2012

Prepared by the
Division of
Legislative Audit

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

A Summary of 2010 through 2012 Audit Recommendations

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State of Alaska
Single Audit
for the
Fiscal Year Ended
June 30, 2011

Department of Health and Social Services

Audit Control Number
02-40012-12

There are two primary objectives for the State of Alaska Single Audit for the Fiscal Year Ended June 30, 2011 (Statewide Single Audit). The first is to determine if the financial statements of the State of Alaska are fairly presented in accordance with generally accepted accounting principles. The second is to determine if the State has materially complied with the various federal laws, regulations, and contract provisions when expending federal financial assistance.

The Department of Health and Social Services (department) had 16 recommendations in the most recently issued Statewide Single Audit. Fourteen recommendations relate to the department's compliance with federal laws and regulations in the administration of federal programs. The other two issues relate to proper financial accounting and budgetary effects of collecting less revenue than budgeted.

- **Recommendation A:** The DHSS Finance and Management Services (FMS) assistant commissioner should ensure personal service expenditures charged to federal programs comply with federal cost principles.

  Time charged to federal programs for employees who worked on multiple federal programs was not adequately supported. Errors identified in testing 42 employees included the following:

  - One employee timesheet could not be located;
  - One employee's time charges did not agree with the approved timesheet; and
  - Records documenting time charged by seven employees did not identify the time worked by program or other cost objective.

  Additionally, time charged by two of 13 tested employees who worked on a single federal program was not supported by the required semi-annual certifications.

  Without the use of positive timekeeping, the time charged to the programs is not in compliance with federal requirements. The federal programs affected by these errors are the Medical Assistance Program (Medicaid) and the Women, Infants, and Children Special Supplemental Nutrition Program (WIC).

  Questioned costs are $67,559.

- ✓ **Agency Response:** Agreed.

  According to the department, the WIC unit has implemented internal control policies to ensure that all program staff will perform positive timekeeping to the collocation code. Supervisors will verify charges are captured appropriately. The Administrative Assistant I will track semi-annual certifications for employees working on a single federal program.

- ❖ **Current Status**

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- **Recommendation B:** The FMS assistant commissioner should ensure that quarterly reconciliations comparing federal revenues to federal expenditures are performed accurately and timely.

  Expenditures eligible for federal reimbursement are reconciled to federal revenues quarterly by DHSS staff to ensure federal revenues are drawn and received timely. Eleven of 14 quarterly reconciliations covering five major federal programs contained errors. The errors were in four main areas:

  - Reconciliations were not performed or not performed in sufficient time to be an effective control;
  - Necessary reconciliations were not processed;
  - The reconciliation did not contain all eligible expenditures; and/or
  - Information in the reconciliations could not be traced to the state accounting system (AKSAS) due to accounting structure changes processed after the reconciliations were performed.

  Federal programs affected by these errors include: Adoption Assistance, Medicaid, Childrens' Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Child Care and Development Fund (CCDF).

  Not performing reconciliations accurately and/or timely increases the risk that DHSS staff could overdraw federal revenues resulting in an interest liability, or underdraw federal revenues, resulting in a loss of interest revenue to the State.

- ✓ **Agency Response:** Agreed.

  According to the department, management within the revenue unit has changed. Staff members are working on developing appropriate reconciliation tools for federal entitlement programs. All FMS units are tasked with complete written updates to policies and procedures.

- ❖ **Current Status**

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- **Recommendation C:** The FMS assistant commissioner should ensure the backlog of subrecipient audit reports are addressed in accordance with federal requirements.

  DHSS staff did not follow up subrecipient single audit reports from December 2010 through August 2011. The backlog of subrecipient audits could not be determined because DHSS stopped logging the receipt of the audits in April 2011. Management decisions regarding single audit findings were not issued, and DHSS staff did not ensure that subrecipients took appropriate and timely corrective action. Monitoring subrecipient audit findings is a significant internal control which, if not implemented, can lead to noncompliant grantees receiving additional federal funds.

- ✓ **Agency Response:** Agreed.

  According to the department, DHSS long-time internal audit staff both retired in April 2011, and one of the positions was filled in February 2012. DHSS continues to actively recruit the remaining position while addressing both current and backlog subrecipient reports.

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- **Recommendation D:** The Division of Public Assistance (DPA) director should ensure only valid expenditures are charged for the WIC program.

  In May 2011, the WIC subsystem erroneously created an additional file of food warrant transactions totaling $119,819 that interfaced with AKSAS and resulted in duplicate charges to the program. The error was identified by DHSS staff, but due to insufficient follow-up and inadequate supervisory review it was not corrected. The erroneous posting resulted in an overdraw of federal funds.

  Questioned costs are $119,819.

- ✓ **Agency Response:** Partially agreed.

  According to the department, the transaction totaling $119,819 did not result in a duplicate charge on the federal report, since it was posted to AKSAS in an account which was not picked up in the federal report. DPA has implemented a new process to ensure monthly reconciliations are placed in a "tickler" file for follow-up, and weekly discussions will occur with the direct line supervisor to ensure loops are closed when identified.

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- **Recommendation E:** The FMS assistant commissioner should develop procedures to comply with subaward reporting requirements for the *Federal Funding Accountability and Transparency Act* (FFATA).

  During FY 11, DHSS staff did not file the required reports to comply with the FFATA subaward reporting requirements for 14 of 16 WIC subrecipients. DHSS management was not familiar with the new federal requirements. Failing to comply with FFATA requirements may jeopardize future federal funding.

- ✓ **Agency Response:** Partially agreed.

  According to the department, FFATA is an unfunded federal mandate for which the department must absorb the workload and costs. DHSS estimates that as a prime awardee, it may have to evaluate, at a minimum, 250 individual subawardees and no system exists that provides the required information to assist with this assessment.

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- **Recommendation F:** The DPA director should ensure reports are monitored and there is follow-up as required for the WIC program.

  In FY 11, nine of twelve food instrument (FI) reports and cash value voucher disposition reports (FI disposition report) tested and seven of 26 FI price enforcement and error reports tested were not monitored, nor was follow-up performed. Report monitoring includes review and appropriate follow-up within 120 days of detecting questionable items or suspected errors.

  Insufficient monitoring is due, in part, to a lack of procedures for report review and follow-up, and inadequate oversight by program managers. Report monitoring primarily ensures costs of food items are contained, and only eligible participants receive benefits.

- ✓ **Agency Response:** Agreed.

  According to the department, the WIC Vendor Unit has implemented corrective action measures to ensure that reports are adequately reviewed with appropriate follow-up action within the required timeframes. Corrective action measures have also been developed to ensure that reviews and follow-up actions are sufficiently documented.

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- **Recommendation G:** The DPA director should ensure vendors participating in the WIC program are adequately monitored according to federal requirements.

  Federal program requirements include monitoring of WIC vendors, compliance investigations of high-risk vendors, and a review of vendors that potentially derive more than 50 percent of their annual food sales revenue from WIC food instruments. During FY11, all of the required compliance investigations were performed; however, one of the ten required investigations failed to meet compliance requirements due to insufficient documentation.

- ✓ **Agency Response:** Agreed.

  According to the department, the Vendor Unit has developed procedures for conducting a high-risk vendor assessment for the 186 currently authorized Alaska WIC vendors according to the criteria listed in the State Plan. Ten high-risk vendors have been identified and prioritized for compliance investigations. The Vendor Manager will conduct a review of each compliance investigation and report results to the Alaska WIC Program Manager.

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- **Recommendation H:** The DHSS TANF program manager should take action to ensure that TANF clients meet all eligibility requirements.

  Federal law prohibits states from providing TANF funds to individuals who have been convicted within the last ten years of having made a fraudulent statement or misrepresentation with respect to place of residence in order to simultaneously receive assistance from two or more states under TANF, Title XIX, the Food Stamp Act of 1977, or the Social Security Supplemental Security Income program.

  DHSS currently performs a felony check during the application process, however, not all crimes associated with fraudulent statements or misrepresentations with respect to place of residence are felonies. Additionally, current felony check procedures do not identify non-Alaskan crimes. As a result, there could be TANF clients that are not eligible because of fraudulent crimes committed during the prior ten-year period. This finding was reported as a recommendation in FY10, and DLA determined that DHSS' application procedures were unchanged in FY11.

- ✓ **Agency Response:** Agreed.

  According to the department, there is no national record or database DHSS can access to verify felony convictions specific to public assistance fraud. DPA currently uses two methods to determine whether applicants are receiving benefits from another state. The general application asks applicants if they received public assistance in another state. If the answer is positive, applicants are asked to specify which states they received benefits in. DPA staff will then contact the other state to determine whether benefits are still being received, the number of countable months used, and whether there were any penalties put in place in the other state. DPA also participates in the Public Assistance Reporting Information System (PARIS) match, which provides states with information about benefits clients may be receiving from other states. When the PARIS match shows a recipient is receiving benefits from another state, further investigation is conducted by staff and fraud penalties instituted as needed.

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- **Recommendation I:** The DPA administrative manager should ensure federal Child Care Development Fund (CCDF) financial reports are supported in detail by the accounting records.

  The FY 11 quarterly financial ACF-696 reports for three CCDF grants were not supported in detail by the agency's accounting records. This was the result of incorrect coding of activity in the accounting structures and a lack of written procedures to ensure accurate tracking and reporting of CCDF expenditures. The CCDF program could lose funding or have its grants terminated if the State fails to comply with the CCDF grant terms which includes reporting requirements.

- ✓ **Agency Response:** Disagreed.

  According to the department, quarterly direct expenditures are based on underlying accounting records in AKSAS. DHSS only relies on its MAXCARS system for indirect costs which reports .01% of total expenditures in any given quarter. The department also maintains that funding for CCDF comes from four sources (Mandatory, Matching, Discretionary, and Maintenance of Effort), and the CCDF reports requires that expenditures be reported at the quarterly allocation within the ceilings of each expenditure rate. The Administration for Children and Families (ACF) Online Data Collection (OLDC) has edit checks that prevent a report from being submitted if funding restrictions are not followed.

  The department also claims that current year corrections of prior year errors led DLA auditors to believe that reports are not supported by accounting records.

  Legislative Auditor's Additional Comments: We have reviewed DHSS' response to this recommendation, and nothing contained in the response provided sufficient information to persuade us to revise or remove this recommendation. DPA's reliance on a worksheet for the financial support is insufficient accounting support because the worksheet numbers do not reconcile to the accounting records in AKSAS.

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- **Recommendation J:** The DPA director should identify and recover unallowable child care payments for the CCDF program.

  The Child Care Program Office (CCPO) is not actively reviewing and making determinations on referrals received from local administrators regarding potential overpayments of program benefits or intentional program violations. Only three determinations were made on the 141 referrals received in FY11. Further, 58 referrals from FY 10 remained unresolved. Management cited staff turnover and conflicting priorities as reasons for the backlog. By not actively pursuing overpayments and program violations, the CCPO allows providers and recipients to potentially abuse the federal CCDF program.

  Questioned costs were indeterminate.

- ✓ **Agency Response:** Partially agreed.

  According to the department, current referrals were prioritized over older referrals to remain compliant with CCDF requirements in FY12. CCPO staff will be working into their workload all FY11 potential overpayments of program benefits or intentional program violations. In the event of significant staff turnover in the Child Care Assistance Team, the Child Care Assistance Program Coordinator and the CCPO Manager will collaborate to explore options for maintaining timeliness, including re-prioritizing projects and work, shifting workloads, utilizing staff members from other CCPO teams, or hiring a non-perm employee to focus on potential overpayments or program violations.

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- **Recommendation K:** The FMS assistant commissioner should improve procedures over the reporting of Medicaid program expenditures.

  The CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) reports for the first and third quarters of state fiscal year 2011 underreported the federal share of Medicaid program expenditures by $268,235 and $627,494 respectively. The underreporting was due to formula and input errors caused by a lack of clear procedures for the preparation of federal reports, including post preparation review. Consequently, reported amounts do not reflect actual expenditures.

- ✓ **Agency Response:** Partially agreed.

  According to the department, current management has revamped the fiscal administration from two to three units. The third unit, Federal Allocation Management Unit, oversees the preparation of the CMS-64 report and recruited an additional accountant as of March 1, 2012 to manage the federal reporting responsibilities associated with the Medicaid program. Written policies for federal reporting are being drafted with procedures and internal controls documented. Existing spreadsheets are under review and will be updated with improved cross controls.

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➢ **Recommendation L:** The DHSS Division of Senior and Disabilities Services (DSDS) director should establish written procedures and provide oversight to ensure that provider files include complete requirements for certification.

DSDS lacks adequate procedures to ensure provider certification files are documented in a complete and accurate manner. Provider certification files do not consistently contain supporting provider certification documentation, and multiple files are missing records, such as provider background checks, training certifications, and lead provider agreements. The health and welfare of the recipients of these services is at risk when DSDS certification files cannot provide assurances that providers and their employees were properly screened and adequately trained prior to certification.

✓ **Agency Response:** Agreed.

According to the department, the division has since taken action to develop and implement procedures to ensure all certification files are complete and support the certification of home and community based service providers. Improvements include use of a standardized provider file table of contents, conversion of an application into new content order, notice to providers to submit evidence of compliance, and no renewal of certification without all evidence of compliance in the provider file.

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- **Recommendation M:** The DHSS Division of Health Care Services (DHCS) director should ensure the Medicaid fiscal agent complies with the contract requirements relating to surveillance and utilization reviews.

  In the FY 10 Statewide Single Audit, DLA found that the DHSS Medicaid fiscal agent did not conduct the required number of utilization reviews per quarter, nor did they meet the required enrollment levels in the Care Management Program (CMP) as stipulated in the fiscal agent's contract. The contract specifies the fiscal agent must conduct 25 utilization reviews per quarter and enroll 150 Medicaid recipients in the CMP. In FY 11, the fiscal agent met the CMP enrollment requirement, but did not meet the contractually required 25 utilization reviews per quarter. Only five reviews were conducted in FY 11. Failure to meet surveillance and utilization review requirements increases the risk of fraud and abuse associated with allowable costs, allowable activities, and eligibility.

- ✓ **Agency Response:** Agreed.

  According to the department, efforts are underway to restructure the surveillance and utilization review (SURS) program and to ensure fiscal agent contract compliance.

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- **Recommendation N:** The FMS assistant commissioner should improve procedures over the reporting of federal expenditures on the Schedule of Expenditures of Federal Awards (SEFA) to meet OMB Circular A-133 reporting requirements.

  Errors in the amount of federal expenditures reported in the SEFA of five percent or greater were identified in six programs. The federal expenditures for those programs were corrected by the agency and are correctly reported in the statewide SEFA. The reporting errors are primarily due to the agency's continued lack of clear procedures for preparing the SEFA, including post-preparation review.

- ✓ **Agency Response:** Partially agreed.

  According to the department, FMS is in the process of updating its policy and procedure manuals. However, DHSS disagrees with the referenced five percent or greater errors found within six programs identified as being corrected. Five of the items identified relate the federally allowable TANF transfers to the CCDF and SSBG programs. These amounts were reported within the revenue and expenditure cells of the SEFA rather than the adjustments column. This action was considered necessary as the SEFA excel spreadsheet did not allow for any adjustments to locked and formatted columns. DHSS believes the substance of the information was included within the content of the schedule.

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- **Recommendation O:** The DHSS commissioner should take steps to address deficiencies in internal controls over its fiscal administration.

  Numerous systematic control deficiencies associated with DHSS financial management were detected. Many of the deficiencies are associated with the department's cost allocation system, MAXCARS, which was implemented in 2008. MAXCARS was not designed to facilitate federal reporting nor was it designed to facilitate cash management. However, the department is relying on the system to accomplish both of these important tasks. To compensate for the system's shortcomings in cash management and federal reporting, DHSS management has implemented numerous manual processes. These manual processes have not proven successful in terms of effectively using the department's resources or in providing reliable, accurate data in a timely manner. Six types of control deficiencies were found, including: 1) program code changes in AKSAS, resulting in an inadequate audit trail, 2) untimely allocation of federal revenue receipts, 3) lack of and/or inappropriate approvals, 4) untimely reconciliations, 5) poor documentation and lack of support, and 6) untimely federal reporting. These deficiencies can lead, in part, to unsupported or inappropriate expenditures, lost interest revenue, increased likelihood of questioned costs for federal programs, and difficulty in managing budgets.

- ✓ **Agency Response:** Partially agreed.

  According to the department, DHSS management is aware of MAXCARS deficiencies regarding federal reporting and revenue collection. Potential updates and/or new systems are being explored as resources allow. Per the agency, all major federal public assistance programs must be under a Public Assistance Cost Allocation Plan (PACAP) and all of these programs are subject to mandated changes – many times multiple changes in any given year. In order to maintain compliance with federal regulation changes or directives from federal granting agencies while maximizing federal revenue, changes to the assigned program codes are necessary and need to continue. Program code changes that are valid and appropriate will occur during the State's fiscal year and will appear to have been in place effective July 1 of the fiscal year because the State's current accounting system (AKSAS) does not provide any alternative.

  Legislative Auditor's Additional Comments: We have reviewed DHSS' response to this recommendation, and nothing contained in the response provides sufficient information to persuade us to remove or revise this recommendation. DHSS has failed to maintain an audit trail of changes to program codes. Without an audit trail, costs charged to federal programs may be unallowable as they are not supported by the State's accounting system.

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- **Recommendation P:** The 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. Eight potential shortfalls previously identified in FY 10 are still outstanding in FY 11.

Appropriation	Appropriation Title	Amount
AR 22975-09	Senior and Disabilities Services	$1,782,804
AR 22980-09	Departmental Support Services	$111,376
AR 22812-10	WIA Youth Juvenile Justice – RSA	$8,310
AR 22820-10	Bring the Kids Home – RSA	$4,123
AR 22930-10	Health Care Services	$1,897,003
AR 22970-10	Public Health	$823,343
AR 22980-10	Departmental Support Services	$828,632
AR 23847-10	Safety and Support Equipment	$30,663

Additionally, five new potential shortfalls have been identified.

Appropriation	Appropriation Title	Amount
AR 22794-11	Future Use	$1,739
AR 22820-11	Bring the Kids Home – RSA	$7,207
AR 22950-11	Public Assistance	$910,984
AR 22970-11	Public Health	$743,569
AR 26121-11	Pioneer Home Deferred Maintenance	$12,732

The revenue shortfalls are the result of weaknesses in internal controls over the monitoring of revenue collections and untimely revenue billings.

- ✓ **Agency Response:** Agreed.

According to the agency, FMS is aware of revenue shortfalls being calculated due to ineffective year-end financial closeout processes in prior years. FMS is in the process of correcting prior year accounting system transactions. For those appropriations that cannot be corrected by AKSAS transactions and remain in revenue shortfall status, DHSS will need to seek ratification.

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Department of Education and Early Development and Department of Health and Social Services
Special Education Service Agency

Audit Control Number
05-20073-12

REPORT CONCLUSIONS

In concluding whether the Special Education Service Agency's (SESA) termination date should be extended, we evaluated SESA operations using the 11 factors set out in the State's "sunset" law, AS 44.66.050(c). These factors are used to assess whether an agency has demonstrated a public need for continuing operation.

With the exceptions noted in the Findings and Recommendations section of this report, SESA is operating in the public's interest. In our opinion, SESA meets a valid public need by: (1) assisting school districts in providing students affected by low incidence disabilities (LID) an education that meets their unique needs; (2) affording opportunities to enhance school district teachers and paraprofessionals' capabilities; and (3) providing LID and special education resources.

Under AS 44.66.010(a)(6), SESA is scheduled to terminate June 30, 2013. We recommend SESA's termination date be extended until June 30, 2021.

- **Recommendation A:** SESA's board president should revise board policies and procedures to improve SESA oversight and accountability.

  SESA's board did not provide adequate oversight of certain SESA activities. Specific areas the board should address include: (1) lack of oversight of employee-related contracts; (2) Lack of administrative ethics policies; (3) Inadequate notice of public board meetings, and; (4) board work meetings are not publicly noticed or documented.

- ✓ **Agency Response:** Agreed.

  According to the department, work is underway to make necessary changes. Since the board president cannot revise board policies and procedures by herself, the full board of directors conducted a comprehensive review and revision of its policies and procedures, including employee-related contracts and administrative ethics policies. The board also passed a motion to give notice of SESA work sessions and meetings seven days in advance of the actual date of the meeting.

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Department of Health and Social Services
Statewide Suicide Prevention Council

Audit Control Number
06-20074-12

REPORT CONCLUSIONS

Overall, the Statewide Suicide Prevention Council (council) is operating in the public's interest. The council seeks to broaden the public's awareness of suicide. Furthermore, the council coordinates the efforts of other suicide prevention entities throughout the state and provides a comprehensive statewide suicide prevention plan in which communities can participate. We recommend the council's termination date be extended to June 30, 2019.

Beginning in FY 10, the council made notable improvements. The improvements include greater meeting attendance and participation by members, and completion of a new Statewide Suicide Prevention Plan. Additionally, the council played an integral part in assembling the 2010 and 2012 Statewide Suicide Prevention Summits. The improvements are attributed to an organizational alignment with the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse as well as the shared services of the boards' executive director.

While improvements are noteworthy, the organizational structure may not continue to be effective long term. There is no agreement in place to ensure the executive director's time and abilities will continue to be shared effectively between the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the council. With no agreement in place, turnover in the executive director's position or a change in the focus and direction of either board could lessen the effectiveness of the council. This finding is discussed further in Recommendation A.

This report also includes two additional recommendations to improve the council's effectiveness. We recommend the council report poor meeting attendance to the Office of the Governor (discussed in Recommendation B). Furthermore, we recommend the council develop performance measures to evaluate progress in achieving statutory objectives (discussed in Recommendation C).

- **Recommendation A:** The council should, in accordance with statute, appoint its own coordinator and conduct annual performance reviews.

  As a result of the council's co-location with the Alaska Mental Health Board (AMHB) and the Advisory Board on Alcoholism and Drug Abuse (ABADA) in 2010, the AMHB and ABADA executive director also performs the duties of the council coordinator. The coordinated leadership has been successful; however, there is no agreement among the three entities outlining responsibilities, budgeting, and lines of authority. Furthermore, due to a lack of awareness of statutory requirements, the council has not evaluated the executive director's performance as council coordinator.

- ✓ **Agency Response:** Agreed.

  According to the department, DHSS will work with the council to maintain its effectiveness and achieve independent sustainability. According to the council, a joint meeting of the three executive committees is being pursued to discuss how to implement this recommendation.

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- **Recommendation B:** The council should monitor meeting attendance and inform the Office of the Governor of poor member attendance.

  From FY 09 through March 2012, eight council members demonstrated poor meeting attendance (defined in statute as the failure to attend three or more consecutive meetings). The council does not enforce statute with regard to member attendance, and does not track absences. Consequently, the Office of the Governor does not have the information necessary to follow the statutory requirement of replacing members with poor attendance.

- ✓ **Agency Response:** Agreed.

  According to the department and the council, council staff implemented an attendance log pursuant to this recommendation, which will be shared with the Governor's Office and the legislature annually. The council also emphasized that attendance and participation by council members has improved significantly since 2010.

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- **Recommendation C:** The council should develop and monitor performance measures that support statutory duties and annually report progress.

  The council does not have established performance measures for quantifying the results of its activities. Furthermore, the council lacks a method for evaluating progress in achieving statutory duties. Since 2009, the council has omitted performance measures from its annual reports. Council members were not involved in developing the measures, and believed some were not appropriate indicators of council performance. While the council has established short term goals, it has not developed quantifiable performance measures. Performance measures are necessary to evaluate progress in meeting statutory duties and to communicate results to policy makers. Without quantifiable measures, policy makers lack the necessary information to evaluate the council.

- ✓ **Agency Response:** Partially agreed.

  According to the council, while performance measures have not been provided to the Office of Management and Budget, the council has considered how best to measure the effectiveness of its work. At the 2009 meeting in Anchorage, the council reviewed existing performance measures and worked with a paid facilitator to establish new strategic direction. In 2011, the council engaged in a formal strategic planning session. The result of this work was a guidance document identifying the roles, responsibilities, and actions of the council in furtherance of its statutory obligations. The council will coordinate with the DHSS commissioner's office to have council performance measures included in departmental information communicated to the Office of Management and Budget in FY 2013 and thereafter.

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