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SUMMARY OF: State of Alaska, Single Audit for the Fiscal Year Ended June 30, 2014

PURPOSE AND SCOPE OF THE REPORT

This report summarizes our review of the State of Alaska's basic financial statements and the State's compliance with federal laws and regulations in the administration of approximately $3.1 billion of federal financial assistance programs. The audit was conducted in accordance with auditing standards generally accepted in the United States of America and ***Government Auditing Standards***, issued by the Comptroller General of the United States. It also complies with the federal *Single Audit Act Amendments of 1996* and the related ***United States Office of Management and Budget Circular A-133***.

The report contains an opinion on the basic financial statements of the State of Alaska for FY 14, recommendations on financial and compliance matters, auditor's reports on internal controls and compliance, the Schedule of Expenditures of Federal Awards, and the Summary of Prior Audit Findings.

REPORT CONCLUSIONS

The basic financial statements for the State of Alaska are fairly presented in accordance with accounting principles generally accepted in the United States of America without qualification, except for the Governmental Activities and General Fund financial statements which are qualified. We were unable to obtain sufficient appropriate audit evidence to support an opinion on the expenditures for Medicaid and Children's Health Insurance Program services and related revenues as of June 30 2014. Medicaid information systems controls were not effective during the fiscal year ended June 30, 2014. (See Recommendation No. 2014-021.)

We were unable to obtain sufficient appropriate audit evidence to support the State of Alaska's compliance with the Allowable Costs and Eligibility requirements applicable to the Medicaid Cluster and Children's Health Insurance Program administered by the Department of Health and Social Services. (See Recommendation No. 2014-019.) Failure to comply with these compliance requirements resulted in a material weakness for Medicaid and the Children's Health Insurance Program. The State has substantially complied with applicable laws and regulations in the administration of its other major federal financial assistance programs. The report does contain recommendations regarding significant deficiencies in the State's internal control over financial statements and federal programs.

FINDINGS AND RECOMMENDATIONS

This report contains 43 recommendations, of which 17 are unresolved issues from last year. Three of the 43 recommendations are made to Alaska Housing Finance Corporation, one is made to the University of Alaska, and two are made to the Department of Environmental Conservation whose audits were performed by other auditors. Some of the recommendations made in this report require significant changes in procedures or a shifting of priorities, and therefore, may take more than one year to implement. The Summary Schedule of Prior Audit Findings in Section III identifies the current status of most prior audit recommendations not resolved by the release of the FY 14 statewide single audit.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES (DHSS)

Eighteen recommendations were made to DHSS in the *State of Alaska, Single Audit for the Fiscal Year Ended June 30, 2013.* Prior year Recommendation Nos. 9, 13, 14, 15, 16, and 19 have been resolved. Prior year Recommendation Nos. 8, 20, 21, and 22 were not a significant issue in the current year and are not reiterated in this report. Prior year Recommendation Nos. 11, 12, 17, 18, 23, 24 and 25 are not resolved and are included in this report as part of Recommendation Nos. 2014-013, 2014-014, 2014-015, 2014-016, 2014-017, 2014-018, and 2014-020, respectively. Some of the issues associated with prior year Recommendation No. 10 have been resolved. The unresolved portion of prior year Recommendation No. 10 is included in this report as part of the new Recommendation No. 2014-012.

In addition to the new current year recommendation mentioned above (Recommendation No. 2014-012), eight additional new recommendations have been made during the FY 14 statewide single audit and are included in this report as Recommendation Nos. 2014-008 through 2014-011, 2014-019, and 2014-021 through 2014-023.

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Recommendation No. 2014-008

The Division of Public Assistance (DPA) director should ensure personal service expenditures charged to federal programs comply with federal cost principles.

In testing 109 DHSS employee timesheets, various positive time-keeping errors were identified for employees working on multiple federal programs.

1. Three of 25 DPA eligibility technicians tested for the Children's Health Insurance Program[7] (CHIP) had their time incorrectly entered into the payroll system by administrative staff. Each employee's approved timesheet indicated that hours should have been split between two program codes; CHIP and Medicaid. However, due to insufficient review, the hours for all three employees were charged to a single program code resulting in questioned costs of $522 for Medicaid. These questioned costs were resolved by DPA's operations manager. However, based on the error rate, likely questioned costs are estimated to exceed $10,000.

2. Five of 34 employees tested for the Medicaid program[8] inappropriately split their time between a DPA allocated code and a Medicaid direct code. DPA management approved overtime for eligibility technicians to work overtime on Medicaid determinations made under the new modified adjusted gross income rules. Eligibility technicians were directed to work solely on Medicaid during overtime and charge time accordingly. Upon inquiry, five employees indicated they did not work solely on Medicaid during the overtime periods. These errors result in an indeterminate amount of Medicaid program questioned costs.

3. The DPA employee who administers the Special Supplemental Nutrition Program for Women, Infants, and Children[9] (WIC) and the Commodity Supplemental Food Program (CFSP) charged no time to the CFSP. DPA management asserts that the hours worked on the CFSP are minimal, and therefore, positive timekeeping was not performed. Because the hours worked on the CFSP were not tracked, the amount of WIC questioned costs resulting from this error is indeterminate.

United States Office of Management and Budget Circular (OMB) A-87, Attachment B, section 8.h.4 requires appropriate time distribution records support employee compensation charged to more than one federal grant or other cost objective. Additionally, the time distribution records must reflect actual time worked on a program.

We recommend DPA's director ensure that personal service expenditures charged to federal programs comply with federal cost principles.

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[7]CHIP FFY13 federal award identification numbers (FAIN): 1305AK5021 and FFY14 FAIN: 1405AK5021.
[8]Medicaid administration - FFY13 FAIN: 1305AK5ADM and FFY14 FAIN: 1405AK5ADM.
[9]WIC administration - FFY13 FAIN: 13137AKAK7W1003 and FFY14 FAIN:14147AKAK7W1003.

CFDA 10.557, 93.778
Questioned Costs: Indeterminate

Federal Agency: USDA, USDHHS
Noncompliance
Allowable Costs

CFDA 93.767
Questioned Costs: $522

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. The division has initiated staff training on positive time keeping during SFY 2015.

Contact Person: *Sana Efird, Assistant Commissioner*
Finance and Management Services
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Recommendation No. 2014-009

The Financial and Management Services (FMS) assistant commissioner should redefine CapPlus system accounts to strengthen information system controls.

CapPlus, a web-based application implemented by DHSS in the quarter ending March 31, 2013, allocates indirect costs among federal and state programs. DHSS employees utilizing CapPlus are assigned up to three levels of access: *Read Only*, *User*, or *Admin*.

At the time of testing, seven of the nine active CapPlus system accounts were *Admin*, which enabled employees to perform functions beyond the business needs related to their job duties, including the ability to add users and to adjust prior period data.

State of Alaska Information Security Policy (ISP) 171 5.4.4 requires user accounts to be based on a business need related to the user's duties. Furthermore, ISP-171 5.5.1 requires that all system and application user accounts incorporate role-based access control in order to restrict access to authorized uses.

According to DHSS management, employees were assigned the *Admin* role because the *User* role cannot perform primary system functions such as weekly revenue draws and updating the quarterly statistical plans. According to DHSS management, most employees were granted *Admin* access to allow them to perform these primary functions. Consequently, CapPlus system accounts do not sufficiently enforce proper segregation of duties and increase the risk of unauthorized use of the system.

FY 14 major federal programs with material indirect costs (defined as at least five percent of total program expenditures) that were impacted by this finding are Medicaid,[10] CHIP,[11] Adoption Assistance,[12] and CFSP.[13]

We recommend FMS' assistant commissioner redefine system accounts to strengthen CapPlus information system controls.

CFDA: 10.565, 93.659, 93.767, 93.778
Questioned Costs: None

Federal Agency: USDA, USDHHS
Significant Deficiency
Allowable Costs

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. The Federal Allocation Management Unit (FAMU) and revenue unit managers have reduced the number of staff with administrative rights. In SFY 2015 FMS will work with the Interactive Voice Applications (IVA) to expand the levels of CapPlus access from three to four levels to further strengthen the information system controls.

Contact Person: *Sana Efird, Assistant Commissioner*
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Recommendation No. 2014-010

FMS' assistant commissioner should ensure required federal financial reports are submitted.

The FFY 13 Low-Income Home Energy Assistance (LIHEA) program[14] annual SF-425 Federal Financial Report (FFR) for the period ending September 30, 2013, was not submitted due to miscommunication between DPA staff and FMS' revenue unit staff regarding the amounts to report.

The SF-425 FFR is required for block grants received by the State per 45 CFR 96.30(b). By not filing the report, DHSS did not provide timely information to the federal program administrators.

We recommend FMS' assistant commissioner ensure required federal financial reports are submitted.

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[10]FAIN: 1305AK5ADM and 1405AK5ADM.
[11]FAINs: 1305AK5021 and 1405AK5021.
[12]FAINs: 1301AK1407 and 1401AK1407.
[13]FAINs: 13137AKAKA1Y8005 and 14147AKAK1Y8005.
[14]FAIN: G-13B1AKLIEA.

CFDA: 93.568
Questioned Costs: None

Federal Agency: USDHHS
Noncompliance
Reporting

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. The Division of Public Assistance (DPA) and the FMS Revenue Unit are working toward establishing roles and responsibilities as it relates to all federal reporting elements. A written process for the Low Income Energy Assistance Program (LIHEAP) has been drafted for the review and submission of its Federal Financial Report (FFR).

Contact Person: *Sana Efird, Assistant Commissioner*
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Recommendation No. 2014-011

DPA's director should ensure the social security number (SSN) of Medicaid benefit applicants is verified prior to providing benefits.

Two of 25 Medicaid recipients tested for eligibility lacked evidence of SSN verification prior to being approved to receive benefits.

In accordance with 42 USC 1320b-7(a)(1), each applicant for, or recipient of, Medicaid benefits must furnish to the State his or her SSN. The State uses the SSN to identify financial records of the applicant or recipient.

DHSS eligibility procedures include making a copy of the physical social security card for the case file and/or verifying the number through the Internal Revenue Service's income and eligibility verification interface (IVES). Due to oversight, eligibility technicians did not copy applicants' social security card or document a review of IVES to verify the number prior to benefit approval for two of 25 Medicaid applicants tested. Lack of SSN verification increases the risk that ineligible recipients will receive Medicaid[15] benefits.

We recommend DPA's director ensure the SSN of Medicaid benefit applicants is verified prior to providing benefits.

CFDA: 93.778
Questioned Costs: None

Federal Agency: USDHHS
Noncompliance
Eligibility

[15]FAINs: 1305AK5MAP and 1405AK5MAP.

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. DPA staff has taken corrective action by performing the SVES verification and updating the files.

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Recommendation No. 2014-012

DPA's director should ensure reports are monitored and follow-up is performed as required for the WIC program.

Prior Finding

During FY 11, FY 12, and FY 13, report monitoring and follow-up by program staff was not adequately performed in accordance with federal requirements for the monthly food instrument and cash value voucher (FI) disposition report. Report monitoring includes review and appropriate follow-up within 120 days of detecting questionable items or suspected errors.

Four types of monthly disposition reports require review and follow-up by DHSS staff: expired, voided/lost/stolen, duplicate, and un-match. Nine of 12, six of 12, and nine of 12 FI disposition reports were not sufficiently monitored in FY 11, FY 12, and FY 13, respectively, as required by 7 CFR 246.12(q).

Insufficient report monitoring was due, in part, to a lack of adequate procedures for report review and follow-up and inadequate oversight by program managers to ensure review activities were completed as required. Report monitoring primarily ensures costs of food items are contained, and only eligible participants receive benefits. By not performing adequate monitoring functions sufficiently and routinely, food costs could unreasonably increase and ineligible participants could receive benefits, both of which result in reducing benefits available for eligible participants. Per 7 CFR 246.23(a)(4), *Claims and Penalties*, the federal oversight agency could establish a claim against the State for not taking appropriate follow-up action on redeemed FIs that cannot be matched against valid enrollment and issuance records.

Legislative Audit's Current Position

DHSS implemented a new WIC information system, SPIRIT, in October 2013 and developed new procedures for monitoring and following up FI disposition reports. Testing confirmed the new procedures were operating effectively and the prior year control deficiency was addressed. Although the prior year control deficiency has been addressed, instances of inadequate report

review and follow-up[16] were found when testing monthly FI disposition reports due and submitted prior to implementation of the new system. Noncompliance included:

- Current year testing of three months of reports due in FY 14 showed no review or follow-up on any of the reports for September 2013. The lack of review and follow-up was caused by the retirement of the project assistant who performed this function.

- The expired report was unavailable for May 2013 due to incorrect report parameters making the report useless for FI disposition purposes. KeyBank corrected the error prior to June 2013, but did not provide a corrected report for May 2013.

- DHSS follow-up on the May 2013 voided/lost/stolen report was incomplete. WIC personnel sent information requests to seven local agencies and documented the receipt of follow-up information from three of the seven. There was no record of follow-up for the remaining four local agencies. The lack of follow-up and/or documentation was caused by the retirement of the project assistant who performed this function.

We again recommend DPA's director ensure reports are monitored and follow-up is performed as required for the WIC program.

CFDA: 10.557
Questioned Costs: None

Federal Agency: USDA
Noncompliance
Special Tests and Provisions

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. Policies and procedures are in the process of being finalized and the new WIC information system, SPIRIT, has automated several of the reporting requirements discussed in this recommendation.

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[16]FAIN: 13137AKAK7W1006.

Recommendation No. 2014-013

The Division of Senior and Disabilities Services' (DSDS) director should continue to improve documentation procedures and provide oversight to ensure provider certification files are complete.

Prior Finding

DSDS staff lacked adequate procedures to ensure provider certification files were accurate and complete for 15 of 39, seven of 20, and six of 10 files tested in FY 11, FY 12, and FY 13, respectively. Provider certification files did not consistently contain supporting provider certification documentation and multiple files were missing records.

Federal regulations require DSDS management to provide satisfactory assurance that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of services to be eligible to provide home and community-based waiver services.[17] Furthermore, federal regulations require the State to maintain sufficient information to support compliance with the required assurances.[18] State regulations require home and community-based waiver service providers to meet applicable certification criteria, including the qualifications and program standards set out in DHSS' home and community-based waiver service certification application packet.[19]

The health and welfare of service recipients are at risk when DSDS certification files cannot provide assurance that providers and their employees were properly screened and adequately trained prior to certification.

Legislative Audit's Current Position

In FY 14, 16 of 30 Medicaid[20] provider certification files reviewed were incomplete. The incomplete files did not provide assurance that providers and employees were properly screened and adequately trained prior to certification. Although DSDS management developed procedures to improve documentation, testing found procedures were not followed.

We again recommend DSDS' director continue to improve documentation procedures and provide oversight to ensure provider certification files are complete.

CFDA: 93.778
Questioned Costs: None

Federal Agency: USDHHS
Significant Deficiency, Noncompliance
Special Tests and Provisions

[17] *Title 42 of the Code of Federal Regulations, section 441, subsection 302(a).*
[18] *Title 42 of the Code of Federal Regulations, section 441, subsection 303.*
[19] *Title 7 of the Alaska Administrative Code, section 130, subsection 220* and 7 AAC 125.060.
[20] FAINs: 1305AK5MAP and 1405AK5MAP.

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. In SFY 2014 DSDS continued to strengthen its procedures by performing quality assurance reviews of a sample of the provider certification files for each worker to ensure consistency and sufficient documentation that providers meet certification standards. In SFY2015 DSDS will conduct refresher trainings for staff on the proper use of the checklist and provider certification documentation procedures; specifically background check documentation. DSDS has also implemented Provider Certification procedures and established a standardized file system to document that qualifications have been met prior to certification.

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Recommendation No. 2014-014

The Division of Behavioral Health's (DBH) director should continue to make improvements to ensure out-of-state residential psychiatric treatment center (RPTC) providers are paid in accordance with federal and state requirements and that rates are properly documented.

Prior Finding

During FY 12, all 23 out-of-state RPTC provider files lacked documentation supporting the rate utilized. In FY 13, RPTC provider files were not made available for the federal compliance review.

The *OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments* requires that costs be adequately documented to be allowable under federal awards. Regulations state negotiated rates for out-of-state services may not exceed the provider's usual and customary charges for the same service to the general public.
DBH personnel are responsible for negotiating and documenting rates for out-of-state RPTC providers, yet personnel did not have written policies and procedures that sufficiently described how to implement the regulation. DBH personnel were unaware of requirements for documenting the rate determination methodology.

Legislative Audit's Current Position

In FY 14, DHSS' Office of Rate Review management developed policies and procedures for documenting rate setting for RPTC providers. However, procedures were not followed as designed indicating that additional improvements are needed.

Fourteen of 22 tested RPTC provider files for the Medicaid[21] and CHIP[22] programs lacked evidence that provider data used to support the rates were verified for completeness and accuracy. Three additional provider files tested did not document the rate setting methodology. One RPTC provider file did not have the specialized services assessment required by regulations.

Lack of proper verification and documentation supporting RPTC rates increases the risk for overpayments.

We recommend DBH's director continue to make improvements to ensure out-of-state RPTC providers are paid in accordance with federal and state requirements and that rates are properly documented.

CFDA: 93.767, 93.778 — Federal Agency: USDHHS
Questioned Costs: Indeterminate — Significant Deficiency, Noncompliance
Allowable Costs

Agency Response – Department of Health and Social Services

DHSS partially concurs with the recommendation. DHSS agrees RPTC providers should be paid in accordance with federal and state requirements. The Office of Rate Review (ORR) worked with DBH staff to design a template of steps (i.e. rate checklist) for DBH staff to complete and submit to ORR for review and recommendation before DBH sets a rate. The checklist both expressly and implicitly requires verification of provider data through documentation that supports key steps of the rate setting process that is described in regulation.

During SFY2015 ORR continues to strengthen internal controls by expanding the checklist to describe all necessary documentation required for each step and is currently in the process of implementation. As before, the DBH user must collect and attach such documentation before submitting the checklist and materials to ORR for review and recommendation. While this practice may not have been perfectly executed in the past, ORR believes that the rates that have been set under this process within the last two years are still fully consistent with current regulations and have not resulted in any overpayments.

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[21]FAIN: 1305AK5MAP and 1405AK5MAP.
[22]FAIN: 1305AK5021 and 1405AK5021.

Legislative Auditor's Additional Comments

We have reviewed DHSS' response and nothing contained in the response persuaded us to revise the recommendation.

Recommendation No. 2014-015

LIHEA's program manager should continue to improve training and monitoring to ensure program benefits are calculated in accordance with the LIHEA State Plan.

Prior Finding

In FY 13, 62 LIHEA benefit recipients were tested for compliance with federal eligibility and allowable costs requirements. Due to a systematic flaw in the methodology for calculating seasonally employed applicants, an applicant whose income exceeded the allowable eligibility income level inappropriately received LIHEA benefits totaling $4,950.[23] Additional questioned costs were likely because of the systematic nature of the error. Additionally, lack of training and monitoring of eligibility technicians resulted in benefit calculation errors for six recipients. Calculation errors occurred despite eligibility technicians' access to comprehensive procedures manuals that guide the calculation of LIHEA benefits. These calculation errors resulted in overpayments totaling $450.

Title 42 of the United States Code, section 8624(c) requires a state plan to be submitted annually describing the eligibility requirements to be used by the State and how the State will determine the benefit level for LIHEA recipients. Per 42 USC 8624(b)(2)(B), the income level eligibility limit is 150 percent of the federal poverty level. Errors in determining eligibility and calculating benefit amounts reduce the amount of benefits available for eligible participants.

Legislative Audit's Current Position

During FY 14, DHSS' LIHEA program manager provided training to address the errors identified in the FY 13 audit. However, FY 14 testing found one of 40 FY 14 LIHEA[24] recipients tested was ineligible. The applicant's income exceeded the program limit resulting in an unallowable benefit payment of $405. Projecting the error to the population indicates likely questioned costs greater than $10,000 exist. This error occurred despite eligibility technicians' access to comprehensive procedures manuals that guide the calculation of LIHEA benefits and the additional training.

We recommend LIHEA's program manager continue to improve training and monitoring to ensure program benefits are calculated in accordance with the LIHEA State Plan.

[23] LIHEA program staff used the state funded Alaska Heating Assistance Programs' eligibility income level of 225 percent of the federal poverty level rather than the federal LIHEA eligibility income level of 150 percent of the federal poverty level.

[24] FAIN: G-14B1AKLIEA.

CFDA: 93.568
Questioned Costs: $405

Federal Agency: USDHHS
Noncompliance
Allowable Costs, Eligibility

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. The division updated the LIHEAP procedures manual in SFY 2014 and provided training to staff at the beginning of the season. Case reviewers have also started verifying that the correct eligibility criteria are being applied.

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Recommendation No. 2014-016

LIHEA's program manager should ensure the LIHEA State Plan complies with federal requirements.

Prior Finding

The FFY 13 LIHEA State Plan did not include all benefit determination criteria. Of the 62 FY 13 LIHEA benefit recipients tested for compliance, 10 lived in a dwelling type not included in the State Plan, and three lived in a dwelling size that was omitted from the plan. The dwelling type and size categories are used by LIHEA staff to calculate the allowable benefit payment. Due to oversight, the State Plan did not address all dwelling types and sizes used in benefit amount calculations.
Per 42 USC 8624(c)(1)(B), the State must include benefit level determinations in the annual State Plan. By failing to include all required benefit determination criteria, the criteria were not subjected to the appropriate federal oversight.

Legislative Audit's Current Position

In FY 14, the State Plan was revised to include additional dwelling types. However, not all dwelling types were included in the revision. Three of the 40 FY 14 LIHEA[25] benefit recipients tested for compliance lived in a dwelling type or size omitted from the plan. According to program staff, these additional dwelling types and sizes were not incorporated into the State Plan because the agency is considering comprehensive changes to the program.

[25]FAIN: G-14B1AKLIEA.

We again recommend LIHEA's manager ensure the LIHEA State Plan complies with federal requirements. The plan should include all dwelling types and sizes that DHSS uses to calculate benefit payments.

CFDA: 93.568
Questioned Costs: None

Federal Agency: USDHHS
Noncompliance
Allowable Costs

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. The division is continuing to work toward changes in the way benefits are calculated. Since this requires a change in statute and regulation prior to updating the LIHEAP state plan, the anticipated resolution is within the next two years.

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Recommendation No. 2014-017

DSDS' director should ensure provider employees receive timely, complete, and approved background clearances and that the information supporting the clearance is properly documented.

Prior Finding

As part of the provider certification process, DSDS requires a criminal history background check for provider employees. DSDS staff works with DHSS' central Background Check Unit to conduct an initial review of criminal history. Provider employees are given provisional status and allowed to work with clients if they pass an initial review. If they do not pass the initial review, provider employees are barred from working with clients. Those employees receiving a provisional status are also subject to a fingerprint-based criminal history background check. Again, DSDS staff works through DHSS' central Background Check Unit to conduct the more thorough criminal history check. Once a provider employee successfully passes the fingerprint-based criminal history check, they move to *approved* status. DHSS management considers three months to be a reasonable time period for completing the background checks.

In FY 13, DSDS staff did not follow up on incomplete background checks for six of 10 provider files tested. Also, DSDS staff did not document followup with providers when barred employees were identified. For one provider, testing identified four employees in provisional status ranging for a period of six months to three years. This same provider had two other

employees in provisional status for almost three years before a barred determination was issued.

Legislative Audit's Current Position

In FY 14, 15 of 30 tested Medicaid[26] provider certification files were missing complete criminal history background checks. Each provider certification file may include multiple employees requiring background checks. Further testing of the 15 provider files disclosed the following issues:

- For four providers, no background clearances were located for 12 employees, and five employees were barred.
- For two additional providers, three employees were also barred.
- For two providers, six employees were in provisional status for a period of time ranging from five to eight months.

None of the DSDS provider certification files included documentation to support that DSDS staff followed up with providers with regard to barred employees or incomplete or missing background checks.

DSDS staff does not follow up on noted discrepancies until the provider's next site review — if one is required. A site review may not happen for a year or two following identification of a discrepancy, and some providers, such as transportation providers, do not have site reviews.

According to DSDS management, due to the volume of providers and lack of staff resources, DSDS staff must rely on DHSS' Background Check Unit to ensure provider employees in provisional status are ultimately approved. By not following up on the status of the background checks, DSDS staff does not know if provider employees are ultimately approved to work with clients. Additionally, DSDS staff does not have procedures to ensure barred employees do not continue to work for providers.

Per 42 CFR 441.302, the State is to provide satisfactory assurances that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of services. State regulation requires all certified providers to furnish proof of a valid fingerprint-based criminal history check for all individuals associated with the provider.[27]
Failure to adequately screen providers and their employees puts the health and welfare of service recipients at risk.

We again recommend DSDS' director ensure provider employees receive timely, complete, and approved background clearances and that the information supporting the clearance is properly documented.

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[26]FAIN: 1305AK5MAP and 1405AK5MAP.
[27]*Title 7 of the Alaska Administrative Code, section 10, subsection 910.*

CFDA: 93.778
Questioned Costs: None

Federal Agency: USDHHS
Significant Deficiency, Noncompliance
Special Tests and Provisions

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. In SFY 2014 DSDS continued to strengthen its processes and procedures by developing a background check verification form and implementing it as essential documentation for the provider agency folder. DSDS also participated in a department-wide project to address applicants in provisional status over 90 days resulting in outstanding cases being resolved. Early in SFY 2015 procedures were adopted and implemented for individuals with a barred status including a file documentation requirement. Additionally, DSDS has incorporated the background check clearance process into the written procedures for provider certification and certification renewal which includes printing out the agency's background check program account and including it in the provider agency folder.

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Recommendation No. 2014-018

The Medicaid and Health Care Policy (HCP) deputy commissioner and FMS assistant commissioner should improve procedures to ensure overpayments to Medicaid providers are refunded to the federal agency within the specified time frame.

Prior Finding

In FY 13, an overpayment recovered from a Medicaid services provider was not refunded to the federal agency within one year. As a result, the federal agency overpaid the State $73,181.

Federal regulation[28] requires the State to refund the federal share of overpayments subject to recovery to the federal agency through a credit on the quarterly statement of expenditures, the Centers for Medicare and Medicaid Services (CMS) 64 report, within one year of discovery.

The overpayment was not refunded because program integrity personnel did not provide the FMS accountant responsible for CMS-64 reporting a complete list of overpayments as required

[28] *Title 42 of the Code of Federal Regulations, section 433, subsection 320(a)* and section 6506 of the *Affordable Care Act.*

by program integrity policies and procedures. Additionally, FMS' CMS-64 policies and procedures were not sufficient to detect all overpayments for reporting purposes.

Legislative Audit's Current Position

In FY 14, procedures were updated; however, upon review of the procedures it was noted that they do not address all types of overpayments or recoveries. Additionally, a Medicaid[29] services provider overpayment was not refunded to the federal agency within one year during FY 14.

Incomplete written procedures and processes increase the risk that Medicaid overpayments or recoveries will not be refunded timely to the federal agency.

We again recommend HCP's deputy commissioner and FMS' assistant commissioner improve procedures to ensure overpayments to Medicaid providers are refunded to the federal agency within the specified time.

CFDA: 93.778
Questioned Costs: None

Federal Agency: USDHHS
Significant Deficiency
Allowable Costs

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. In SFY 2014 DHSS updated procedures to ensure accurate federal reporting and in SFY 2015 is in process of expanding those procedures to include every potential type of overpayment.

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Recommendation No. 2014-019

DHSS' commissioner should take action to implement effective controls to ensure Medicaid claims are processed accurately and timely.

During FY 14, DHSS replaced its legacy Medicaid management information system. The Alaska Health Enterprise (AHE) system, also known as the Medicaid claims system, began operating October 1, 2013, and encountered significant widespread defects. Because of the defects, the AHE system was not a fully operational or federally certified Medicaid system during FY 14. The AHE system processed approximately $1.1 billion in claim expenditures during FY 14 which

[29]FAIN: 1405AK5MAP.

resulted in $658.8 million in federal revenues. AHE expenditures were material to the Medicaid and CHIP federal programs.

The AHE defects resulted in a material weakness in internal controls over the Medicaid and CHIP programs' allowable costs and eligibility compliance requirements. Due to the complexity of Medicaid program operations, we were unable to support an opinion that Medicaid and CHIP expenditures were in compliance with applicable laws and regulations without the ability to rely upon the AHE system's internal controls. We could not obtain sufficient evidence to determine the accuracy of the claims processed and conclude if eligibility requirements were applied correctly through the interface process.

While we could not express an opinion on compliance with allowable costs and eligibility compliance requirements, testing identified the following noncompliance caused by the system defects.

- Providers were paid for duplicate claims and were over and/or under paid due to the inaccurate claim eligibility and pricing. Identified Medicaid[30] federal questioned costs for duplicate claims totaled $10,459. Likely questioned costs are higher for this deficiency.

- Claims were assigned incorrect funding codes. Four non-Medicaid recipients were identified and miscoded to Medicaid resulting in federal questioned costs of $10,970. Additionally, approximately $1.8 million was identified in claims that were incorrectly coded to CHIP.[31] Likely questioned costs are higher for this deficiency.

- Providers received incorrect and untimely reimbursement for services. To mitigate the impact of untimely and/or incorrect payments, DHCS issued cash advances to providers totaling approximately $143 million in FY 14. Based on an incorrect analysis by DHSS staff of the advances and suspended AHE claims, DHSS obtained approval from the federal oversight agency to draw $131 million of federal funds without identifying eligible expenditures. The $131 million of ineligible expenditures were reported as valid expenditures on the CMS-64 report. (See Recommendation No. 2014-022 for further details.) The $131 million of ineligible expenditures were properly excluded from the schedule of federal awards.

- Program errors related to the Medicare buy-in program caused incorrect payments to the federal agency including payments for ineligible recipients. Questioned costs were indeterminate.

[30]FAINs: 1305AK5MAP and 1405AK5MAP.
[31]FAINs: 1305AK5021 and 1405AK5021.

- The surveillance and utilization review program[32] was ineffective due to unreliable system data and inadequate staffing. Staff was reassigned from the surveillance and utilization review program to help address system defect errors.

- Program integrity staff was unable to complete investigations and pursue collections of potential overpayments from providers due to unreliable system data.

The extensive system defects and known noncompliance increase the risk that Medicaid and CHIP expenditures were incorrect, ineligible, incomplete, and reported inaccurately. Additionally, lack of controls increases the risk for fraud, waste, and abuse.

Federal regulation 42 CFR 433.32(a) and Medicaid State Plan, section 6.1 require the State to maintain an accounting system and supporting fiscal records to assure that claims for federal funds are in accordance with applicable federal requirements. The State is required to determine client eligibility in accordance with eligibility requirements defined in the approved State Plan. Additionally, 42 CFR 430.30(c)(2) requires federal reporting be based on the State's accounting of actual recorded expenditures, not estimates. *OMB Circular A-87* requires costs (i.e. claims) to be adequately documented to be allowable under federal awards.

We recommend the DHSS' commissioner take action to implement effective controls to ensure Medicaid claims are processed accurately and timely.

CFDA: 93.778
Questioned Costs: $21,429
CFDA: 93.767
Questioned Costs: $1,768,845

Federal Agency: USDHHS
Material Weakness, Noncompliance
Allowable Costs, Eligibility

CFDA: 93.778
Questioned Costs: None

Federal Agency: USDHHS
Noncompliance
Reporting

CFDA: 93.778
Questioned Costs: Indeterminate

Federal Agency: USDHHS
Significant Deficiency, Noncompliance
Special Tests and Provisions

Agency Response – Department of Health and Social Services

DHSS concurs that effective controls must be in place to ensure that Medicaid claims are processed accurately and timely. The Department continues to address AHE system defects

[32]*Title 42 of the Code of Federal Regulations, section 456* requires the State to implement and monitor a statewide surveillance and utilization control program and take correction action to ensure the effectiveness of the program.

and deficiencies with Xerox's performance in order to provide for continued access to health care for Alaskans in need.

The Alaska Health Enterprise (AHE) Medicaid claims processing system went live on October 1, 2013. During the first days and weeks of operation, it became evident that significant system defects and issues existed that adversely affected the timely and accurate processing of Medicaid claims. Early in the go-live period, AHE was unable to recognize certain types of claims resulting in those submitted claims not being accepted into the system at all. The Department immediately assessed the status of Xerox's claims processing capacity and identified several areas of critical failure. Documents released to the public by the Department of Law on September 22, 2014 (Attachment Nbr #1) explain in detail the significant actions taken by DHSS during the go-live period and beyond to address these critical system issues.

DHSS acknowledged during the audit period that defects existed within AHE causing certain claims to be priced incorrectly; to be paid incorrectly; and to be denied or suspended inappropriately. To compensate for Xerox's failure to accurately process claims, the state was forced to develop and implement workaround processes. These efforts ensured that providers could receive payment via claims processing through AHE, which would include a remittance advice for each payment even if the payment included errors. This allowed for providers to maintain claims submission and accounting controls. Defect claims were then isolated for correction at a later time when approved system-based resolution could be introduced into AHE. Full disclosure to support these required workarounds was provided at the time of the audit including documentation showing that effective state controls were in place to identify, track and reprocess claims that were paid with errors in the defective AHE system.

During SFY 2014, some providers suffered an ongoing significant loss of dependable Medicaid reimbursement plus additional and burdensome administrative costs while providing routine and continuous care to Alaskans in need. In order to maintain the Department's top priority of access-to-care, DHSS issued more than $143 million in cash payments to our most financially vulnerable providers so they could continue to operate under the duress of a defective Medicaid claims processing system.

During the audit, documentation was provided to show that controls existed to support the dollar amount of claims associated with these cash payments. Due to Xerox's inability to address all AHE deficiencies during this time, unresolved defect claims were part of these documented expenditures. For federal reporting purposes, DHSS attempted to design and implement a manual adjudication process based on the identified claims. This approach was shared with the Centers for Medicare and Medicaid Services (CMS) and DHSS received approval from the CMS regional office to claim $131 million of these expenditures (resulting in $78 million in federal draw down) and did so in QE 6/30/14. However, due to concerns raised by Legislative Audit in November 2014, the Department reversed the adjustment on the CMS64 federal expenditure report for QE 12/31/14 and reported it as a decreasing prior period adjustment for QE 6/30/14.

In SFY 2015 DHSS continues its efforts to ensure that Medicaid claims are processed accurately and timely within AHE. The development of Xerox's Corrective Action Plan (CAP) was initiated in October 2014 and was scheduled to be completed in February 2015. The CAP, which was published on the DHSS webpage, addresses corrective actions, expectations and deadlines for AHE Medicaid claims processing solutions. Litigation was also initiated by the department and the first hearing regarding the state's claim was scheduled for the week of February 16, 2015 with other hearings scheduled in August, 2015.

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Legislative Auditor's Additional Comments

We have reviewed DHSS' response and nothing contained in the response persuaded us to revise the recommendation. However, we offer the following points of clarification. In a highly automated environment, manual internal controls are not effective to prevent payment errors. Thus, DHSS did not have effective controls in place to identify, track, and reprocess the magnitude of claims that were either paid with errors or suspended due to AHE system defects. Additionally, no effective controls existed to support the dollar amount of claims associated with cash advances. As discussed in the Recommendation No. 2014-022, review of DHSS' analysis of suspended claims found multiple errors that overestimated the amount of suspended claims related to the advances.

Recommendation No. 2014-020

FMS' assistant commissioner should take measures to resolve revenue shortfall issues.

The *State Budget Act* provides that if actual collections fall short of appropriated program receipts, an agency is required to reduce its budget by the estimated reduction in collections.

Nine potential shortfalls previously identified in FY 13 are still outstanding in FY 14 in the following amounts.

Appropriation	Appropriation Title	Amount
22980-08	Department Support Services	$ 3,183,171
22812-10	Workforce Investment Act Youth Juvenile Justice – Reimbursable Service Agreement (RSA)	$ 8,310
22820-10	Bring the Kids Home – RSA	$ 4,123
23847-10	Safety and Support Equipment	$ 30,663
26116-12	Deferred Maintenance, Renovation, Repair, and Equipment	$ 11,004
26122-12	Replacement of Telephone Systems	$ 15,224
26123-12	Safety and Support Equipment	$ 11,225
26212-12	Mental Health Special Needs Housing	$ 15,000
26318-13	Mental Health Treatment and Recovery Based Special Needs Housing	$ 15,000

Additionally, five new potential shortfalls have been identified.

Appropriation	Appropriation Title	Amount
22620-14	Division of Public Assistance	$ 4,642
22704-14	Modifications for IRIS – RSA	$ 36,570
26117-14	E-Grants	$ 3,824
26132-14	Denali Commission Grants for Health Care Facility Improvements	$ 2,621
26137-14	Master Client Index	$ 280,336

These revenue shortfalls are due to weaknesses in internal controls over monitoring revenue collections, untimely revenue billings, ineffective year-end financial processes, and a settlement with CMS for the disallowance of Medicaid School Based Services expenditures.

We recommend FMS' assistant commissioner work with division directors to collect earned revenues where possible. Additionally, FMS' assistant commissioner should work with the State's Office of Management and Budget to correct revenue shortfalls and request supplemental appropriations if necessary. We further recommend FMS' assistant commissioner improve procedures for billing and monitoring revenue collections to prevent future revenue shortfalls.

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation. DHSS has submitted ratification requests to the Office of Management and Budget (OMB) for all appropriations (AR) listed with the exception of AR 22620-14 Division of Public Assistance and AR 22704-14 Modification for IRIS-RSA. It is anticipated the two remaining appropriations may not require ratification as DHSS is expecting the necessary revenues. This is a point in time determination and DHSS is always working toward minimizing differences to prevent shortfalls.

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Recommendation No. 2014-021

DHSS' commissioner should work with Xerox to correct defects in the AHE system.

On October 1, 2013, DHSS replaced its legacy Medicaid management information system that processed and paid Medicaid and CHIP claims with the new AHE system. DHSS and its system development contractor, Xerox, were aware the AHE system contained 44 defects at the time it was implemented. Rather than delay implementation of the system until the defects were addressed, DHSS and Xerox developed work-around plans to manage the known system

defects and proceeded with implementation. Once implemented, the number of defects climbed to 546. While some defects were addressed during FY 14, the AHE system had identified 451 unresolved defects as of the end of August 2014.

Because of the defects, the AHE system was not a fully operational or federally certified Medicaid system during FY 14. Examples of issues resulting from system defects include:

- *Suspended Claims Backlog*: As of the end of August 2014, the AHE system had a significant backlog of 98,736 suspended claims totaling $184 million. It is not possible to accurately identify the number and amount of claims suspended due to system defects as opposed to other non-system related reasons. Furthermore, it is not possible to determine how many of these claims will be deemed eligible and the amount paid until the claims are successfully processed by the AHE system. Since claims are not determined eligible and priced until processed by the AHE system, suspended claims delayed providers from being compensated for services provided.

- *Interface Issues*: The AHE system has interface problems with DHSS' eligibility information system, pharmacy benefit management system, third party liability system, and the Department of Commerce Community and Economic Development's occupational licensing database. As a result of these issues, risks exist that eligible members are not receiving services and ineligible members are inappropriately receiving services; pharmacy claims are being processed incorrectly; providers without licenses are receiving payments; and private insurance reimbursements are not being collected. While Xerox and DHCS personnel are performing manual procedures to mitigate system defects, considering the volume of claims, the manual procedures are only partially effective in identifying and correcting all errors.

- *Payment Issues*: The AHE system has numerous payment related deficiencies, including paying providers for duplicate claims, over and underpaying providers due to miscalculation of claim eligibility and pricing. While some of the defects causing payment issues were corrected during FY 14, the adjustments to correct previously processed inaccurate claims were not fully processed as of fiscal year-end.

- *Funding Source Issues*: Claims are assigned funding sources by the AHE system which, among other things, are used to determine the percentage of federal reimbursement for which each claim is eligible. AHE system defects caused claims to be assigned incorrect codes which resulted in inaccurate federal reimbursement.

- *Check-Write Issues*: Claims processed and paid through the AHE system (check-writes) should be seamlessly interfaced with the state accounting system (AKSAS). However during FY 14, the AHE interface files required manual adjustments to ensure they correctly interfaced AHE system activity with AKSAS.

Information technology best practices dictate that systems should be tested and significant defects corrected prior to implementing a new system. Specifically, the ISP requires management to test a new information system prior to putting it into production to ensure that the system is configured correctly.[33] Furthermore, the National Institute of Standards and Technology special publication, *Security and Privacy Controls for Federal Information Systems*,[34] commonly regarded as national best practices, requires organizations to conduct an assessment of the information system, system component, or information system service prior to acceptance and update. It states:

> *Organizations conduct assessments to uncover unintentional vulnerabilities and intentional vulnerabilities including, for example, malicious code, malicious processes, defective software, and counterfeits.*

During FY 14, the AHE system processed approximately $1.1 billion in General Fund expenditures, which resulted in $658.8 million in federal grants-in-aid revenues. Because of the complexity of medical claims processing, we could not determine the extent of misreporting resulting from system defects. However, since the defects affected every area of AHE system operations and the amounts processed through the AHE system are material to the financial statements, the combination of the issues above represent a material weakness in internal control and could result in a material misstatement to the financial statements. The FY 14 General Fund and Governmental Activities audit opinions were qualified in recognition of the material weakness and a lack of ability to obtain adequate evidence.

We recommend DHSS' commissioner work with Xerox to correct the defects in the AHE system.

Agency Response – Department of Health and Social Services

DHSS concurs with the recommendation and continues to address AHE system defects and deficiencies with Xerox's performance in the implementation of an operation ready system which has required DHSS to implement manual processes to ensure continued access to healthcare for Alaska's vulnerable constituents.

Documents released to the public by the Department of Law on September 22, 2014, and provided as attachment #1, explain the considerable preparation that was completed by DHSS prior to Xerox taking the AHE live on October 1, 2013. The preparation followed best practices for Information Technology system replacement. DHSS also received a signed certificate of system fitness for operational implementation from Xerox (Attachment #2) and a security plan prior to go-live from Xerox, who hosts the AHE system. Additionally, the professional technical assistance contractor (TAC), Qualis Health, another contractor for the state of Alaska, stated

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[33]State of Alaska ISP-162 - System Planning and Acceptance, 5.2.2.

[34]National Institute of Standards and Technology Special Publication 800-53 Revision 4, *Security and Privacy Controls for Federal Information Systems and Organizations, SA-12(7).*

on page 4 of 10 in their "October 2013 IV&V Report" dated November 8, 2013: "By industry standards, the Alaska implementation can be considered successful because at Go-Live, the system..." followed by seven items supporting their conclusion. However, this report was later tempered by the issuance of another report after Go-Live titled "Alaska Health Enterprise Acceptance Testing Assessment" dated November 20, 2013.

Attachment #1 also explains the significant actions taken by DHSS following Go-Live. In SFY 2015 DHSS continues to rectify the operational and system deficiencies with Xerox.

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Recommendation No. 2014-022

DHSS' commissioner should ensure financial activity is properly classified in AKSAS.

DHSS incorrectly classified $131 million in advance payments to Medicaid providers as FY 14 General Fund expenditures. During FY 14, AHE system defects prevented some providers from receiving correct and timely reimbursement for provided services. (See Recommendation No. 2014-021.) To ensure Medicaid clients continued receiving services, DHSS management advanced funds to affected providers. The practice of advancing general funds without federal reimbursement caused DHSS to encounter expenditure authorization problems as the related appropriations were funded, in large part, by federal receipts.

Based on an analysis by DHSS staff[35] that suspended claims supported the $131 million in advances, DHSS obtained approval from the federal oversight agency to draw federal funds. Federal approval was initially made under the condition that the suspended claims would be successfully processed by the end of the federal fiscal year (FFY) and recorded correctly on the CMS-64 report. Ultimately, this was not possible, and CMS oversight officials allowed DHSS to retain approximately $78 million of related federal revenues and report the advances on the CMS-64 report as expenditures for the FFY ended September 30, 2014, with the understanding that DHSS will make adjustments to correct inaccurate claiming in the future.

To support the draw of federal funds, $131 million in advance payments were reclassified in AKSAS from advances to expenditures. The reclassification was made even though advances or the related suspended claims had not undergone final eligibility and pricing and, therefore, had not been determined eligible. DHSS management incorrectly considered suspended claims to be eligible expenditures because they expected these claims to be eventually deemed eligible by the AHE system once processed.

[35]Review of DHSS' analysis of suspended claims found multiple errors that over-estimated the amount of suspended claims related to advances.

The *Codification of Governmental Accounting and Financial Reporting Standards* states that expenditures cannot be recognized until applicable eligibility requirements are met. In this case, the eligibility requirements are rules of the Medicaid and CHIP promulgated by federal regulations and the Medicaid State Plan. Due to the complexity of rules and variables associated with claim processing, claims can only be effectively priced by processing through the AHE system. Paid advances or related suspended claims were not priced by the AHE system; thus, the eligibility requirements have not been met for expenditure recognition.
As a result of the misclassification, $131 million was incorrectly reported as General Fund expenditures instead of advances, and the associated $78 million of drawn down federal funds was reported as revenue instead of a liability. Once identified, the Department of Administration's Division of Finance staff processed a correcting adjustment to properly classify the activity in the State's *Comprehensive Annual Financial Report.*

We recommend DHSS' commissioner ensure financial activity is properly classified in AKSAS.

Agency Response – Department of Health and Social Services

DHSS concurs that financial activity should be properly classified in AKSAS. Due to extenuating circumstances surrounding the AHE conversion and in order to maintain its Medicaid program, DHSS attempted to design and implement a manual adjudication process. The agency shared its proposed approach with the Centers for Medicare and Medicaid Services (CMS) and the Division of Finance. DHSS received approval in advance from CMS regional office and dedicated significant internal efforts toward satisfying the federal requirements for federal reporting as required for adjudicating Medicaid claims and to ensure the expenditures were reported in compliance with Generally Accepted Accounting Principles (GAAP).

At the time DHSS made the decision to prepare an adjustment for manually adjudicated claims, it was with the understanding that the fiscal agent, Xerox could not process the incorrectly suspended and/or denied claims prior to the state fiscal year end for 2014 (06/30/14) and the adjustment would be reversed prior to the end of quarter ending (QE) 09/30/14 during said quarter the suspended and denied claims were to be processed. Unfortunately, the situation surrounding the AHE operations and system defects only worsened (see Attachment #1).

Due to concerns raised by Legislative Audit in November 2014, DHSS reversed the complete adjustment in December 2014, and it is being reported as a decreasing prior period adjustment for QE 06/30/14 on the CMS 64 federal expenditure report for QE 12/31/14. Screen shots of the adjusting journal entry and online audit trail from the state of Alaska accounting system (ASKAS) are attached for easy reference.

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Recommendation No. 2014-023

DHSS' commissioner should distribute funds in accordance with state statutes and regulations.

In FY 14, DHSS management directly awarded $1,175,000 to the following three nonprofit organizations and municipality without following state procurement laws or grant regulations.

Amount	Entity Name	Purpose
$ 25,000	Covenant House Alaska	To support Covenant House Alaska's Street Outreach Program.
$150,000	North Star Community Foundation	The Winter Bear Project. A traveling play that promotes suicide awareness and community outreach.
$500,000	Municipality of Anchorage	To help fund the Anchorage Domestic Violence Prevention Project.
$500,000	Boys and Girls Clubs of America	To help fund the Statewide Youth Suicide Prevention Project to pilot outcome-driven primary prevention programs in 11 communities.

DHSS management stated the distributions were not grants. DHSS management considers the distribution of funds to be *sponsorships.* DHSS management further believed that the procurement code did not apply because no services were provided to the state. The audit acknowledges that the *Alaska Administration Manual* did exempt certain activities from the procurement code, including expenditures where the state did not receive services. However, the Department of Administration in consultation with the Department of Law eliminated this exemption in 2013 after the legality of the exemption was questioned in an audit finding.

State procurement and grant laws[36] are designed to provide a fair, competitive, and open procurement process. By failing to comply with these laws, DHSS did not fairly and equitably disburse funds and did not provide a mechanism for monitoring the entities' use of funds.

We recommend DHSS' commissioner distribute funds in accordance with state statutes and regulations.

Agency Response – Department of Health and Social Services

DHSS concurs with the general premise that funds should be distributed in accordance with state statutes and regulations; however, DHSS does not agree that these distributions violated state regulation or were subject to the DHSS grant regulations (7 AAC 78).

The funds that were paid to the four identified providers in your letter were appropriated to DHSS as unrestricted funds and not to a DHSS grant program. As such, the money was not restricted in any way as to how DHSS could use it and was not authorized on exemptions

[36]AS 36.30, 2 AAC 12, and 7 AAC 78.

within the Alaska Administrative Manual current or past. DHSS continues to believe that the use of this money was, under its policy and procedure related to Sponsorships, appropriate and in accordance with Alaska statute (AS) section 18.05.010, AS 18.15.355 (Attachment #3). DHSS used the funding to ameliorate and/or raise public awareness to protect and promote important public health concerns, namely suicide prevention and prevention of domestic violence and sexual assault. These payments were done through collaboration with public sector partners to help meet the mission of DHSS (To Promote And Protect The Health And Well-Being Of Alaskans).

The DHSS grant procedures and regulations are robust and comprehensive allowing for both competitive and non-competitive solicitations. Since this appropriation was not a grant, and sponsorships are not part of the grant process this recommendation is not applicable.

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Legislative Auditor's Additional Comments

We have reviewed DHSS' response and nothing contained in the response persuaded us to revise the recommendation. We disagree that all four of the amounts identified above could be reasonably considered to be sponsorships. Direct payments made to the entities appear to circumvent the state procurement rules. We reaffirm our recommendation that the DHSS' commissioner distribute funds in accordance with state statutes and regulations.