system transactions are fully documented to better facilitate their review and approval.

The Office of Financial Services proposed system changes for the future replacement system, OR-Kids, that would provide a better documentation of adjusting entries.

- Department management assign responsibility for developing, implementing, and testing complete system backup and restoration strategies. Items needing specific and immediate attention include ensuring all critical files are backed up and stored offsite, specific roles and responsibilities are defined and assigned, and backup and restoration efforts are formally coordinated with the State Data Center (SDC) via a written service level agreement.

The process for backup and recovery or restoration involves numerous components. Staff have been identified to address these components from which we will determine the work that needs to be accomplished, who needs to conduct the work and the time frame such work can be completed.

Database backups are created on hard drives and reside at the SDC building in Salem. Staff at the SDC has informed us an additional backup copy of our databases is put onto cartridges and stored away from the Salem area; however, we have not independently verified SDC's process. Documentation of the backup and restoration process has improved since the time of the audit and we will continue to make improvements in this area.

DHS OIS and the Information Security and Privacy Office (ISPO) continue to work with the SDC regarding backup plans and restoration. OIS and ISPO will collect documentation from the SDC describing their plan(s). OIS and ISPO will work with SDC in testing their backup recovery plans or acquire documentation from SDC tests as part of the application systems information security assessments. OIS has indicated a December 2011, completion target date for defining Recovery Time and Recovery Point Objectives. However, no dates have been defined for specific system testing.

We agree the business needs to identify which files they determine to be “critical” files and thus determined critical for backup. This also includes the implementation of Service Level Agreements (SLA) between OIS and the business, and a written SLA between DHS and the State Data Center.

- Department management develop more robust program change management policies and procedures to ensure authorized code is safeguarded and all necessary quality assurance steps are performed and documented prior to elevating the code to production.

DHS will work to improve weaknesses in change management processes identified in the audit report. Specifically, the department will address the absence of independent reviews of modified code, formulation and performance of testing plans, and performance of code compares to ensure only authorized changes are performed. We will also restrict access to authorized code prior to moving it to production.

Many of the weaknesses identified are addressed in the DHS OIS Change Management Procedures. Through awareness and education activities, DHS will train staff in appropriate behaviors. Using recently purchased software, DHS will assign individuals to business roles (i.e., developer, DBA) and route the DHS OIS Change Management Procedures to these specific business roles. The software will allow those users assigned to the roles to attest that they have read and understand the procedures. Furthermore, the software will allow DHS to survey individuals or roles concerning their adherence to the procedures. ISPO has indicated a completion date of March 2012; however this date is dependent upon OIS providing the PPDB/WIS/AD information as scheduled in November 2011.

5. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2008, audit # 2009-07, (dated 3/31/09)

- Department management ensure that funding transactions are allowable for federal programs and documented in accordance with OMB Circular A-87.

Corrective action was taken. Training was provided to the staff that made the coding error. Corrections were made to the appropriate accounts.

- Department management implement procedures to ensure coding and client data are accurately entered and appropriately updated in CMS and correct the identified errors.

The Client Maintenance System (CMS) calculates benefits for no-adult cases based on the number in the household, the number in the need group, and the countable income. Examples of no-adult cases are: households where the adult is a non-citizen, SSI recipient, or non-needy caretaker relative. Most errors were related to improper coding of the number in the household. There were no edits in CMS that require this data field to be updated when the caseworker made changes to the case.

The five cases with errors were corrected. An email was sent to the respective branch office line manager notifying them of the case needing correction. All managers reported a review of the case and applicable corrections were made. The corrective action process was completed on June 12, 2009. In three of the five cases, an overpayment of benefits had been written. In two of the five cases, a supplemental payment was issued.

A Policy Transmittal was sent to Self Sufficiency Program staff on June 15, 2009. This transmittal provided clarification and guidance, including OAR citations and Client Maintenance (CM) system coding needs, when accurately determining benefit level for TANF no-adult cases.

A CM system edit was created, and became effective June 25, 2009, that prompts case workers to review the adjusted number in the household when taking an action on a TANF no-adult case.

The TANF Policy Analysts worked with the CAF Training Unit to ensure TANF week 1 training addresses correct calculation of the adjusted number in the household, and required computer coding, in TANF no-adult cases.

- Department management implement a procedure to detect whether assistance payments agree with the signed adoption agreements. We further recommend that department management work with the designated federal agency to determine the appropriate way to resolve any potential overpayments.

Effective February 1, 2003, the department implemented an across-the-board 7.5 percent reduction in foster care payments and a 10 percent across-the-board reduction in personal care/special rates that was concomitantly applied to all previously negotiated Adoption Assistance payments. The change became the foundation for a subsequent law suit. Payment changes were compounded by a reduction to the hourly cost of supervision and recalculation of the number of hours of supervision available to some children through personal care/special rates.

The reduction period lasted through October 2003. Rates were restored pursuant to a court order and direction from legal counsel in November 2003. The increase was determined through a complex calculation agreed to by all parties to the legal proceeding.

During the nine months (February 2003 to October 2003) that Adoption Assistance was subject to an across-the-board reduction, new cases opened during this period of time were negotiated in accordance with lower foster care rates established in February. Children who were receiving personal care/special rates also had that part of their Adoption Assistance payment calculated using the lower hourly rate for supervision. Pursuant to the legal case involving Adoption Assistance cases subject to the original across-

the-board rate reduction, these cases were treated equally for the purpose of rate restoration since they would also have been established at a higher rate in the absence of the original reduction.

The department believes that it was the clear intent that all new cases opened during the rate reduction period were to be established using the newly reduced, across-the-board foster care rates and to be restored summarily with all other open assistance cases. The department does not believe that the restoration of all Adoption Assistance rates to pre-reduction numbers resulted in an ensuing overpayment for every new case established during the reduction period since the basis for the rate was restored to a higher amount.

More than 7,000 adoptive parents with open Adoption Assistance cases were mailed an “Amendment to State of Oregon Adoption Assistance Agreement” dated November 1, 2003, stating that the purpose of the amendment was to revise the current agreement to restore Adoption Assistance benefit payments that were previously reduced due to budgetary reductions and to clarify the manner in which future adjustments to Adoption Assistance benefits may occur. The agreements were to be signed and returned to the department. It is clear that the amended agreements spoke to – and raised – all Adoption Assistance agreements in effect on October 31, 2003, to include new cases open during the reduction period. Parents were advised of the following changes in the amended agreements:

- Monthly payments were increased by 8.108 percent.*
- A special payment was increased by 8.108 percent if it was payable under an Adoption Assistance agreement that was in effect on January 31, 2003, reduced on February 1, 2003, and restored in November, 2003.*
- Special payments were not increased if it was payable under an Adoption Assistance agreement in effect after February 1, 2003.*
- Nonrecurring payments were not impacted.*

Some of the cases established during the reduction period were established at a rate less than the reduced foster care rate through negotiation with the family, some had an added amount for personal care/special rates, and some directly align with the foster care rate by age group. Upon review, it appeared some of the

cases established during this period were treated inconsistently after the initial rate was established and prior to the rate restoration. As discussed below, the department initiated a rigorous re-review of these cases to confirm that rates were correctly managed.

As a result of a prior audit finding, the department had implemented an automated system to detect over- and under-payments. An electronic report is generated by the Integrated Information System (IIS) that identifies discrepancies. A process is in place that includes staff review of the report and correction of any payment discrepancies, as necessary. An additional step involving staff verification that ensures payment corrections have been entered and accepted by the payment system (Integrated Information System) was added to this review process. (See prior year finding 07-42 from Statewide Single Audit.)

The department's Adoption Program completed a review of the reduction period cases identified in the audit to confirm the following:

- Payments opened during the reduction period of February through October, 2003, were established in line with the reduced foster care rate and pursuant to a properly negotiated Adoption Assistance agreement.*
- There was equitable management of payments for new cases opened during the reduction period.*
- All payments for new cases opened during the reduction period were increased at the same time as longer-standing Adoption Assistance cases.*

Part of this file review also addressed the question of whether there was a signed agreement in the file that recorded the changes in payments, both decreases and increases, from the reduction period. While new agreements were sent to all families to correctly document the changes, not all families returned them and the adoption program did not track this at the time, nor did they file returned agreements directly into subsidy case records.

The absence of a signed agreement supporting the current payment is contrary to federal requirements. The manual review found that in a small number of subsidies, there were no signed agreements and incorrect

payments continued until they were identified as a result of the audits and corrective action plan (a period of more than six years). As a result of the review, eight cases were determined to be under-payments in the total amount of \$5,539. A total of 23 cases were determined to be over-payments in the total amount of \$71,693. Most of these were for children placed out of state with more complicated subsidy structures.

Adoption Program management has initiated contact with the Administration for Children and Families Children's Bureau, Region X Child Welfare Program Office regarding how to best resolve the issue. At this point we estimate approximately \$28,000 in federal Title IV-E funds are within the total over-payment amount.

Parents of all children with under- and over-payments will receive a corrected Adoption Assistance Agreement with an explanatory letter appropriate for their circumstance. The agreements are retroactive to November 1, 2003. The department will reimburse parents of children with under-payments for the total difference DHS owes on each agreement.

The department manually reviewed all agreements affected by the reduction in 2003 and implemented new matching agreements on all but 19 active cases. The department developed and implemented a new procedure that involves a second level of review which is conducted on every Adoption Assistance Agreement to ensure that the amount on the agreement and the amount authorized match. The department worked with the designated federal agency and determined there was no overpayment because there is no Federal requirement that Adoption Assistance Agreements reflect the amount of actual adoption assistance payments. This is confirmed in a letter from the Administration for Children and Families. Based on discussions with federal agency no further actions are required. (See Statewide Single Audit Findings 09-19 and 10-23.)

- Department management correct this case in its system so that the appropriate funding source is used for assistance payments and return any disallowed costs to the appropriate federal agency.

The department reversed the Title IV-E Adoption Assistance eligibility for the case in question back to 2001. While the coding changes were made in the system, the federal funds adjustment still needs to be made. An adjustment will be made to the October 2010 quarterly financial assistance claim to reflect this correction. The case will continue to be managed in the future as a non Title IV-E Adoption Assistance subsidy.

- Department management implement controls to ensure all private health insurance listed on client applications is entered into MMIS and seek recovery from the private health insurer for the appropriate portion of the client's claims.

The department's Health Insurance Group (HIG) is responsible for verifying and coding the client's private health insurance information onto the Medicaid Management Information System (MMIS) from the Medicaid application. When Medicaid pays a claim that could be paid by the private insurer, it is automatically billed by the MMIS system and referred to the Medical Payment Recovery (MPR) unit for follow-up and collection. MPR attempts to recover on claims going back up to six years for some coverage plans.

The private insurance information for the client identified during the audit was verified and entered into Medicaid Management Information System. Upon further review of the specific claims addressed in the audit finding, we believe all appropriate coordination of benefit actions have been taken, and that the appropriate third parties were billed by the providers prior to billing the department. Many of the claims listed were for assisted living services, and not covered under the client's third party resource. In addition, a number of the claims listed were for client co-pays which are not subject to third party liability and Medicare cross over claims. After reviewing the details for the various claims, no additional recovery of TPL funds is required related to this finding.

The HIG unit has eliminated the previous backlog and is now working referrals received within 30 days. Processes are in place to continue to meet this deadline. Billings are now being sent automatically out of

MMIS to collect once third party resources are identified. After the initial billing, follow-up billings are now being generated and a "no response" report is being worked by MPR.

- Department management comply with federal regulations and ensure provider agreements contain the required disclosures.

The department provides all current Home Care Workers with information regarding record keeping. Information about advanced directives is not included on the remittance advice for homecare worker payments. Upon reviewing 42 CFR 431.107, we do not believe homecare workers fall under this requirement. Homecare workers are considered domestic employees and do not provide health care. They are not under the direction of a licensed health care professional. They are directly employed by individuals receiving Medicaid services and are not employed by home health agencies.

Changes to the Seniors and People with Disabilities (SPD) Adult Foster Home Provider Enrollment Agreement Form (SDS 738) were made on March 19, 2009, to address the ownership and control disclosure requirements.

In addition, SPD revised residential care and assisted living rules (effective October 1, 2009) to require a resident to provide, prior to move-in, any financial and other legal relationships including advance directives.

Beginning in December 2008, all new Addictions and Mental Health (AMH) Foster Home providers are required to complete the Division of Medical Assistance Program Provider Enrollment Agreement. These agreements have the appropriate disclosure documents. Existing providers without a new enrollment agreement are identified through a system query. Once a provider is identified, they are mailed letters requesting re-enrollment with the new forms. AMH staff estimated that approximately 30 percent of existing providers have completed the necessary forms. The time frame for completing this has been delayed due to MMIS system implementation issues. AMH expects to have the remainder of existing provider forms signed

by the end of December 2010. AMH Adult Foster Homes receive payment through the new Medicaid Management Information System (MMIS).

AMH amended Adult Foster Home rules in August 2009, to include a requirement that all residents be provided the opportunity to complete an advance directive.

- Department management implement procedures to ensure that adequate supporting documentation is maintained for all payments, specifically provider payment rates and any authorized changes to each rate.

While the department feels the reviewed rates were correct, the supporting documentation could be improved. Addictions and Mental Health (AMH) will implement policies and procedures to ensure all requested rates are reviewed prior to entry in the Medicaid Management Information System (MMIS) interface and adequate supporting documentation is maintained for all provider payment rates and authorized rate changes. AMH will develop and implement a procedure regarding notification of any authorized rate changes.

AMH began using the department's MMIS for payment of Medicaid Personal Care services in a variety of residential settings, including Adult Foster Care, when the new system went live in December of 2008. At that time, AMH implemented a rate setting methodology based upon the individualized service plan, the number of hours of Personal Care projected and a projected wage scale. These services are pre-approved using the Plan of Care function in the MMIS. All new requests use this methodology. AMH will revise existing rates as indicated, but the time frame for doing so has been delayed due to system implementation issues.

The reimbursement rates for Adult Foster Care are determined by the Personal Care Plan and the rates are authorized for one year. We anticipate that all of the Personal Care Plans reimbursement rates will have been reviewed and updated by January 2011. The providers will cycle through on an annual schedule, ensuring the rates will be reviewed annually.

- Department continue to use the site visit protocol adopted August 1, 2008. This protocol should be available for review by program employees so that proper monitoring procedures are performed.

The policy was formalized and signed in August 2008. All staff who conduct Vaccines For Children (VFC) site visits receive training on the policy at hire, and with every publication update. (See prior year finding 07-44 from Statewide Single Audit.)

- Department implement procedures to ensure that samples are selected by the program staff such as selecting from databases of vaccinated children or other records.

The Vaccines for Children (VFC) program implemented the VFC Site Visits: Random patient lists to determine vaccine eligibility screening procedure effective February 2009. The health educators use the procedure at each site visit.

- Department consider reducing the chance of errors in manual entries by using a system other than Excel-type spreadsheets for compiling and calculating monthly cost allocation rates. The department is in the process of moving its cost allocation statistics preparation from Excel to Access, to reduce the chance of human error in data entry.

DHS Financial Services filled positions internally to stabilize and revamp three databases required to allocate indirect costs in accordance with the DHS federally approved cost allocation plan. The cost allocation initiative dealt with improvements to the cost allocation process. This included changes to the cost allocation model to properly allocate cost between the two new agencies. Automation of the process was part of the outcome of the initiative, but the implementation of the automation will not occur until the 2011-13 biennium after the new cost allocation model is in place. The work continues on the other two databases and the cost allocation module will be added later. Target implementation for a fully automated system converted to a new database platform is set for the end of January 2012.

- Department management implement procedures to ensure the benchmark worksheets include all the required federal benchmarks. We further recommend department management ensure all approved health insurance plans are in compliance with current benchmark requirements.

As a result of the Benchmark Specialist marking “no coverage” in error on the benchmark worksheets, the audit determined that 24 of 60 subsidy payments tested were made for coverage not meeting the benchmark requiring mental health. Program management has confirmed that all but two of these payments were made for plans containing mental health coverage. The associated benefit plan for the other two payments has been reviewed. Affected plan members were notified, disenrolled from these plans and offered assistance to transfer to an appropriate plan.

The Benchmark worksheets were updated by April 15, 2009. The department reviewed all plans for compliance and corrected all compliance issues by October 31, 2009. The prior period adjustments have been calculated and made.

- Department management should continue to improve their eligibility review process. We also recommend the department determine the amount of State Children’s Insurance Program funds that should be refunded to the federal agency.

Eligibility determinations were not made timely in 29 of the 60 case files reviewed. These errors were made as a direct result of caseload issues and redirected work assignments resulting from Maintenance of Effort (MOE) challenges. Program management staff has since implemented process changes enabling the agency to mitigate the risk of subsidies being paid beyond the 12-month eligibility period. Files identified in audit for year ending June 30, 2008 were processed prior to implementation of these process changes. The agency implemented a manual solution. Eligibility staff work redetermination applications based on the subsidy eligibility date. FHIAP management assesses upcoming redeterminations weekly. Applications closest to the end of their 12-month eligibility period are worked first.

The agency is in the process of restructuring the agency database. The new database will automatically generate reports identifying accounts nearing the 12-month eligibility maximum. Similar to the manual process, staff will then work the files closest to the end of the eligibility period. Implementation of the new database has been delayed.

The office has refunded SCHIP funds that were used in error. The prior period adjustment has been calculated and made.

- Department management should work with the federal government to determine whether it is allowable for the program to pay insurance premiums for private health insurance plans that do not specifically exclude abortion coverage.

The agency disagreed with this finding. This issue was discussed during the initial 2002 waiver negotiations with the Department of Human Services (DHS), Office of Private Health Partnerships (OPHP), and Centers for Medicare and Medicaid Services (CMS). At that time, all parties agreed that because the Family Health Insurance Assistance Program (FHIAP) does not subsidize medical services, but provides a subsidy for private insurance premiums, this requirement does not apply. This is consistent with other states' premium assistance programs.

Further, Oregon maintains that the member portion of the premium would pay for any abortion coverage that may be offered in the private-sector plans. The state does not request federal match for this portion of the premium.

- Department management should consult with Centers for Medicare and Medicaid Services (CMS) to determine whether subsidy prepayments are allowed to be counted toward maintenance of effort and whether prepayments made for adults were allowable since the adults were ineligible for SCHIP funding for the time period prepaid. (See prior year finding 07-41.)

Corrective action has been taken. While the agency believes it operated within its understanding of its contractual obligation with the Centers for Medicare and Medicaid Services (CMS) at the time the expenditures were incurred, a prior period adjustment has been made to adjust expenditures from SCHIP to Medicaid. An increased state fund share was required to pay for these services due to the lower match rate of the Medicaid program at the time.

- Department management should correct the accounting transaction and determine the amount of SCHIP funds that should be refunded to the federal agency. We also recommend department management ensure the transaction approval process is adequate to ensure coding is entered accurately.

As of March 19, 2009, the program added a third level of carrier payment review. Accounting staff now audits the transition between the funding report and the accounting input document line by line prior to final approval by the fiscal manager.

The new database will automatically create SFMA input documents, eliminating the possibility of manual transposition and coding errors. The new database implementation has been delayed.

The office determined the amount of SCHIP funds that needed to be refunded to the federal agency and refunded them on June 25, 2009. The prior period adjustment has been calculated and made.

6. DHS: Oregon State Hospital (OSH) RP Construction, audit # 2009-14, (dated 5/31/2009)

- Department take the following action to further enhance its equipment rental practices: establish agreed upon purchase prices for equipment rented directly from the general contractor and track total equipment rental charges to ensure agreed upon purchase prices are not exceeded.

While the agency had initially negotiated a significant rental cost discount with the contractor, we also revised Project procedures to incorporate this recommendation. We executed a Record of Negotiation with the contractor on August 3, 2009, to agree upon equipment purchase prices that take into account equipment replacement costs.

The contractor submits, with each payment application, a summary log of equipment rentals (the “Rental Log”) from their yard to the Project itemizing items rented and full replacement cost of each item. The Rental Log details: 1) The rented item; 2) Quantity; 3) Rental price; and 4) The full replacement cost of each item.

7. DAS: State Cell Phone Plans, audit # 2009-18, (dated 08/26/09)

- DHS, ODOT, and DOC:
 - obtain from vendors cell phone billing and usage reports that identify cost saving opportunities and share those formats and analyses with other agencies as opportunities arise;
 - regularly review cell phone bills and vendor reports to identify zero use phones and usage patterns that indicate a line should be terminated or a plan should be adjusted;
 - update cell phone inventories now and immediately turn off all phones unaccounted for; and
 - update inventories periodically in the future, including accounting for phone returns and line terminations for separating employees.

The department implemented improved procedures on wireless communication device (WCD) usage, many of which reflect the recommendations in the audit report and have generated savings.

The process of identifying the local WCD coordinators began in January 2009. A pilot program for the (primary vendor) districts began in June 2009. Initial pilot training on the new local review process occurred on July 21, 2009. WCD coordinators are in place and have been trained. As new coordinators are

added training is provided by the Statewide WCD coordinator. Webinar coordinator training is being prepared and will be presented twice a year starting second quarter of 2012. Training covers all vendors.

The department began working with WCD vendors in February 2009, to start the process of creating sub-accounts and bundling minutes. The department worked closely with vendors to create the appropriate sub-accounts, establish local coordinator access and receive ordering system training. The use of Sub-accounts for each District is an example of how invoices are broken out for each Local WCD Coordinator for review. Sub-accounts also provide roll up to one account allowing the agency to take advantage of volume discounts. Vendors provide other methods to achieve the same goal. Invoices from all vendors are sent to Local WCD Coordinators for review. The department also worked with the vendors to reduce expenses by bundling minutes into a shared pool of minutes. These efforts are ongoing. Invoices from all vendors are sent to Local WCD Coordinators for review.

Local WCD coordinators have been assigned the responsibility of ordering, inventorying and monitoring the wireless devices and usage for their districts. Regular updates to inventories are sent to IT Asset Management who maintains the Master WCD Inventory. WCD Coordinators are responsible for examination of rate plans, zero use, and possible inappropriate use. The Statewide WCD Coordinator, with OIS IT Asset Management, is responsible to Spot Check that the local reviews take place. Individual Spot Checks are currently initiated as questions arise. This usually occurs every two to four weeks. A process to assure Spot Checks are completed on all Local WCD Coordinators at least twice a year will be implemented by the end of the first quarter of 2012.

Existing department wide policies and procedures were initially modified in August 2009 to provide better guidance on roles and responsibilities for all parties involved in the WCD process. This should improve communications between WCD administrators, Financial Services, and WCD users. It should also result in a reduction in duplication of work and improved oversight of this process. However, the processes have continued to change since the last policy update. Also they do not reflect the process change that all orders for WCD devices are processed through OIS IT Asset Management.

In support of the policy changes, the WCD order form was updated to improve the methods to track devices, justify business need, clarify plan needs, and identify supervisor responsibilities. It also clearly identifies if a phone is required for emergency preparedness or used as an office check out WCD, which will be indicated in the DHS Master WCD Inventory list. This updated form was posted on the DHS Form Server July 31, 2009.

Earlier in 2009, the central WCD coordinator began developing a new Master Inventory that includes vendor driven information and information collected internally.

The changes to the policies and procedures, the improved order form, and the creation of sub-accounts and local coordinator responsibilities are all changes that will support the new Master Inventory. As mentioned above, central WCD functions have been transferred to OIS IT Asset Management. The inventory database has been created. Efforts to completely update the inventory database are ongoing.

A basic information sheet for new WCD users has been created. This sheet contains important information such as: contact numbers, policy information, plan specifics and basic user instructions. A “WCD Quick Facts” document has been completed and posted to DHS forms server. Form use will be included in upcoming WCD coordinator training.

The WCD Rapid Process Improvement process has been completed. WCD coordinators continue to monitor rate plans, usage and under-utilized devices.

In summary, the department has implemented significant improvements to its Wireless Communication Device system. The implementation of the quarterly review process, update of policies and procedures, and creation/maintenance of the Master WCD Inventory will address all recommendations made within the Secretary of State report.

The department also shared the methods for our quarterly review with Department of Administrative Services, so that they can share this information with other agencies.

8. Oregon Health Plan: Timely Eligibility Determinations Conducted on Clients, audit #2009-21, (dated 09/17/09)

- After the department completes urgent and complex projects such as the client transfer, it also considers a final review to identify any errors.

The Department of Human Services agrees with the audit recommendation to require a post-implementation review when the department is working on a project such as the FHIAP to OHP Standard transfer. One critical outcome of this review would be a final reconciliation of records between the two agencies involved.

9. DAS: Agencies Should Explore Opportunities to Earn Purchase Card Rebates, audit # 2010-12, (dated January 2010)

- The four agencies that missed the rebate periodically explore available strategies and analyze the associated costs and benefits of obtaining purchase card rebates. We also recommend these four agencies consider the specific strategies listed in the report. We also recommend that DHS selectively expand its existing pilot efforts to units and/or programs where it would be cost-effective to do so and consider exploring options for electronic payment and interim rebate reports.

DHS continues to explore available strategies and analyze the associated costs and benefits of obtaining purchase card rebates. Here are the items DHS has been working on since January 2010:

- *Working with the Oregon State Hospital to make their payments weekly. Public Health has switched from monthly payments to weekly payments in the spring of 2010, allowing DHS to take further advantage of the rebates.*
- *Currently, we make payments to our bank by warrant. We are working with DAS on paying by ACH instead of warrant. This will reduce the time it takes the payment to reach our bank.*
- *We are working with DAS to receive the interim and annual rebate report provided by our bank so we can analyze the spending trends.*
- *We are evaluating the purchases made by DHS for peak times SPOTS is used. We want to see if changing the cycle times would increase the rebate.*
- *We are looking at other state agencies' processes to determine if anything they are doing would be beneficial to DHS.*

DHS has received increased rebates since these steps have been implemented. Continued improvements will be made to improve payment cycle time and maximize rebate opportunities.

10. DHS: Human Services, Department of: Purchase Card Controls, Management Letter #100-2010-03-02 (dated 03/17/10)

- Review the design and operation of its controls over purchase card use to assure that those controls align with the level of risk that management is willing to tolerate.

The department updated its SPOTS policies and procedures that strengthen the procurement controls and enhance SPOTS usage monitoring. This new policy and procedure has been incorporated into ongoing training for all card holders and their supervisors. Card holders that do not attend their required refresher training have their cards suspended.

The new manager training addresses manager responsibilities to ensure proper use of the cards, including security, card limits, documentation and monthly review and tracking. This training will be required for all department managers responsible for reviewing SPOTS usage.

The department's Internal Audit and Consulting unit also completed an audit on the department's SPOTS card use. The department has adopted the recommendations of the audit and continues to improve the SPOTS controls.

- Establish controls over the administration of stored value cards that are consistent with the level of risk that management is willing to tolerate.

The department updated and strengthened the controls in its revised SPOTS policies and procedures. This new policy will strengthen the procurement controls and stored-value card tracking.

11. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2009, audit # 2010-19, (dated March 2010)

- Department management seek adequate assurance for the accuracy of all financial information they report. Management should have a documented understanding of the controls involved in transactions, whether automated or manual, to ensure the integrity of the information. When necessary, such as for significant financial systems operated by service providers, department management should obtain independent assurance over the reliability and accuracy of the information. This may be accomplished, in part, by ensuring contracts for significant services require internal control reviews and that the reviews are performed periodically as determined necessary.

The department implemented a new Medicaid Management Information System (MMIS) in December 2008. This system replaced the department's former legacy system used to track, pay and report on a majority of

the state's Medicaid eligible services. Operation of the MMIS is a joint effort between the Department of Human Services, who is responsible for the system, and our service provider, who has been contracted to implement it. Both the department and our service provider have experience designing and maintaining large information management systems. Under the current Operations and Maintenance contract, our service provider maintains control over the source code and is responsible for security of the code. Only our service provider's staff have update access for programming changes, implementing change orders, and correcting system defects. The department remains responsible for physical security of the system, for controlling user access, for updating reference tables and identifying errors in data entry and in output.

Over the course of the audit, the department provided a considerable number of documents outlining system operations and controls at both the department and our service provider. However, the department acknowledges that further work is needed to adequately document, communicate and review MMIS internal controls and processes.

The decision to implement the new MMIS in December 2008, was the only practical option available at that time and continues to be a wise financial decision for the state. The federal government, which had been paying 90 percent of the development costs, refused to pay for additional development. Comparisons to other states showed that Oregon was at a greater state of readiness than other states that had gone live with the same system. Although the quality assurance contractor expressed the reservations referenced in the finding, they also expressed their understanding of the department's legitimate reasons for not delaying implementation further.

The decision to go live was supported by a formal readiness assessment process that weighted outstanding issues against funding pressures, staff morale and the likelihood of full stabilization without being in a production environment. The decision was also supported by manual workarounds to ensure that the business processes functioned properly as the system was stabilized.

External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1, 2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, is due no later than October 31, 2011.

- Department management ensure accounting personnel have the requisite knowledge, skills, and abilities to accurately perform their assigned duties and ensure the resulting accounting records are in accordance with GAAP. Management should emphasize the importance of understanding GAAP to personnel who are responsible for recording transactions, calculating year-end accruals, and making adjustments that cross fiscal years. Management should also create a better awareness of the differences between budgetary accounting and GAAP, and when each is applicable.

The Department of Human Services (DHS) recognizes that staff skills need to improve. DHS's financial situation presents the most complex accounting and financial management questions in Oregon government. Because of this, DHS financial staff should be the best. The department is committed to achieve excellence not only in producing the annual financial statements, but in improving management and federal financial reporting.

The complexity occurs because DHS keeps accounting records for three different purposes – the statewide financial report, budgetary reporting, and federal reporting. Each of these operate on different time periods, closing deadlines, and accrual rules. Thus all staff making entries must be cognizant of the effect of their entry on all three reporting processes.

Although the finding itself is a broad statement about staff skills, it is based largely on errors in the precise area where the three reports differ – accruals, prior period adjustments, and other year-end transactions. The errors themselves largely affected statewide financial reporting, not budgetary or federal reporting. They were immaterial to the statewide financial report and, in some cases, had they been entered correctly, would not have changed the statewide financial report. Nonetheless, many were errors and DHS is responsible to ensure staff has the ability and resources to record them correctly.

Because of the dual nature of this finding, this response will first describe DHS efforts to improve staff ability to properly record transactions and then discuss issues that arise from the specific entries.

Improving skills

Due to efforts made in response to a prior audit finding, DHS believes the performance of its Statewide Financial Reporting Team has improved in the last two years. The team developed and documented a detailed process for estimating year-end accruals based on actual accruals in the prior year adjusted for known variations from prior period activity. This estimation is necessary because state policy requires that financial statement accruals be completed by mid-August – 45 days before the accrual period ends.

The five current members of this unit all have accounting degrees. Two have MBAs and one is a CPA. Although the accrual estimation process has improved and most entries were better supported than in the past, the auditors raised issues with some entries made by the unit. In addition, some errors were made outside the unit by staff making entries for budgetary purposes that were not cognizant of the appropriate way to record the transaction for statewide reporting. The department’s corrective action plan will address both of these issues.

Specific issues

Although many of the entries were errors that simply need to be corrected, there are two areas that DHS believes warrant further discussion – SNAP (food stamp) expenditures and accruals at the comptroller object level.

SNAP expenditures

DHS pays SNAP (food stamp) benefits through a debit card operated by a third party vendor. The client receives the debit card and uses it to purchase eligible food. Each month, DHS authorizes the third party vendor to load each card with the benefit each client is eligible to receive. The client has one year to spend the eligible funds. Each month, DHS and the third party vendor identify and reconcile benefits unspent for more than one year.

Currently, DHS expenses these benefit payments when they are loaded onto the client's card. The audit questioned this practice, asserting the expenditure should be based on when purchases are actually made by the client. The management representation letter was prepared with an adjustment reflecting the audit opinion. On reflection, unspent funds on an EBT card are a liability of the state and are available for expenditure by the client at any time, including any carryover balances from prior months that have not expired. Thus the proper accounting treatment is less clear than either treatment.

Accruals at the comptroller object level

DHS's documented process for making year-end accrual estimates follows the Statewide Accounting and Reporting Services (SARS) criteria for reporting year-end accruals at the GAAP level. The audit examined the accrual entries at the comptroller object level, a more detailed level than required for the state financial report. For example, the department entered its accruals in GAAP Object 6100 – Special Payments. The audit asserted the accruals should have been split into two comptroller Objects 6800 – Distribution to Individuals and 6900 – Other Special Payments. These two entries roll-up into the same line (GAAP object 6100 – Special Payments) in the statewide financial report. In other words, splitting the entries has no effect on the statewide financial report.

As noted earlier, state accounting policy directs agencies to estimate financial statement accruals earlier than is typical for other entities. In effect the policy says the benefits of a timely report are more important than any error introduced by the estimating process. The effect of implementing the audit recommendation

would be to further complicate the estimation process within an already tight timeline for making the estimates and with no benefit to the statewide financial report.

DHS is currently examining the workload and other implications of implementing the recommendations. When that review is complete, DHS would appreciate a discussion of the conflicting priorities.

Further, to improve performance and strengthen staff knowledge, skills and abilities, the Office of Financial Services has taken the following actions:

- Errors identified from the FY09 audit were documented and reviewed by staff.*
- Statewide Financial Reporting (SFR) team staff attended various trainings in FY 10 including the annual GAAP update training held by GASB.*
- The SFR team created an internal and external year-end task list for year-end closing activities. The internal task list was used by the SFR team to ensure that all of the necessary year-end activities were completed. During the FY 10 close period the SFR unit scheduled weekly meetings to review task, update and add to the task list and to problem solve issues. The external year-end task list was sent to OFS staff for the purposes of clarifying each unit's role in the year-end process and providing written guidance on required year-end tasks. SFR team members met with various staff and provided verbal guidance on GAAP required tasks including accruals, prior period adjustments, transferring completed assets, and appropriate backdating of payments and Balanced Transfers. These efforts resulted in reduced errors in FY 10 related to prior period adjustments, improved documentation of entries, and increased staff understanding of their entries related to GAAP requirements. The Lean Daily Management System adopted by DHS has also resulted in improved verbal communication of GAAP throughout DHS's fiscal units.*
- Comptroller object workload impact analysis was conducted by the SFR unit team members. In FY 10 the SFR team was able to accrue Special Payments at the Comptroller object level with a minimal workload addition.*
- Development of the batch release check-list was completed in April 2010. In-person and V-Con training for batch releasers was completed on August 17, 2010. The purpose of the check-list is to set*

expectations and provide guidance on what to review prior to releasing a batch. The checklist is to be used as a reference guide and is not required to be completed with each batch.

- *OFS members opened discussions on accounting for SNAP in the spring of 2010. OFS staff submitted a request to SARS for a new T-Code to account for SNAP. After discussion with SARS and verbal communication with GASB staff it was determined that appropriate transactions could occur at year-end to account for SNAP EBT transactions without the need for a new T-Code. Further discussions will occur this fiscal year to ensure that a new T-code is not needed for the non-EBT portion of SNAP.*
- *Policy discussion on accrual recording level began in May, 2010. Accrual procedure has been updated and will be reviewed yearly for modification.*

We believe that ensuring that accounting personnel have the requisite knowledge, skills and abilities to accurately perform their accounting duties in this complex environment is an on-going process. During the last year we have taken steps to develop a more robust succession plan including more opportunities for cross-training and job developmental and rotations. We continue to use Lean methodologies to document and improve our processes. We have formed an internal training committee with the goal of increasing training on the unique aspects of accounting in DHS/OHA.

- Department management obtain independent assurance over the reliability and accuracy of the system's controls.

External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1,

2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, is due no later than October 31, 2011. (Please refer to finding 09-01 response for further detail.)

- Department management strengthen controls to ensure that all rates are correct and adequately supported. Further, department management should determine the amount of Medicaid funds applied toward the incorrect or unsupported rates and ensure any unallowable amounts are credited back to the federal program.

Of the four rates found to be inadequately supported, three occurred solely because their determination methodology was not promulgated in Administrative Rule. The rate methodology for most of the Medicaid program is outlined in Oregon Administrative Rule 410-120-1340. However, the rate methodology for the Durable Medical Equipment (DME) program has not been promulgated in rule.

The department's rates for these items is currently set by policy. The department reviewed the policy and determined that the payments to the providers was accurate based upon the existing policy.

The remaining inadequately supported rate involved services provided by a Seniors and Peoples with Disabilities (SPD) Community Developmental Disability Program (CDDP) provider. This determination of this rate was not adequately documented. The federal amount of questioned costs for these services was \$3,464.

The rate found to be incorrect was for a physician administered drug which is priced using Medicare Average Sales Price (ASP) fee schedule. The ASP fee schedule was manually entered into the old claims payment system with a data entry error of two cents and carried over into the new MMIS data conversion. Based on the department's research, the rate was incorrect for a one quarter period (October 1, 2008 to December 31, 2008) before it was corrected. This data entry error caused 30 claims to process incorrectly during the time period at a cost of \$28.24 Total Funds.

The department reviewed the Administrative Rule and determined that the rule should reside in OAR 410-122-0186 and not 410-120-1340 as the prior response indicated. The department originally planned to include the payment method for DME in OAR 410-122-0186 and file it with the Secretary of State on October 15, 2010, with an effective date of January 1, 2011. Unfortunately, the department did not revise the rule as planned. Since October 2010, the department has been working with stakeholders to develop a payment methodology that is consistent with Medicare. The Division of Medical Assistance Programs (DMAP) filed OAR 410-122-0186 on July 29, 2011, to be effective August 1, 2011. This OAR contains the payment methods in effect for Date of Service August 1, 2011 and after.

For the remaining inadequately supported rate, SPD limited the staff authorized to complete the assessment tool used to determine payment rates. Only staff in the Restructuring Budgets, Assessments and Rates Unit within SPD may implement the tools that determine these rates, unless otherwise authorized. This allows for greater standardization and permits SPD to retain better records of the client assessment and subsequent rate calculations. Prior to the 2009-2011 Biennium, assessment tools could be completed by CDDP or Regional Crisis Diversion staff.

The process that resulted in the use of the one incorrect rate has been discontinued. Beginning July 2009, the process for entering rates into the MMIS system changed from a manual data entry function to an automated download process. The rates are downloaded directly from the Centers for Medicare and Medicaid Services (CMS) website containing the ASP fee table. This file is loaded into a test environment where rates are reviewed by the department's Business Service Unit and Policy Unit. Once this review takes place and the file has been approved, our MMIS service provider is instructed to move the test table into production. An additional review is done during this move in order to assure the file transferred accurately.

DMAP performed a system mass adjustment process (SMAP) to our MMIS for that specific physician administered drug code. A total of 32 claims were found to be incorrect and a SMAP was performed August 5, 2011. The CMS-64 will reflect a prior period adjustment on the quarter ending September 30, 2011.

SPD also made adjustments of \$15,157.81 to federal funds for the periods affected by the unsupported client rate change identified in the original finding. The first of these adjustments for \$3,464 was made in March 2011, and the second for \$12,693.81 was requested in August 2011. The CMS-64 will reflect a prior period adjustment for the second adjustment on the quarter ending September 30, 2011.

- Department management strengthen controls over the eligibility process to ensure that applications are complete, income determinations are accurate, and information entered into the department's systems is accurate. Further, department management should determine the total amount of CHIP funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

Children, Adults and Families (CAF) Self Sufficiency Programs (SSP) continues to proactively strengthen controls over the eligibility process. Income budgeting, signatures, third party liability, placement into correct medical programs and documentation issues are being addressed.

Streamlining eligibility:

In October 2009, the department streamlined the Children's Health Insurance Program (CHIP) eligibility process.

- *The CHIP countable income calculation used for the initial eligibility decision was reduced from a three-month income average to a two-month average.*
- *The un-insurance requirement was modified to make it less restrictive and easier to verify.*
- *Decreased the CHIP un-insurance waiting period from six to two months.*
- *The CHIP resource limit was eliminated.*
- *Increased the CHIP income limit to 201% of the Federal Poverty Level.*

In May 2010, the department revised OAR 461-115-0705 (Required Verification) providing the new policy that verification is required for any income a client has received as of the date of request. All other income is anticipated unless questionable.

In July 2010, the department revised OAR 461-115- 0071. This rule was revised to require only one signature per application, and now aligns with all SSP Programs.

SSPAT CHIP reviews 2009:

The Self Sufficiency Program Accuracy Team (SSPAT) conducted a special project of CHIP reviews consisting of ten branches between April and June 2009. The primary areas of review were budgeting, available third party resources, effective dates and correct program decisions. Trend information was shared with Program Managers, Line Managers and eligibility workers at the ten branch offices and with the medical training team. Following the project, SSPAT staff developed a CHIP training PowerPoint, which was distributed statewide for local and district use starting in February 2010. The PowerPoint covers date of request, effective date, private major medical insurance, pursuing assets, income, combining Oregon Health Plan (OHP) households, and changing household members.

Application changes:

In July 2009, DHS implemented the Oregon Health Plan On-Line Application (OHP 7210W). The on-line application is submitted electronically into the imaging system and has an electronic signature.

For all medical programs, staff are trained that an individual does not need to complete a new Oregon Health Plan Application (7210) or Application for all Programs (415F) as long as the client is currently receiving DHS program benefits at the time they make the request for medical benefits. DHS staff review the application currently on file and “pend” for any verification that is needed to determine ongoing medical benefits. The August 2009 On Target newsletter included an article on when an application is needed for medical benefits.

Oregon Health Authority has hired a consulting firm to review the OHP 7210. The purpose is to make the application more user friendly.

Medical Quality Control:

CAF SSP Medical Quality Control (MEQC) completed a review of CHIP cases as part of the federal Payment Error Rate Measurement (PERM) and Quality Control (QC) process.

- *Each QC CHIP error was reported to field offices. Eligibility workers and branches were required to take appropriate action to correct errors.*
- *QC CHIP errors are discussed at the monthly statewide Quality Assurance (QA) Panel meetings. This is a statewide discussion of root causes of errors with a focus on prevention. Participants include field staff, Program Integrity, policy, and training.*

In 2010, QC conducted a CHIP review project in collaboration with SSPAT. Cases were sampled from offices with the highest number of CHIP cases. The review focused on error prone eligibility elements identified through the PERM and QC reviews: Earned income and private health insurance.

- *A total of 300 cases were sampled for the project.*
- *Error findings were reported to branch offices as they were identified. Corrective action was required for all discrepancies.*
- *Review project concluded in June 2010.*
- *A Statewide error summary will be provided to field leadership.*

Third Party Liability:

In 2010, DHS is implementing a new on-line interactive medical application. The new on-line medical application will have the capability to accept multiple signatures. (With the July 2010 rule change, two signatures are no longer required. Only one signature per household is required.) This new interactive application will also bring to the attention of the case manager if the individual has third party liability.

The Health Insurance Group (HIG) routinely works MMIS report TPL-0689-M, which identifies clients who have had active third party liability (TPL) for the past six months. When they are reviewing the TPL they also check to see if the client is receiving CHIP medical. For individuals who are receiving CHIP medical

coverage and have TPL, the case is referred to OHP Statewide Processing Center. The OHP Statewide Processing Center eligibility staff review the case to see if the individual is eligible for Medicaid. If there is not Medicaid eligibility, the medical case is closed.

SSP Training:

SSP training staff developed and delivered Healthy KidsConnect training, practice opportunities and learning assessments for SSP and Seniors and People with Disabilities (SPD) eligibility and support staff. Training for SSP and SPD staff who determines eligibility is focused on new eligibility requirements; case coding; and the role of the Office of Private Health Partnerships (OPHP). SSP trainers provided Healthy KidsConnect classroom training for approximately 950 eligibility staff in 55 sessions delivered across the state. Also, approximately 425 eligibility staff participated in one of the 17 Healthy KidsConnect NetLink sessions on-line. SSP trainers developed presentations, talking points, pre- and post-testing materials to support local Healthy KidsConnect training for SSP and SPD reception and support staff. Two Healthy KidsConnect focused skill challenges also helped SSP managers assess and support policy knowledge in local unit meetings.

Areas added to the curriculum Fall 2009

- Screening OHP application for all medical programs.*
- Presumptive medical process.*

In addition, in October 2010, a Skills Challenge regarding placing a client in the correct medical program will go out to all branch offices.

Self Sufficiency Modernization (SSM) efforts:

CAF SSP program staff are working in partnership with Office of Information Services staff to modernize CAF SSP eligibility systems.

- *The first phase of the new web-based application is the on-line OHP 7210W. The 7210W is a version of the OHP 7210 submitted electronically by the user into the SSP imaging system. A later version of an interview style on-line medical application is being developed for expected implementation in 2011.*
- *In addition to updating some legacy computer systems, a more intuitive user interface will be implemented. Applicant information will be entered on a common data interface screen and the data will be used to populate other screens or systems, reducing data entry errors and improving the accuracy of the client data.*
- *New imaging technology will streamline the eligibility determination process and allow workers instant access to documents, including income documentation. Use of imaging technology will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.*
- *The department plans to automate the medical program eligibility decision process using a web-based computer system.*
- *An additional component is a medical benefit calculator for eligibility workers. Eligibility workers will enter client information for each applicant, including income, household composition and other eligibility factors. The benefit calculator will review the eligibility factors for each medical category, including countable income, and assist the eligibility worker in making an eligibility determination. Income calculations will be automated. The new income calculation functionality will improve the accuracy of earned income calculations.*
- *The modernization efforts will continue to be implemented in phases, continuing throughout 2011.*

In June 2010, the department determined the amount of CHIP funds paid on behalf of the ineligible clients identified in the finding and credited the federal program.

On November 1, 2010, the department eliminated the two-month income average for OHP (including Standard) and Healthy KidsConnect (HKC) and implemented budget month income. The client reports what they have received during the budget month and what they anticipate the rest of the month. This new rule

streamlines and simplifies the eligibility determination process for eligibility workers and clients. The rule changed from using two-month average to one-month.

With the budgeting change there is ongoing training, Informational Transmittals, On Target Newsletter, and QC Reviews. This will help staff in placing the client in the correct medical program.

The department continues to educate staff on when the two-months can be waived. Office of Healthy Kids sent out a “cheat sheet” for staff explaining when the two-months period can be waived. Office of Healthy Kids is also working with the federal government to see if the State can eliminate the two-months wait period.

The department is using more imaging technology. This allows workers instant access to documents and with the use of imaging, this will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.

- Department management identify and correct all system coding to ensure compliance with federal eligibility requirements. In addition, department management should ensure follow-up and resolution occurs if a client coded as ineligible in the system remains on the monthly report. Further, department management should determine the total amount of TANF funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

The department discovered during the audit that some family support services that meet the TANF requirements if provided to an eligible client were programmed in the department’s financial system to be funded by TANF regardless of the client’s eligibility for TANF. This apparently resulted from a misunderstanding of TANF requirements that occurred in the 2007-2009 budget process. The services were incorrectly charged beginning in November 2007.

An analyst in the Federal Compliance Unit is responsible for monitoring the monthly report of clients who

have or are approaching services exceeding the \$25,350 annual limit. The analyst is responsible for ending the clients' TANF eligibility. Each month the analyst would verify the clients on the previous month's report had been made ineligible. However, the analyst and management did not research why some clients continued to show on the monthly report.

The department will ensure that the funding for the services, which were programmed to charge federal TANF funds incorrectly, is corrected. The payments were reprocessed to ensure the federal funds are reimbursed based on the clients' eligibility. The department determined, documented and made appropriate funding adjustment to the federal program. The documentation and adjustments include the clients who had exceeded the \$25,350 limit to ensure all payments funded by TANF beyond the clients' eligibility have been credited back to the federal program.

The department has implemented a monthly Federal Funding Program Update meeting. Representatives from budget, financial services, federal compliance and program policy will be represented at this update meeting. The current expenditures of the federal funds will be monitored and discussed. Proposed changes to use of federal funds will be discussed and decisions will be made jointly by department fiscal and program management.

The department corrected the funding for the services, which were programmed to charge federal TANF funds incorrectly, in May 2010. In July 2010, the department made adjustments for the 2007-09 biennium and a portion of the 2009-11 biennium to credit funds back to the TANF federal program. In October 2010, (the next quarterly TANF report), an additional adjustment will be made for the remainder of the 2009-11 biennium. In total, these adjustments will equal approximately \$6.27 million. We provided the accounting detail regarding the manual adjustment mentioned above to the Region X Office of Administration for Children and Families (ACF). The adjustments were based on the total payments for the service that was incorrectly coded to use TANF funds by using the eligibility of the client. The documentation and adjustments included the clients who had exceeded the \$25,350 limit to ensure all payments funded by TANF beyond the clients' eligibility have been credited back to the federal program.

The department will continue to monitor the monthly \$25,350 report to ensure that any clients reported on previous reports receive the necessary adjustment to payments. Any client that remains on the report more than two months will be completely analyzed, any problems identified will be corrected and documentation of actions taken will be attached to the monthly \$25,350 report. Procedures have been created for this process.

October 2010, Central Office modified the \$25,350 report to include a break down per case, per monthly payment. This ensures a more timely and accurate determination of ineligibility when a client exceeds the \$25,350 limit.

As previously noted, the department did create procedures to improve the monitoring and analysis of \$25,350 report. The finding 10-13 Oregon Department of Human Services Eligibility – System coding issues, found that the procedures were being completed accurately; however, services were still being claimed to TANF-EA after the eligibility was appropriately denied. As discussed in the 10-13 Oregon Department of Human Services Eligibility – System coding issues finding, Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds. The OR-Kids system implementation date is August 29, 2011. It is the department's belief that payments will be funded accurately in the OR-Kids system based on the child's eligibility. The federal compliance unit currently has a dedicated staff (on job rotation) to monitor the appropriate use of federal grants. This position will monitor all reimbursement processes in the OR-Kids system to ensure accuracy. This position will also be used to query the past expenditures which were erroneously reimbursed by TANF funds in order to complete the manual adjustment. The goal is to complete the manual adjustment by October 31, 2011.

- Department management ensure that eligibility re-determinations are conducted timely and that all eligibility criteria are substantiated. Further, department management should determine the total amount of TANF funds paid on behalf of ineligible clients and ensure it is properly credited back to the federal program.

Child Welfare (Emergency Assistance Re-determinations)

Procedures established in September 2008, requiring the completion of annual re-determinations for Child Welfare related TANF Emergency Assistance, have resulted in improved compliance. The monthly report used to notify Child Welfare Federal Revenue Specialists (FRS) when re-determinations are due is the same report used by the Federal Compliance Unit analyst to monitor ongoing compliance. Unfortunately, this report can be difficult to understand due to conflicting eligibility history data on Child Welfare's legacy system. The department took or is taking the following actions:

- *Child Welfare sent an Action Request instead of a Policy Transmittal. CW-AR-10-008 was sent to Federal Revenue Specialists and the Supervisors on December 15, 2010.*
- *Provide refresher training to individual FRS' (identified from the Federal Compliance Unit analyst's monitoring of the re-determination report) who are not completing the annual re-determinations timely. A monthly report is provided to all Federal Revenue Specialists in the field offices via e-mail to notify them when an annual re-determination is due. The monthly e-mail reminds the Federal Revenue Specialists of timelines and re-determination procedures.*
- *Continue to analyze and fine tune to monthly report to increase its completeness, accuracy and usability. The monthly report has been enhanced as much as the current system will allow. Unfortunately, due to the complexity of the current Child Welfare IIS/FACIS system some cases are not included on the monthly re-determination report.*

The department sent an e-mail to the Child Welfare FRS to remind them of the requirement to complete TANF re-determinations annually. Refresher training was provided to individual FRS' (identified from the Federal Compliance Unit analyst's monitoring of the re-determination report) who are not completing the annual re-determinations timely.

The department will also continue to analyze and fine tune the monthly TANF re-determination report to increase the accuracy and usability of the report to ensure all re-determinations are being reported and completed timely.

Self Sufficiency (Pre-TANF Eligibility)

The Transition, Referral, and Client Self-Sufficiency (TRACS) narrative system is used to maintain a chronological, legal record of program eligibility and client case plan activity. Information narrated by case workers in TRACS includes specific financial and non-financial information related to eligibility for the Pre-TANF and TANF cash assistance programs, and the final program eligibility determination. The TRACS narrative for the identified Pre-TANF case did not contain clear, detailed information regarding eligibility based on deprivation. The department will take the following actions:

- *Send a Policy Transmittal to Self Sufficiency field staff - reminder of TANF financial and non-financial eligibility requirements and TRACS narration to support the eligibility decision.*
- *Review and update training materials related to TANF non-financial and financial eligibility factors and TRACS narration.*

In addition, the Operations Improvement Committee, Self Sufficiency Program Managers and others continue to discuss outcomes regarding narration of information in the TRACS system. Included are minimum standards of narration related to financial and non-financial program eligibility, case plan activity, confidentiality and sensitivity of health-related information, and payments in the form of benefits or support services made to families.

To support the intent of TRACS to provide a chronological, legal record of actions taken, the use of standardized narration guidelines and other tools are being explored to assist in capturing the minimum necessary information needed. The SSP TANF Program Analysts and Training Unit Staff meet monthly to discuss SSP policy and training related issues. These meetings provide an opportunity to discuss the application of policy and review training materials for accuracy and clarity, and gave the opportunity to

discuss specific policy related to the eligibility for the Pre-TANF program and basic needs and support service payments.

The three incorrect payments identified and issued on the Pre-TANF case, were properly credited back to federal funds by the Office of Financial Services, in June 2010. The department will determine the total amount of TANF funds paid on behalf of the child welfare ineligible client and credit it back to the federal program.

The department continues to send monthly e-mails to the Child Welfare Federal Revenue Specialists to remind them of the requirement to complete TANF re-determinations annually. The department determined that the monthly TANF re-determination could not be fine-tuned anymore. The report is negatively affected by the current legacy systems Individual Eligibility screen. The Individual Eligibility screen is used to document eligibility for three (3) federal programs (TANF-EA, Title IV-E and SSI). Anytime a Title IV-E specialist changes the individual eligibility code it starts the clock for the calculation of when the TANF-EA re-determination is due. It is not possible to change that functionality in the legacy system; however this issue will be corrected with the implementation of the new OR-Kids system on August 29, 2011. Each federal eligibility program, TANF-EA, Title IV-E and Title XIX, will have its own unique eligibility screen. The update to the TANF-EA policy and procedure manual was delayed because the entire policy and procedure manual had to be updated with the implementation of OR-Kids. The scheduled completion date is December 31, 2011.

- Department management ensure that verification of IEVS required screens are documented when determining client eligibility.

This finding occurred because the department no longer enters into its case management narration system, for every case, separate specific statements that each Income and Eligibility Verification System (IEVS) screen has been checked.

The TANF program policy requires Self Sufficiency workers to verify and document eligibility. Staff are also required to use the information from the IEVS screens as well as other documentary evidence (oral or written) in determining and verifying financial and non-financial eligibility. This is consistent with federal guidance. The three cases identified in this audit included information in the Transition, Referral, and Client Self-Sufficiency (TRACS) narrative system indicating they were eligible.

While the department agrees that verification of financial and non-financial requirements must be adequately documented when determining client eligibility, the department disagrees that the use the IEVS related screens must be independently documented for every client. States are required to participate in the IEVS. Oregon participates as required through regular use of IEVS screens by eligibility workers and cross matching of data across other agencies including: Unemployment Compensation match with Oregon Employment Department (OED); wage match with OED; Social Security Administration income match and SSN verification. Discrepancy reports are created monthly for use by eligibility staff. The three cases identified in this audit did not appear in the discrepancy reports.

The IEVS requirement is that States use the information obtained through IEVS. Section 1137 (a)(4)(C) of the Social Security Act provides that “the use of such information shall be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments, and no State shall be required to use such information to verify the eligibility of all recipients.” There is not a federal requirement for documenting each time IEVS screens are viewed for every case. ACF policy instruction: TANF-ACF-PI-2007-08 provides that eligibility decisions, including denials or closures, cannot be made solely based upon the results of IEVS checks. Consequently, Self Sufficiency staff are required to validate the data obtained through a variety of resources using the source with the most reliability for the given scenario.

Recently, the Office of Self Sufficiency has been working to achieve a more streamlined environment. This is in response to the need for increased efficiency given the high number of intakes and resulting higher than

budgeted caseloads. This needed efficiency also comes as a result of staffing related to the TANF program field administration being approximately 40 percent of need.

One of the recent efficiency improvements involved discontinued use of narrative templates. Self Sufficiency workers are still required to document their eligibility decisions, including decisions based on both financial and non-financial requirements. However, staff are instructed to report how they verified pertinent eligibility information about a client.

While the department's TANF program participates in IEVS as required, the department recognizes improvements could be made to better utilize data from some of our federal partner agencies.

While the department expressed concern with this finding, the department's processes for meeting this requirement were not adequately communicated during the audit.

The department will review current policies and guidance to staff regarding verification and documentation of eligibility. The department will also continue to work with federal partners to improve the State's systematic approach to meeting the IEVS requirement.

The department continues to research the requirement to utilize information contained in IEVS screens to support program eligibility related decisions and the options for narration of findings. In addition, DHS is reviewing existing Interagency Agreements with the respective IEVS agencies for language related to information sharing, limitations of information usage, and general information sharing guidelines.

Communication of narration guidelines is messaged to Children, Adults and Families (CAF) Division, Self Sufficiency Program (SSP) staff through existing TRACS and program training. It is also communicated to Districts through feedback by the Accuracy Unit staff of case record reviews.

On July 29, 2010, Self Sufficiency Program Managers, program accuracy, CAF training and CAF Field Services met to discuss narration guidelines. CAF Field Services sent a reminder of the TRACS narration guidelines to all staff on August 19, 2010. The monthly accuracy newsletter, "On Target", for August also included the narration guidelines. The guidelines specify financial eligibility is an aspect that must be addressed in the narrative. Examples of what must be narrated are: "Income - earned, unearned, excluded, calculation, pay stubs/verification used, self employment, results of screen checks, if no income how they are meeting basic needs; NC1/NC2 calculations; resources; pursuing assets; good cause; categorical eligibility."

CAF will continue to reinforce the TRACS narration guidelines with SSP eligibility workers and staff. In addition, SSP will develop and revise training curriculum as needed. Benefit certification periods are six to 12 months in length and SSP serves thousands of families. Because of this, CAF anticipates this additional attention will yield improvement with applications and re-determinations completed beginning September 2010.

The department continued to reinforce the narrative guidelines with field managers in the Fall of 2010. The department also contacted the Self-Sufficiency Training Unit to ensure the TRACS narrative guidelines are taught in eligibility training, including TANF. On September 13, 2010, CAF issued a policy transmittal reminding staff that when determining eligibility in the TANF and Pre-TANF program staff must ensure TRACS narration includes all financial and non-financial eligibility factors. The policy transmittal reminded staff that, "In addition to information obtained from the DHS 415F [Application for Services] and intake interview, case workers can view records from other agencies, such as the Department of Motor Vehicles and Oregon Employment Department, regarding potential income and resources. Eligibility narration must also include income or resources obtained from these records, if applicable." The CAF Field Services Narrative Guidelines were also included in this policy transmittal. Local line managers and lead workers also reviewed (as is the expectation) this transmittal with the staff who determine eligibility.

- That training be provided to personnel on the use of the electronic time keeping system and applicable work charge codes for the relevant grants, and that all payroll adjustments be based on corrections to actual time and effort charges and not to overcome funding deficiencies. Shared staff should document their actual time and effort at least monthly, and more frequently if they experience constant daily variations as to which grants they work on. Time that cannot be subdivided between grants should be allocated based on an acceptable cost allocation methodology as discussed in OMB Circular A-87.

Within the Health Promotion and Chronic Disease Prevention (HPCDP) Section there are several “shared” staff who are budgeted in all the HPCDP Chronic Disease grants or cooperative agreements that are included in the CDC Investigations and Technical Assistance Program. These budgets are approved by the CDC. These staff are typically responsible for the management and administrative functions across all the Chronic Disease grants and provide support to all the grants all the time. The charges to any of these grants for shared staff time are approved and allowable expenditures under each grant.

A recent CDC Request for Applications specifically encouraged a shared approach to leveraging resources for chronic disease programs. Our methodology for managing the costs of shared staff across all the grants was based on our interpretation of this guidance from the CDC. We have initiated conversations with CDC about these audit findings. They agree that states, like Oregon, who have acted on their direction to integrate programs and leverage resources across multiple grants are in a difficult situation when it comes to time/activity reporting. The CDC Chronic Disease and Health Promotion Center has agreed to work with Oregon to find a mutually acceptable way to monitor personnel expenses for shared staff whose work crosses multiple grants and cannot be easily dissected to individual grants, while still remaining in compliance with OMB Circular A-87.

The department agrees that a mistake was made in the second instance described above. The employees in the Office of Disease Prevention & Epidemiology who work on multiple grants or cooperative agreements included in the CDC Investigations and Technical Assistance Program are required to do time and activity reporting. They must meet this requirement by over-riding the default coding on the monthly electronic

timesheet with the coding for the grants/activities where they worked during the month. Management does not shift payroll costs for employees from one grant to another disproportionately, without regard for which grant the individual actually worked on. The payroll adjustment that was made did not reflect actual grant activity for the month of May 2009. Rather, adjustments to time/activity reporting needed to have been done over several earlier months to reflect actual time spent on the Cancer Prevention and Control grant.

Per the recommendation above, training was provided in February 2010, for those HPCDP staff whose time is paid from multiple grants. The training included use of the electronic time keeping system and guidance on how to apply charge codes for relevant grants to reflect actual time and effort. Managers and staff on a monthly basis review and project time and effort during the month. Shared staff then document their actual time and effort during the month. Over the past several months, managers have reviewed and see close consistency between projected and actual time spent on various grant activities. Thus, this method of documenting time and effort appears to be a good solution for HPCDP.

The CDC Chronic Disease and Health Promotion Center has undergone multiple major reorganizations over the last several months. However, we have had discussions with the project officers for our various grants and they are supportive of the steps we have taken to assure that time reporting does reflect time and effort.

- Department management implement a procedure to completely review and detect whether assistance payments agree with the signed adoption agreements and to get any amended assistance agreements filed in the case files. We further recommend that the department management work with the designated federal agency to determine the appropriate way to resolve any potential overpayments.

The department's Adoption Program completed a review of the reduction period cases identified in the audit to confirm the following:

- *Payments opened during the reduction period of February through October, 2003, were established in line with the reduced foster care rate and pursuant to a properly negotiated Adoption Assistance agreement.*
- *There was equitable management of payments for new cases opened during the reduction period.*
- *All payments for new cases opened during the reduction period were increased at the same time as longer-standing Adoption Assistance cases.*

Part of this file review also addressed the question of whether there was a signed agreement in the file that recorded the changes in payments, both decreases and increases, from the reduction period. While new agreements were sent to all families to correctly document the changes, not all families returned them and the adoption program did not track this at the time, nor did they file returned agreements directly into subsidy case records.

The absence of a signed agreement supporting the current payment is contrary to federal requirements. The manual review found that in a small number of subsidies, there were no signed agreements and incorrect payments continued until they were identified as a result of the audits and corrective action plan (a period of more than six years). As a result of the review, eight cases were determined to be under-payments in the total amount of \$5,539. A total of 23 cases were determined to be over-payments in the total amount of \$71,693. Most of these were for children placed out of state with more complicated subsidy structures.

Adoption Program management has initiated contact with the Administration for Children and Families Children's Bureau, Region X Child Welfare Program Office regarding how to best resolve the issue. At this point we estimate approximately \$28,000 in federal Title IV-E funds are within the total over-payment amount.

Parents of all children with under- and over-payments will receive a corrected Adoption Assistance Agreement with an explanatory letter appropriate for their circumstance. The agreements are retroactive to

November 1, 2003. The department will reimburse parents of children with under-payments for the total difference DHS owes on each agreement.

The department manually reviewed all agreements affected by the reduction in 2003 and implemented new matching agreements on all but 19 active cases. The department developed and implemented a new procedure that involves a second level of review which is conducted on every Adoption Assistance Agreement to ensure that the amount on the agreement and the amount authorized match. The department worked with the designated federal agency and determined there was no overpayment because there is no Federal requirement that Adoption Assistance Agreements reflect the amount of actual adoption assistance payments. This is confirmed in a letter from the Administration for Children and Families. Based on discussions with federal agency no further actions are required. (See Statewide Single Audit Findings 07-42, 08-28 and 10-23.)

- The agency provide additional training for the one district on transferring case files. We also recommend the agency communicate to all CAF Self Sufficiency branch offices the importance of following established business procedures for transferring case files.

District 8 modified their approach from delivering a training, to designating staff to participate on a district-wide group comprised of transfer clerks from each of the branches and two Line Managers. The group has developed a standard district-wide process and database for documenting case files transferring in and out of the branches within their district, as well as, files from the remainder of the branch offices around the state. The group has met six times, June 17, 2010, July 22, 2010, August 26, 2010, September 23, 2010, October 28, 2010 and November 18, 2010. They have created a shared drive for the district's case file transfer clerks' use. The shared drive consists of individual branch file folders that contain branch tracking sheets for all information transferred in and out of the offices.

The department has communicated the expectation of following established transfer procedures at various CAF statewide meetings including: Self Sufficiency Program Managers (April 14, 2010) and the Self

Sufficiency Line Manager quarterly meetings (April 20-22, 2010). District Managers have also been engaged in the discussion (July 7, 2010). Case File transfer procedures (FSM MP-WG # 21) are located in the Family Services Manual (MP-WG # 21) and the Field Business Procedure Manual (XVI. Case Files, A. Interoffice Transfer of Case Files).

- Department develop and implement a system to track actual personnel compensation for those individuals working on multiple Federal grants but whose time is not allocated using another time effort and reporting method. We recommend that those allocations based on actual amounts be reflected in the accounting system and properly allocated to the federal grants.

The DHS cost allocation unit has provided training for the staff affected to ensure appropriate time codes are used to reflect multiple program areas these staff now work on. Codes and basic instructions were communicated to staff on December 16, 2009, for Self Sufficiency Program Accuracy Team (SSPAT) and December 17, 2009, for Quality Control (QC). These instructions directed staff to begin using these codes immediately. Follow-up training was also conducted for both affected areas.

The questioned costs identified in this audit were corrected through an adjustment to the SNAP administrative grant. Furthermore, July 2009 through December 2009, administrative costs for these staff were reviewed and similarly adjusted.

- Department management apply the correct estimated clearance pattern to all applicable vocational rehabilitation expenditures and implement a review process to ensure federal draws are calculated correctly and drawn in compliance with established estimated clearance patterns. Additionally, the department should determine the effect of the errors for the year and assess whether interest is owed to the federal program for vocational rehabilitation federal funds drawn too soon during state fiscal year 2009.

This was the first year that the vocational rehabilitation program was required to calculate a clearance pattern under the Cash Management Improvement Act (CMIA).

All of the formula related errors have been corrected and desk procedures on the check clearance pattern were updated for the OVRs draw process.

We have developed and implemented a review process to ensure federal draws are correctly calculated and drawn in compliance with established check clearance patterns.

Based on the audit recommendation the department analyzed how the original draws were calculated and compared them to the appropriate CMIA estimated check clearance pattern and determined no interest was due to the federal government. The OVRs CMIA for FY 2009 was independently reviewed again to verify that no interest was due. This CMIA report was submitted to the Department of Administrative Services for inclusion into the state CMIA Report.

- Department management comply with federal requirements and ensure eligibility is determined or eligibility extensions are filed within 60 days of an individual's application for services.

The Office of Vocational Rehabilitation Services (OVRs) statewide field services managers sent out a statewide communication, on March 22, 2010, to promptly address the agency expectations for all vocational rehabilitation counselors to perform the eligibility determination process within a 60-day time frame or file for an eligibility extension as appropriate. This statewide correspondence will also serve to help reduce the misperception that eligibility determinations are due within a "two month period" when the specific requirement is within 60 days.

The eligibility process, including these standardized time frames, became a focus in the new counselor training module being conducted regionally throughout the state during 2010. OVRs administration staff developed a worksheet to assist vocational rehabilitation counselors to better identify and track the salient elements required when completing an eligibility determination, i.e., the number of documented disabilities,

and corresponding functional limitations when determining eligibility, and due dates. This new worksheet was distributed during the new counselor trainings.

All VR counselors who failed to meet the eligibility requirements at the time of the Secretary of State audit were sent a personalized letter by OVRs field services managers addressing the performance expectations of eligibility determination compliance time frames.

OVRs administration engaged the branch managers, during the April & May 2010 Statewide Branch Managers' Meeting, in a discussion regarding strategies for achieving compliance on the timeliness of eligibility determinations for services. One such strategy regarded the redirection of the flow of work when the vocational rehabilitation counselor of record is unexpectedly absent due to illness or other unanticipated reasons. Branch managers also reviewed case movement from application through eligibility by generating the "Activity Due Report" in the ORCA case management system. This duty was performed every two weeks for each counselor during the first six months of this corrective action implementation.

OVRs conducted administrative file reviews to monitor compliance and identify the need for technical assistance. Client files were randomly reviewed for quality control by the program technician in the region to evaluate the circumstances pertaining to a client's eligibility status. Notifications of the deficiencies in a staff member's performance are being reported to the local branch manager. The branch manager has been conducting one-on-one discussions with counselors if a deficiency occurs during a random review of the files. To enhance statewide performance, OVRs field services managers have been reading and responding to the case file review sheets being submitted to the administration office on a monthly basis.

The Secretary of State Audits Division completed a federal compliance audit in December 2010 and no finding was noted for eligibility determinations during this review period.

In 2011, OVRs administration and the State Rehabilitation Council significantly expanded the OVRs policy manual to address the recommendations from the Secretary of State Audit Division. All OVRs field staff

members were required to attend a mandatory training on these policy changes. There was a specific training module dedicated to both presumed eligibility and eligibility determinations and compliance time frames. The branch managers were trained on the new policy manual in Salem on March 9 & 10, 2011. The regional staff trainings were conducted as follows: Clackamas & East Portland branches on March 29 & 30, 2011; Salem branches on April 5 & 6, 2011; Linn-Benton-Lincoln & Lane branches on April 13 & 14, 2011; Central & North Portland branches on April 20 & 21, 2011; Roseburg & Medford branches on April 26 & 27, 2011; Washington County branch on May 3 & 4, 2011; Bend & Eastern Oregon branches on May 11 & 12, 2011; and in a make-up session for any staff missing their original training site was held in Salem on June 15 & 16, 2011.

Additionally, a mandatory online exam was required of all OVRS field staff on each of the new policy training sections to include eligibility determinations. The online six-part examination required an average of three hours to complete with a deadline for completion by July 15, 2011.

12. DHS: Office of Vocational Rehabilitation Services: Save on Vocational Costs to Serve More Clients, audit #2010-31 (September 2010)

- Oregon's Office of Vocational Rehabilitation Services (OVRS) should take several actions that can help discontinue Order of Selection by serving more clients with its current state and federal resources. In order to save costs OVRS should:
 - Ensure counselors work with clients to approve realistic employment plans by better identifying impediments to future employment and discontinuing payments when clients show an inability to achieve the employment goal.
 - Ensure counselors adhere to the employment plan and only approve expenses directed toward employment impediments and employment goal achievement.
 - Consider using a fee schedule to ensure a reasonable cost to the program for commonly purchased services.

- Monitor counselor spending approvals to ensure the most prudent decisions are made.
- Establish realistic budgets for counselors and branch offices that are based on client types, economic conditions and other related factors.
- Consider reviewing and revising the client contribution policy.
- Continue with the addition of client maintenance system controls such as the current effort to link authorizations and payments to plan services.

The Office of Vocational Rehabilitation Services (OVRs) has designated a Program Improvement Manager who has acted as a Project Manager to assist the OVRs Executive Team to develop a plan for program improvement in case management, quality assurance, accountability and cost containment. The Program Improvement Plan is complete and being implemented. A Gantt chart of all program improvement activities to be implemented has been developed and monthly reviews to track the benchmarks identified within the overall plan are being conducted.

OVRs has established a goal to reduce the average cost per case served by 20% from comparable FFY 2008 levels by FFY 2012. This will be accomplished through the implementation of the Program Improvement Plan and close monitoring of program expenditures while simultaneously maintaining the quality of employment outcomes.

OVRs already has the following spending guidelines and controls in place for counselors:

- *Spending authority limitations are presently incorporated in ORCA, the program's case management system. The spending authority for counselors is \$5,000 per authorization, \$20,000 for branch managers, and \$50,000 for field services managers. ORCA will not permit the issuance of payment documents beyond one's authority.*
- *All four-year school plans must be reviewed and approved by a field service manager and the agency administrator.*

- *All vehicle purchases must be reviewed and approved by the administrator. Vehicle purchase is currently an exception to policy and will only be considered when other modes of transportation are not feasible.*
- *New counselors' authorizations for services must be reviewed by their managers during their first six months of employment (trial service).*

In addition, in 2008 OVRS began exploring a shift to performance-based contracted services as a strategy to increase the quality of services for the dollars spent. Accordingly, during 2009 OVRS established minimum qualifications for job developers and provided them with training on how to perform job development using practical marketing and sales techniques appropriate for securing jobs for clients with any level of an employment barrier. OVRS job placement contracts now emphasize performance-based outcomes in three categories: job development, job placement, and job retention. The full implementation to the performance-based methodology was initiated on January 2, 2010. Data analysis regarding the job placement and job retention outcomes and cost analysis will be incorporated as a portion of the Program Improvement Plan.

In addition to performance-based contracts for its job development service providers, OVRS is currently collaborating with Alliance Enterprises, the creator of the program's case management system, in a pilot to develop a report card that will give managers and administrators more information about the performance of vendors. The report card will provide information on the effectiveness of individual vendor success rates across a number of disability and demographic variables. In addition to supporting better program oversight and administration at the management level, this information will help counselors and participants to make informed choices and assist the program to identify best practices. It will also serve as an objective foundation to discontinue issuing contracts to ineffective vendors.

OVRS will take the following additional actions relating to cost containment:

- *OVRS will review current spending approval levels and methodologies. The review will include consideration of setting budgets for counselors and branch offices that are based on client types,*

economic conditions and other related factors such as prior budget management, average costs and rehabilitation rates. The review will also look at improving ways to efficiently monitor and analyze spending patterns and ultimately set a process for routine reviews of spending approval levels.

- *Adjustments to spending levels will be made following the review, as needed.*
- *OVRs will ask the State Rehabilitation Council (SRC) to partner with them in a review of the current participation contribution policy. OVRs developed the consumer's contribution policy with the SRC, and any change in the existing policy would require their approval. OVRs will engage the SRC in a discussion about the level of the participant's contribution as a percentage of income as well as the income threshold for contributing to the cost of services. Changes to the existing policy will be proposed following that discussion, as needed.*
- *OVRs will explore options for a fee schedule that will maximize resources and ensure timely access to appropriate medical providers and make recommendations based on that research, as needed. In addition, it will track the implementation of healthcare legislation and the opportunities for the use of comparable needs to meet the rehabilitation related healthcare needs of the program's participants.*
- *OVRs will review and revise its Medical Restoration policy in order to provide more effective guidance on medical fees.*

The OVRs Administrator and the new Program Improvement Manager have set concrete timelines for completion of these additional action items as part of the Program Improvement Plan.

- In order to help client success rates OVRs should:
 - Ensure counselors develop and adhere to milestones within employment plans and take quick, appropriate actions if those milestones are not met.
 - Establish higher rehabilitation goals for counselors and take constructive actions when those goals are not met.
 - Ensure counselors establish clear client expectations.
 - Ensure counselors address any prior issues when clients return.

OVRs is implementing a new case management data monitoring system to identify individual case management issues and program-wide reporting on open cases. This system will strengthen monitoring consumer compliance to the mutually agreed benchmarks incorporated within the employment plans. The system was fully implemented on February 3, 2011, and training of all staff will now commence.

In support of more consistent practice, better counselor decision-making, and stronger management oversight, OVRs has taken the following steps focusing on improved case management.

In May 2010, OVRs began revision on the case closure policy to provide more specific guidance for counselors regarding conditions under which an individual's case file can be closed. After consulting with the Rehabilitation Services Administration (RSA), the OVRs Executive Team and State Rehabilitation Council Policy Committee approved the new policy in August 2010. The State Rehabilitation Council Executive Committee approved this policy in September 2010. The program will move forward with rule making. OVRs expects to provide training to branch managers on the new policy in March of 2011. Training for all staff is scheduled to begin in March of 2011.

Over the last two years, training has been provided to counseling staff on how to identify and intervene when participant motivational issues impede engagement in the process and hinder progress with plan services. As a best practice, counselors are being asked to routinely use this methodology when a participant has failed to make sufficient progress toward plan benchmarks.

OVRs has enhanced its automated case management system so that services identified in a client's case plan are linked to services being authorized as the plan is implemented. This automation means that an individual counselor cannot pay for services that are not detailed in the plan or extend services without amending the plan. This enhancement was made available when the newest version of the Oregon Rehabilitation Case Automation System (ORCA) was implemented winter 2010.

Finally, in conjunction with the Spring 2011 ORCA update, OVRS will provide training on informed choice to emphasize the application of best clinical practices in the areas of vocational goal selection, establishment of benchmarks to assess and track the client's progress, selection of vendor(s), and specific goods and services. This clinical training will also help counselors provide better occupational guidance to clients. These efforts are expected to result in client plans better aligning with realistic employment goals.

- In order to better assist counselors in performing their duties OVRS should:
 - Complete the drafting of its policy manual.
 - Develop better data monitoring to identify program-wide and individual case management issues, including better reporting on open cases.
 - Conduct regular performance evaluations that incorporate case closure.
 - Explore cost-effective training solutions such as those provided for free by vocational rehabilitation Technical Assistance and Continuing Education centers.

OVRS will complete a significantly expanded revision of the program's policy manual no later than March 1, 2011, to address the increased need for consistency in client expenditures across the state. Regional trainings will be conducted on the new policy manual beginning May of 2011.

As a consequence of the Order of Selection, in January 2009, OVRS re-trained all current staff on the eligibility determination process to ensure statewide consistency in establishing the consumer's disability-related functional limitations impacting employment. Eligibility became the focus of recent file reviews conducted by the program's field technicians. Results from those reviews were shared with managers who work with any staff who need additional support and/or who had deficiencies in this area.

In February 2009, the program revised its new counselor training to more narrowly focus on case management and critical case questioning. In March 2009, this class was conducted regionally across the state and was attended by new counseling staff and counselors who would benefit from refresher training.

The program offered this training again in September and December 2010, and will continue to offer it on a regularly scheduled basis. The program will provide training on plan development including appropriately ensuring clear client expectations and appropriate follow-up on any prior problems when clients return. Training will be prioritized for new counselors and counselors in need of additional training. On a go-forward basis, OVRS will continue to provide training, as well as utilize regional resources, to improve counselors' skills to provide effective and cost appropriate services and to promote better counselor decision-making.

Every 12 months, OVRS conducts a branch wide review to include a random sampling of cases from each counselor. These branch wide quality assurance reviews are conducted by the regional program technicians and results are provided to each branch manager. The agency will continue to perform file reviews and identify branch level and statewide trends to develop trainings and to coach staff. In addition, OVRS will take the following actions:

- Under an existing Oregon Administrative Rule, a person may be eligible for VR services if he/she is in the U.S. for other than a temporary purpose and legally entitled to hold employment in this country. On September 1, 2010, OVRS notified all managers that effective immediately OVRS will now require all prospective applicants to supply valid documentation of their legal status to work and proof of identity prior to initiating an application. An application will not be accepted until documentation is obtained and a copy placed in the client's file. Temporary guidelines have been provided to managers throughout the state. Revision on this associated policy will start immediately. Additionally, OVRS is, on its own, randomly auditing 500 files to ensure compliance.*
- OVRS Central Office Administration is putting in place an enhanced monitoring system to ensure that annual performance reviews and professional development plans with clear expectations are being conducted by supervisors.*

13. DHS: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2010, audit # 2011- 06, (dated March 2011)

- We recommend the Department remove conflicting access rights where it can. In those instances where the conflict remains, DHS should develop and implement a detective control to specifically address those instances.

Due to budget cuts resulting in a hiring freeze coupled with increased caseloads and demands for services, offices needed to reassign some of the daily duties to support staff to accommodate the increasing demand for services.

In January 2011, the Seniors and People with Disabilities RACF administrator sent an email to the SPD Sub-Administrators asking them to review their existing reports and remove any unnecessary current access rights.

In February 2011, Children, Adults and Families (CAF), District Business Experts began a manual compensating controls review process. These reviews are occurring in CAF Self Sufficiency Program (SSP) Field offices monthly.

The Resource Access Control Facility (RACF) report is distributed monthly to the CAF Field Business Experts and Self-Sufficiency Office Managers, as well as, the SPD Field Offices. The RACF report identifies employees within a branch office and their respective computer access rights. In addition, a two-page cheat-sheet has been developed and distributed to Business Experts and SSP Office managers to assist in reading the report and accurately identifying those employees with conflicting access.

In addition, an ad-hoc monitoring report has been created. This report is currently in draft and under review for accuracy, but is anticipated to be finalized by the end of September 2011. When completed, the report will be used to identify potential SSP and SPD employees who performed conflicting access functions and will replace the current manual compensating controls process.

It should be noted that a statewide hiring freeze remains in effect. CAF received permission to fill some previously vacant positions; however, this will only bring CAF staffing up to 70 percent of the need. Based on continued reduced staffing and limited resources, it is anticipated the need for staff to have conflicting access will continue.

The department projects corrective action will be completed by October 31, 2011.

- We recommend that the department management work with the designated federal agency to determine the appropriate way to resolve any overpayments, or to stop using federal funds for future payments in the 52 cases without a revised adoption agreement and to repay amounts previously overpaid.

After consultation with the Administration for Children and Families, and confirmed in a letter received from ACF, there are no overpayments owed because there is no federal regulation that require Adoption Assistance Agreements reflect the amount of actual adoption assistance payments. Federal policy allows automatic adjustments without parental concurrence only in the case of an across the board rate reduction or increase in foster care maintenance rates. Consequently, when there has been an across the board rate reduction or increase in foster care rates, the State could also impose that reduction to the adoption assistance program recipients and the Title IV-E agency need not execute new, signed agreements that reflect the change to the rate. Based on the documentation relative to this finding, ACF will not recover Federal funds. Based on discussions with federal agency no further actions are required. (See Statewide Single Audit Findings 07-42, 08-28 and 09-19.)

- We recommend the agency implement a process to review applications provided by participants for fraudulent or incorrect information. In addition, we recommend attendance logs be received more timely for review of services provided. We also recommend overpayment letters be sent immediately or as soon as reasonably possible to recover any improper payments.

Eligibility staff are currently trained to pursue questionable information and utilize available resources including Oregon Birth Verification Records. The DHS Child Care Provider Listing form (DHS7494) also asks the provider if they are related to the children. The form states that DHS will not pay the provider if they are the parent, step parent or legal guardian of the child. When processing the form, the Direct Pay Unit (DPU) reviews all open cases for the provider and client to see if all household members are included on the form. If DPU notices a birth father on the open case, they are prompted to further investigate.

Effective October 1, 2010, DHS eliminated the temporary approval of providers while undergoing the background check and now requires the provider (and other subject individuals) to complete and pass the DHS Background Check before allowing payment or authorization for payment to the provider. Though the main reason for this change was to reduce potential risk to children, it may also help identify some fraudulent providers. If information is discovered in the background check that shows evidence that the child care provider is the parent of the child in care, it is reported to the DHS Direct Pay Unit and the provider will not receive payment.

If the information is discovered after payment has been made, DHS pursues an overpayment on the provider. In the fraud case mentioned in the finding, a referral was made to Investigations, an overpayment was written and the client signed an Intentional Program Violation waiver admitting to the charges. On the other overpayment case mentioned, DHS acknowledges that the overpayment letter was not written timely. However, the overpayment had been identified to be worked prior to the audit. This delay was partially due to reduced staffing in the Overpayment unit.

Temporary Assistance for Needy Families (TANF) eligibility includes the requirement that a parent cooperate with the Division of Child Support (DCS) to establish paternity and locate and obtain child support payments for each needy child. Over the past year, DHS and DCS have jointly developed and delivered tools, cheat sheets and in-person training modules to staff that have resulted in increases to the paternity establishment percentage rate and the number of TANF cases which a child support collection is made.

With implementation of the ERDC reservation list (October 1, 2010 to April 30, 2011, and again effective August 1, 2011), ERDC eligibility is contingent upon receipt of TANF within the prior three months. Combined with the recent emphasis by DHS and Division of Child Support (DCS) on child support, the number of ERDC cases in which a payment may be made to a parent is further diminished.

DHS is moving to real time knowledge of child care usage rather than waiting for provider submission of paper billing forms for manual processing. This will be accomplished with the Child Care Billing and Attendance Tracking (CCBAT) project. This project is in development with a planned initial implementation date of November 1, 2011.

In addition to 11 classes provided to new eligibility workers in 2011, field staff has been given five ERDC refresher classes and one Netlink with expanded questions/scenarios as a reminder on who can be a provider. All training emphasizes specific questions workers can ask the client if they find a potential provider situation questionable. A May 2011 ERDC Skill Challenge and April 2011 article in the "On Target" staff newsletter reviewed in depth who can be a provider and what to do when a situation is questionable. Further, 95 ERDC cases are reviewed monthly by the DHS Accuracy Team to identify and give immediate feedback on errors. We have found staff education useful in reducing client and provider fraud.

- We recommend management ensure the required ADP risk analysis and system security reviews are conducted on the new Medicaid Management Information System (MMIS).

The Information Security Office (ISO) ran a successful application assessment of the MMIS on May 6, 2009, and our vendor made corrections based on the findings. This assessment was conducted and the results were verified by ISO personnel. An application assessment process is being built into the System Development Life Cycle (SDLC).

ISO began the MMIS network and server vulnerability scan using the MMIS test environment. ISO began with the test environment due to the limited number of servers, impact to the business, and ISO developed the network and server testing processes using a newly purchased software solution.

ISO ran a successful assessment of the MMIS test environment on December 9, 2010, resulting in no network and server vulnerabilities. This assessment was run and the results were verified by ISO personnel.

The ISO completed the MMIS production network and server vulnerability scan utilizing the knowledge gained from the test environment assessment. The initial start date for the production assessment occurred on January 31, 2011. This assessment period covered multiple days due to the large number of servers and the use of multiple software solutions. ISPO is also scheduling an annual MMIS network vulnerability assessment.

The Information Security and Privacy Office (ISPO) completed an initial application vulnerability assessment for the Medicaid Management Information System (MMIS) web application during May 2011. As part of the MMIS web application Release Management process, ISPO performs an application vulnerability assessment. The last MMIS web application vulnerability assessment was completed during August 2011.

- We recommend department management identify and correct system coding for all services for which the system is not considering eligibility. Once all service and coding issues have been corrected, department management should identify and reimburse the federal agency the total amount of TANF funds spent on behalf of ineligible clients for these services starting in fiscal year 2009.

The department discovered during the audit that certain services that meet the TANF requirements were programmed in the department's financial system to be funded by TANF, regardless of the client's eligibility for TANF. The services in question appear to be contracted System of Care services; therefore the

department will review the process and procedures for inputting executed contracts into the department's financial system.

The department will implement the recommendation by ensuring all services which were programmed incorrectly are corrected. The payments will be reprocessed by using a manual adjustment of funds. The amount of the adjustment will be reported to the federal agency. The department will correct the process and procedures for inputting executed contracts if the review of the current process uncovers a deficiency.

Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds. The OR-Kids system implementation date is August 29, 2011. It is the department's belief that payments will be funded accurately in the OR-Kids system. The federal compliance unit currently has a dedicated staff (on job rotation) to monitor the appropriate use of federal grants. This position will monitor all reimbursement processes in the OR-Kids system to ensure accuracy. This position will also be used to query the past expenditures which were erroneously reimbursed by TANF funds in order to complete the manual adjustment. The goal is to complete the manual adjustment by October 31, 2011.

- We recommend department management strengthen controls over the eligibility process to ensure that eligibility redeterminations are performed timely and income determinations are accurate.

One of the three cases lacking timely redetermination documentation addressed above involved Children, Adults and Families (CAF), Child Welfare. In this case, we believe the redetermination was completed in a timely manner, however, the proper documentation was missing from the client's case file. The other two cases lacking timely redeterminations were for Seniors and People with Disabilities (SPD) clients. Both SPD clients were determined eligible for Title XIX prior to and after the audit period.

The three cases involving incorrect income and resources determinations were Children, Adults and Families (CAF), Self Sufficiency Programs (SSP) cases.

CAF Child Welfare:

A Federal Revenue Specialist (FRS) is responsible for completing Title XIX redeterminations every 12 months. The FACIS system creates a notice on the assigned FRS workload when a redetermination is due. The notice date is based on the review due date captured on the IIS Individual Information screen. Based on conversations with the FRS and the data displayed on the IIS Individual Information screen, the redetermination was completed appropriately.

Unfortunately the legacy system does not capture the history of when redeterminations are completed if there is no change to the eligibility reason code, which was the situation on this case. The only proof that the redetermination was completed timely was dependent upon a paper copy of the CF190 – Medical Eligibility Form, which the FRS prints upon completion of a redetermination. The copy of the CF190 is given to the case worker to be filed in the Financial Section of the case file. The FRS must rely on other support staff or the case worker to ensure the CF190 is filed. This is a manual documentation process that will be remedied with the implementation of the new OR-Kids system.

The department implemented the recommendation by sending a reminder to the FRSs (via email) of the importance of completing redeterminations timely and ensuring that the CF190 is filed in the case file. The process of filing a paper copy of the CF190 will no longer be necessary with the implementation of the new Child Welfare system called OR-Kids. OR-Kids will keep an electronic history of all eligibility determinations and the CF190 can be printed upon request. The actual implementation date for the OR-Kids system was August 29, 2011. As of that date redeterminations will be kept in an electronic history of all eligibility determinations and the CF190 can be printed upon request.

Seniors and People with Disabilities:

SPD managers will be asked to remind their staff of the importance of annual redeterminations and utilize reports to monitor compliance. Staff will be reminded to use the tickler system for notification. Within available resources, managers will assign case managers to cover staff absences. Seniors and People with Disabilities has provided training to AAA/SPD Field Managers to specifically address these eligibility redetermination issues. This training was completed in April 2011, and we believe it will strengthen and enhance controls over the eligibility process.

CAF Self Sufficiency:

CAF Self Sufficiency Programs continue to look at ways to streamline and simplify Medicaid and CHIP eligibility criteria.

On November 1, 2010, the department eliminated the two-month income average for OHP (including Standard) and Healthy KidsConnect (HKC) and implemented budget month income. The client reports what they have received during the budget month and what they anticipate the rest of the month. This new rule streamlines and simplifies the eligibility determination process for eligibility workers and clients. The rule changed from using two-month average to one-month.

October 2009, the department made a policy change to waive the six-month private major medical coverage to two-months. The department continues to educate staff on when the two-months can be waived. Office of Healthy Kids sent out a “cheat sheet” for staff explaining when the two-months period can be waived. Office of Healthy Kids is also working with the federal government to see if the State can eliminate the two-months wait period.

The department is using more imaging technology. This allows workers instant access to documents and with the use of imaging, this will reduce the amount of paper documents that can potentially be misplaced or misfiled and increase the accuracy of the information used to determine eligibility.

As of July 15, 2010, the department implemented policy requiring only one signature per household. Policy Transmittal was sent to eligibly workers and the Family Services Manual was updated.

Statewide training for all Self Sufficiency Program medical eligibility staff has been provided to support the November and December policy and application changes. Classroom training consisted of 52 half day sessions for approximately 1,030 staff members. In February 2010, an article was placed in the On Target newsletter around the Autumn 2010 SSP policy changes.

Ongoing training and educational efforts include training tools and newsletters to keep staff alert to current trends and successes; resource materials developed to support worker efforts; specialized websites with training tools and resources; monthly policy transmittals; weekly Self Sufficiency policy update teleconference meetings and ongoing cheat sheets for staff.

As of March 1, 2011, Oregon Administrative Rule 461-115-0530 was amended to allow OHP Standard recipients to receive a twelve-month certification period instead of six months as was previously allowed. This change brings OHP Standard into alignment with all other DHS medical programs.

Combined, these changes reduce the number of redeterminations and streamline budgeting and verification requirements among all DHS programs.

SSPAT:

The Self Sufficiency Program Accuracy Team (SSPAT) has developed a new medical error trends training which focuses primarily on the error prone areas of budgeting, income and verification. This is a 3.5 hour scenario-driven block of instruction. The training will be delivered at branch sites to minimize impact on branch production while maximizing communication and learning within branch teams. Training materials were developed in coordination with policy analysts, quality control staff and CAF trainers. The first session was conducted on March 9, 2011. Trainings will be scheduled based on each district's priorities and branch accuracy trends.

MEQC:

CAF SSP Medical Quality Control (MEQC) and Program Management Evaluations review medical policy decisions, processes and medical application procedures and report out errors. Corrective Action Plans to prevent similar errors are developed and implemented statewide.

- We recommend department management ensure that complete and accurate client information is used to compile the quarterly data reports.

The department established a work group to review the errors in the ACF-199 and ACF-209 reports identified in the finding. The Child Welfare SFMA crosswalk file has been updated to identify cases paid with TANF funding using appropriate payment codes. The ACF-199 and ACF-209 are now reading this coding and reporting all cases from Child Welfare that are paid with TANF funds. This system fix was completed in June 2011 and new data was re-transmitted to ACF covering second quarter data for April, May and June 2010.

- We recommend department management ensure coding is correct when making manual coding adjustments. Department management should correct the coding errors identified.

All coding errors have been corrected. When the coding errors occurred the funding for the TANF block grant had already been drawn to the limit, therefore no overdraw of federal funds had occurred.

Corrective actions were completed in January 2011. Correcting journal entries were made to fix errors and to move funds from federal to other funds. Implementation of the new OR-Kids system will restrict the ability to make manual coding adjustments in the future.

- We recommend department management ensure that the clearance pattern used to draw down federal funds is updated to reflect any changes in the treasury-state agreement.

The State FY 2009 CMIA patterns were inadvertently used for the State FY 2010 federal draws. No interest is due to the Federal government for this issue as funds were drawn at a slower rate than we were entitled to receive.

Corrective actions were completed in March 2011. The department has verified the correct rates are being used for State FY 2011 draws. In addition, a "task" has been entered on staff's June 2011 calendar to verify any CMIA changes needed for the State FY 2012 draw spreadsheets.

- We recommend department management update their contracting policy to address suspension and debarment for governmental entities and communicate this change to contract staff.

The Office of Contracts and Procurement has a procedure on checking the Excluded Parties List System, however the policy indicated only non-governmental entities were required to be checked.

The debarment policy addressed above was updated on February 14, 2011, to require all contracting entities be checked for debarment. This issue was discussed at the Office of Contracts and Procurement all staff meeting on February 15, 2011. The updated procedure was also distributed to all staff.

14. DHS: Adequate Computer Controls in Place for the Medicaid Management Information System, audit # 2011-12, (dated June 2011)

- We recommend that department management take action to further expedite resolution of the erroneous transactions that resulted from system errors.

The department supports the findings and timelines of the SOS auditors; however emphasizes that efforts to complete the payment reconciliation process have been underway for several months and were initially scheduled to be completed by June 30, 2011(see below). The new Medicaid Management Information System

(MMIS) was brought on-line before all functionality was fully operational. This decision was made to ensure the enhanced Federal funding for this project continued.

During the post-implementation stabilization and subsequent maintenance periods, all operational decisions were made to ensure the critical services provided to our clients and the financial solvency of our servicing providers were maintained. An example of this support was creation of the “transitional payments” process, allowing estimated payments to be made to Managed Care plans, with a subsequent reconciliation effort to resolve discrepancies. Owing to the anticipated operational effects of these decisions and the impact they would have to our servicing providers, many of these decisions were made after consultation and planning with Managed Care plan representatives.

The Managed Care subsystem for enrollment and disenrollment was especially problematic in unique circumstances. The corrective programming required to correct these complex enrollment discrepancies was not completed until October, 2010. These Managed Care enrollment and disenrollment errors are directly linked, and have compounded, the Fee-For-Service (FFS) errors identified by the SOS auditors, by paying claims as FFS when the correct payer should have been (but was unknown at the time due to the enrollment errors) a Managed Care plan. The sequential logic used in the processing of these incorrect capitation and FFS payments must now be sequentially reversed during the corrective action period to ensure additional errors are not created.

Starting in October, 2010, following correction of the majority of system defects, the labor and systematic intensive reconciliation process for Managed Care Organizations (MCO) enrollment errors began. After extensive consultation and planning with our Managed Care partners to develop and execute this large effort, the department expected to complete the enrollment/disenrollment and subsequent capitation adjustments (both overpayments and underpayments) by June 30, 2011. However, this initial target date has been extended to December 30, 2011.

The exact amount of the FFS payment errors, and the corresponding corrective action, cannot be fully defined until the MCO reconciliation process is complete. For example, if a FFS claim was paid for a client who was, during the MCO reconciliation process, determined to be covered by a MCO, then the payment associated to the FFS claim will be recovered and the appropriate capitation payment processed. If a FFS claim was paid for a client who was determined to not be covered by a MCO at the time the service was rendered, then the FFS payment was appropriate.

Once the MCO reconciliation process is finalized, then the last sequential step in the payment reconciliation plan will begin. This last step is to overlay the corrected MCO client enrollment onto the FFS claims payment history and determine the appropriateness of each FFS payment made for these enrollment-adjusted clients. Incorrect FFS overpayments will be recovered and any appropriate FFS claims that were previously denied will be paid. This final reconciliation step is expected to be completed by December 30, 2011.

- We recommend that department management implement the recommendations provided in our confidential security letter.

The department agrees with the recommendations provided in the confidential security letter provided to the department per ORS 192.501. We have taken and will continue to take corrective actions as discussed in our confidential response to the security letter.

Beginning on July 1, 2011, only those reports issued specifically to the Department of Human Services or the Oregon Health Authority will be included in their individual Audit Response Report.

15. OHA: Improved Controls over Child Enrollment Reporting and Advertising Expenditures, audit # 2011- 19, (dated September 2011)

- We recommend OHA management develop a consistent process to compile and review the bonus award enrollment figures for future submissions. We also recommend OHA management work with the federal government to adjust the bonus award amount.

To qualify for a CHIPRA performance bonus payment, a state must apply to the federal government and demonstrate it meets two criteria, defined in CHIPRA law:

- *It implemented specific program features that are known to promote enrollment and retention of children in medical coverage; and*
- *Its enrollment of children in Medicaid increased above the CHIPRA enrollment target.*

If a state meets both criteria, the state qualifies for a bonus award based on the number of children exceeding the target. As mentioned in the report, for federal fiscal year 2009 (the first year states could qualify for CHIPRA bonuses) OHA applied for and received a CHIPRA bonus for \$1.6 million. The federal government awarded only eight other states CHIPRA bonuses for 2009. For federal fiscal year 2010, OHA applied for and received a CHIPRA bonus for \$15 million. The federal government awarded only 14 other states CHIPRA bonuses for 2010. As identified in the audit, OHA over reported its 2010 enrollment count by approximately 7,400 non-citizen children. As a result, the federal government awarded OHA approximately \$4.5 million more than it should have received. OHA still qualifies for a bonus of more than \$10 million.

OHA has already taken a number of steps to correct the 2010 bonus award. OHA contacted the federal government about the enrollment reporting error. OHA stopped drawing bonus money from the federal account, leaving approximately \$5 million unspent from which the federal government will adjust the original grant award. OHA corrected, tested, and documented the data query used for CHIPRA enrollment reporting. OHA also submitted to the federal government a revised enrollment count for 2010.

Based on the revised enrollment count, the federal government recalculated Oregon's 2010 bonus award. Based on this recalculation, the federal government decreased OHA's unspent award by \$4,488,017 on August 11, 2011.

Moving forward, OHA management will review in detail the data query criteria and data query results with Information Services staff and staff responsible for caseload monitoring before each year's submission of its Medicaid enrollment of qualifying children. OHA will also compare the data query criteria and results with the prior year's data pull to identify any issues.

OHA will utilize the improved process to pull and review the enrollment data for federal fiscal year 2011 in early October to be submitted before the federal deadline of November 1, 2011.

- To strengthen its controls over the Healthy Kids advertising expenditures, OHA and Healthy Kids management should:
 - ensure purchase orders and contracts are in place as appropriate, and are properly executed;
 - implement an effective payment tracking process to reduce the risk of overpayment;
 - ensure timely delegation of signature authority;
 - obtain and retain proof of performance documentation that clearly supports the services provided;
 - correct the recording errors identified during the audit; and
 - determine and resolve the effect of the incorrect reimbursement rate resulting from the miscoded transactions.

Oregon Healthy Kids is a tremendously important program for families across the state. The new Oregon Health Authority, Office of Healthy Kids was created in August 2009, and since then has enrolled about 94,000 more children into the health coverage they need. As a result, Oregon cut its child uninsurance rate in half during this time, a significant achievement. We appreciate the efforts of the Oregon Audits Division to help us make this highly successful program even stronger.

Healthy Kids has instituted a tighter tracking and filing system for purchase orders, invoices and contracts that will help make sure that all required documentation is obtained and saved. In addition, Healthy Kids has instituted a tighter tracking and filing system for advertising purchases and will explicitly require proof of purchase in all advertising contracts. Although Healthy Kids staff did catch the duplicate payment found by the audit prior to the start of the audit and recently received a credit for the remaining \$541 outstanding costs, we are in agreement that more systemized tracking methods could further reduce the possibility of any future over or duplicate payments. Office of Healthy Kids staff have already met with staff from other programs within the Department of Human Services to review their invoice tracking tools and will require all invoices be checked against purchase orders and payments before being submitted for payment.

The Oregon Health Authority has updated its delegated authority policy, procedures and form and is implementing a new delegated authority system that will provide better tracking and reporting of delegations. In addition, the agency is in the process of completing a full roll-out of the new delegation form for all staff with expenditure authority.

Further, the three coding errors identified during the audit have been corrected and the appropriate reimbursement rate recorded.