



DEPARTMENT OF HEALTH

Management Letter
For the Year Ended June 30, 2012

Report No. 12-22

*Keeping Utah
Financially Strong*

AUSTON G. JOHNSON, CPA
UTAH STATE AUDITOR



Auston G. Johnson, CPA
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MANAGEMENT LETTER NO. 12-22

November 6, 2012

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

Dear Mr. Patton:

This management letter is issued as a result of our audit of the basic financial statements of the State of Utah as of and for the year ended June 30, 2012 in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our report thereon, dated October 19, 2012, is issued under separate cover. This management letter is also issued as a result of the Department of Health's (the Department) portion of the statewide federal compliance audit for the year ended June 30, 2012. Our report on the statewide federal compliance audit for the year ended June 30, 2012 is issued under separate cover. The federal programs tested as major programs at the Department were the Women, Infants and Children (WIC) Cluster, the Title XIX Medicaid Cluster, the Children's Health Insurance Program, and the Centers for Disease Control & Prevention–Investigations & Technical Assistance Program.

In planning and performing our audit of the financial statements of the State of Utah, we considered the Department's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinions on the basic financial statements but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control over financial reporting. Additionally, in planning and performing our audit of the federal programs listed above, we considered the Department's compliance with the applicable types of compliance requirements as described in the OMB Circular A-133 Compliance Supplement for the year ended June 30, 2012. We also considered the Department's internal control over compliance with the requirements previously described that could have a direct and material effect on the federal programs in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control over financial reporting or compliance.

Our consideration of internal control over financial reporting or compliance was for the limited purposes described in the preceding paragraph and was not designed to identify all deficiencies in internal control over financial reporting or compliance that might be significant deficiencies or material weaknesses and, therefore, there can be no assurance that all such deficiencies have been identified. However, as

discussed below, we identified a certain deficiency in internal control over financial reporting or compliance that we consider to be a material weakness and other deficiencies that we consider to be significant deficiencies.

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

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

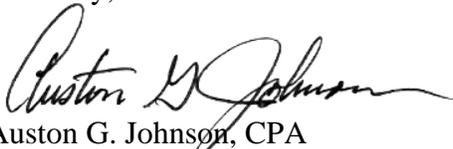
In addition, we noted another matter involving internal control over compliance which we are submitting for your consideration. This matter is described in the accompanying schedule of findings and recommendations.

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

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

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

Sincerely,



Auston G. Johnson, CPA
Utah State Auditor

cc: Robert Rolfs, MD, MPH, Deputy Director / State Epidemiologist
Michael T. Hales, Deputy Director / Director of Division of Medicaid and Health Financing
Shari A. Watkins, CPA, Director, Office of Fiscal Operations
Darin L. Dennis, CPA, Director, Internal Audit
Marc E. Babitz, MD, MPH, Director, Division of Family Health & Preparedness
Teresa A. Garrett, Director, Div. of Disease Control and Prevention
Jennifer Brown, Bureau Director, Bureau of Epidemiology

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Finding Type:

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

Applicable To:

s State Financial Statements
f Federal Program

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FINDINGS AND RECOMMENDATIONS FOR THE YEAR ENDED JUNE 30, 2012

1. INCORRECT ELIGIBILITY AND INCOME DETERMINATIONS

Federal Agency: **DHHS**

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

Federal Award Number: **5-1105UT5021**

Questioned Costs: **\$5,215**

Pass-through Entity: N/A

We reviewed the eligibility determination and documentation process for 60 Children's Health Insurance Program (CHIP) payments. We noted internal control weaknesses and noncompliance for 12 (20%) cases related to the 60 payments as described below. Three (5.0%) of the 60 payments, totaling \$65 (federal and state portions), were considered unallowable due to incorrect eligibility decisions. The 60 CHIP payments tested totaled \$4,427 and were taken from a total population of \$70,610,018 (federal and state portions). During our testwork we noted other noncompliance associated with the CHIP cases included in our sample. As a result of the incorrect eligibility decisions and other noncompliance issues, we have questioned the federal portion of costs associated with the errors identified for these cases: \$3,193 for federal fiscal year 2012 and \$2,022 for federal fiscal year 2011.

a. Incorrect Eligibility Decisions

For two cases, the caseworker placed children on CHIP even though they were eligible for Medicaid Child Age 0-5. According to CHIP policy 201, a child who is eligible for Medicaid is not eligible for CHIP; therefore, we have questioned all costs for these cases during the time the children were eligible for Medicaid, totaling \$2,666. The cause of these errors appears to be that the caseworker did not properly consider Medicaid eligibility.

b. Improper Eligibility Review

For one case, because a change of income was reported during the 12 months prior to the February 2012 review, the review should have included income verification, per CHIP Policy 704. However, only a simple review form, which does not ask for verification of the household income, was sent for the February 2012 review. If a mandatory review form had been sent as required, it would have noted a household income that exceeded the CHIP limits. In addition, the client reported a change in income during the second month of the certification period (March 2012) which was calculated to be above the CHIP income limits. Although CHIP eligibility is normally determined only once per year, CHIP Policy 704-1, states that if income changes that make the household ineligible are received too late to correct the first month of the new certification period, the change should be made in the second month, if possible. These errors resulted in the household being placed on CHIP when it was not eligible. We have questioned the costs associated with this case during the

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time the household was ineligible less the premiums paid by the household to be on the program, totaling \$380. The cause of this error appears to be caseworker misunderstanding of CHIP policy for eligibility reviews when income changes are reported.

c. Available Employer Insurance Not Considered

For one case, the household remained on CHIP even after the child had access to employer-offered health insurance with a cost less than 5% of the household's gross countable income. Per CHIP policy 220-4, if an applicant has had at least one chance to enroll their child in any health insurance plan offered by an employer that is less than 5% of their household's gross countable income, the child is not eligible for CHIP. When an employer's insurance is available, the case should be closed when the current certification period ends. We have questioned the costs associated with this case during the new certification period less premiums paid by the household, totaling \$598. The cause of this error appears to be failure by the caseworker to consider available employer insurance.

d. Income Calculation Errors

- 1) For one case, earned income was calculated incorrectly because the caseworker did not use the correct number of expected weekly hours of a new job. Per CHIP Policy 415-1, income eligibility should be determined by establishing a "best estimate" of expected income. If the reasonable best estimate income had been calculated using the correct expected weekly hours, one child in the household would have been eligible for Medicaid Child Age 0-5 instead of CHIP. We have questioned the costs related to the ineligible child less premiums paid by the household, totaling \$1,379.
- 2) For two cases in the same household, the household's self-employment income was not calculated in accordance with CHIP Policy 410-2. This error caused the household to be placed on the incorrect CHIP plan, with a lower premium than the plan for which the household was eligible. We have questioned the costs for the premiums the household should have paid, totaling \$96.
- 3) For two cases, best estimates of monthly income were calculated incorrectly because the caseworker did not factor income in accordance with CHIP policy 415-4. These errors caused the households to be placed on the incorrect CHIP plan. Because one of the households was on a CHIP plan with a lower premium than the plan for which the household was eligible, we have questioned the costs for the premiums the household should have paid, totaling \$96.

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- 4) For two cases, best estimates of monthly income were calculated incorrectly because the case worker did not annualize unemployment income or seasonal income as required by CHIP policy 415-1. These errors resulted in the households being placed on the incorrect CHIP plan. Because the households for these cases paid more in premiums than required had they been on the correct CHIP plan, we have not questioned any costs associated with these errors.
- 5) For one case, the caseworker did not follow CHIP policy 415-3 to establish a reasonable best estimate of household income. After we brought this case to the Department's attention, a different reasonable best estimate income was provided. Because the household was eligible for the same CHIP plan under the new calculation, we have not questioned any costs associated with this error.

The cause of these income calculation errors appears to be caseworker misunderstanding of policies regarding best estimate income calculations, as well as human error.

The Department of Health sets CHIP policy and processes all CHIP expenditures. The Department of Workforce Services handles eligibility determination and case file management for CHIP.

Recommendation:

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

- a. **Understand and apply both Medicaid and CHIP eligibility policies during the CHIP application and/or review process.**
- b. **Understand CHIP policy for eligibility reviews when income changes are reported.**
- c. **Consider available employer insurance.**
- d. **Properly calculate household monthly income.**

Department of Health's Response:

The Department of Health (Health) concurs with this finding and recommendation. As the state agency ultimately responsible for CHIP, Health must ensure that eligibility for the program is accurately determined. Health has delegated CHIP eligibility determination and case management to the Department of Workforce Services (DWS) through an operating agreement.

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The operating agreement establishes targets for accuracy and provides bonuses if DWS meets those accuracy targets. State and federal rules require several different reviews to ensure that eligibility decisions are made correctly.

Health has reviewed the corrective action plan submitted by DWS on this finding and will work with DWS to implement the actions they have proposed. Health will continue to work with DWS to involve Health policy specialists with the DWS program specialists to clearly interpret the policy manuals, review training materials for accuracy, and also meet with eligibility workers whenever possible to provide in person training. Health will continue to meet weekly with the eligibility system steering group to further enhance and strengthen the eligibility system (eREP). The Medicaid Quality Control Unit (MEQC) will continue to focus their review projects on error prone areas to shore up DWS' understanding of the policy and how it relates to specific cases.

Health will actively reinforce the corrective action plans as agreed upon between the agencies in the regular weekly meetings with DWS. As DWS perfects their "targeted training" approach, Health will continue its oversight responsibility to verify that the DWS staff are understanding the concepts by watching the various error rate measures for trends and providing appropriate and timely feedback to DWS. Health will work closely with DWS to develop and implement the new Affordable Care Act provisions by January 2014, and ensure that DWS eligibility staff understands the changes in eligibility that will occur.

The questioned costs will be reported on the CMS 21 report for the quarter ending 12-31-2012 and paid back on or before January of 2013.

*Contact Person: Jeff Nelson, Bureau Director, Eligibility Policy, 801-538-6471
Anticipated Correction Date: Ongoing through June 2013*

2. INCORRECT ELIGIBILITY DETERMINATION

Federal Agency: **DHHS, CMS**

CFDA Numbers and Titles: **1) 93.778 Title 19 Medical Assistance Program
2) 93.778 Title 19 Medical Assistance Program – ARRA**

Federal Award Numbers: **1) 05-1205UT5MAP 2) 05-1105UTARRA**

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

Pass-through Entity: **N/A**

We reviewed the case files for 60 Medicaid service expenditures at the Department of Health. The expenditures for these cases totaled \$703,037 and were taken from a total population of \$1,863,315,835. Of these case files, we noted 2 cases (3.3%) with eligibility determination errors.

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- a. For one case, the caseworker did not include the client's monthly Veterans benefit when calculating income for eligibility even though the benefit was documented on both the application and the bank statements. Medicaid Policy 700 indicates that all income should be verified and included when calculating eligibility. This error did not result in an improper eligibility decision, so no costs were questioned. However, such errors could result in improper eligibility decisions.
- b. For one case, the household was put on the Family LIFC program for the months of May through July 2011; however, they only qualified for the Family 12-month transitional program because the household income exceeded the Family LIFC limits. Since the household was eligible for a different Medicaid program, we have not questioned any costs. However, such errors could result in improper eligibility decisions.

The cause of these errors appears to be that caseworkers did not correctly determine eligibility as required by Medicaid policy, mainly due to human error or unfamiliarity with policy.

Although all Medicaid expenditures are processed at the Department of Health, eligibility and case file management for Medicaid is handled by the Department of Workforce Services.

Recommendation:

We recommend that the Department of Health work with the Department of Workforce Services to ensure that they follow established policies and procedures when determining eligibility for Medicaid Programs.

Department of Health's Response:

The Department of Health (Health) concurs with this finding and recommendation. As the state agency ultimately responsible for Medicaid, Health must ensure that eligibility for the program is accurately determined. Health has delegated Medicaid eligibility determination and case management to the Department of Workforce Services (DWS) through an operating agreement. State and federal rules require several different reviews to ensure that eligibility decisions are made correctly.

Health has reviewed the corrective action plan submitted by DWS on this finding and will work with DWS to implement the actions they have proposed. Health will continue to work with DWS to involve our policy specialists with the DWS program specialists to clearly interpret the policy manuals, review training materials for accuracy, and also meet with eligibility workers whenever possible to provide in person training. Health will continue to meet weekly with the eligibility system steering group to further enhance and strengthen the eligibility system (eREP). The Medicaid Quality Control Unit (MEQC) will continue to focus their review projects on error prone areas to shore up DWS' understanding of the policy and how it relates to specific cases.

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Health will actively reinforce the corrective action plans as agreed upon between the agencies in the regular weekly meetings with DWS. As DWS perfects their “targeted training” approach, Health will continue its oversight responsibility to verify that the DWS staff are understanding the concepts by watching the various error rate measures for trends and providing appropriate and timely feedback to DWS. Health will work closely with DWS to develop and implement the new Affordable Care Act provisions by January 2014 and ensure that DWS eligibility staff understands the changes in eligibility that will occur.

*Contact Person: Jeff Nelson, Bureau Director, Eligibility Policy, 801-538-6471
Anticipated Correction Date: Ongoing through June 2013*

3. THIRD PARTY LIABILITY INFORMATION NOT ADEQUATELY OBTAINED OR UPDATED

Federal Agency: **DHHS, CMS**

CFDA Numbers and Titles: **1) 93.778 Title 19 Medical Assistance Program
2) 93.778 Title 19 Medical Assistance Program – ARRA**

Federal Award Numbers: **1) 05-1205UT5MAP 2) 05-1105UTARRA**

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

Pass-through Entity: **N/A**

We reviewed the case files for 60 Medicaid service payments at the Department of Health and noted an error related to Third Party Liability (TPL) for one (1.7%) of the cases. Medicaid Policy 225-1 states that Medicaid applicants must provide information about any possible third party insurance coverage. For one case, insurance coverage for the parents was properly documented, but the caseworker did not obtain or request additional TPL information from the family regarding possible insurance coverage of a newborn child. It was subsequently determined that the parents were trying to add the child to their insurance plan; however, due to an error at the insurance company, there was a delay in getting the coverage for the child. The additional insurance now covers the child back to the day she was born; consequently, a portion of the total federal costs associated with this case of \$236,244 can now be recovered from a third party. After our testwork, DWS referred these costs to the Office of Recovery Services for collection procedures; therefore, we have not questioned any costs associated with this case. This error was probably due to a caseworker oversight. Not properly obtaining potential TPL information could result in Medicaid overpayments.

Although all Medicaid expenditures are processed at the Department of Health, TPL determination and case file management for Medicaid is handled by the Department of Workforce Services.

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Recommendation:

We recommend that the Department of Health work with the Department of Workforce Services to ensure that Medicaid caseworkers follow policies and procedures to report TPL information in a timely manner.

Department of Health's Response:

The Department of Health (Health) concurs with this finding and recommendation. As the state agency ultimately responsible for Medicaid, Health must ensure that eligibility for the program is accurately determined. Health has delegated Medicaid eligibility determination and case management to the Department of Workforce Services (DWS) through an operating agreement. State and federal rules require several different reviews to ensure that eligibility decisions are made correctly.

Health has reviewed the corrective action plan submitted by DWS on this finding and will work with DWS to implement the actions they have proposed. Health understands the cost of missing TPL on a case. Health has met with DWS and the eREP system to work towards a unified solution that helps ensure a single process can be developed and implemented that is agreeable and effective across all the stakeholders. Health focused an entire Medicaid Quality Control (MEQC) review on the TPL area and will do so again during the next fiscal year. Health will work to ensure that each responsible agency understands the impact of proper TPL collections, considers the impact of programming changes to the overall collection process, and work to review the process from start to finish. Each agency should continue to look for ways to make this process more efficient and correct.

Contact Person: Jeff Nelson, Bureau Director, Eligibility Policy, 801-538-6471

Anticipated Correction Date: Ongoing through June 2013

4. **NONCOMPLIANCE WITH TIMING REQUIREMENTS OF HEALTH AND SAFETY STANDARD SURVEYS FOR NURSING HOME FACILITIES**

Federal Agency: **DHHS, CMS**

CFDA Number and Title: **93.778 Title 19 Medical Assistance Program**

Federal Award Number: **05-1105UT5MAP**

Questioned Costs: N/A

Pass-through Entity: N/A

The Centers for Medicare and Medicaid Services (CMS) require that Health and Safety surveys be conducted by the Department of Health on nursing home facilities receiving Medicaid payments no less frequently than every 15.9 months. These surveys help ensure facilities meet

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FINDINGS AND RECOMMENDATIONS FOR THE YEAR ENDED JUNE 30, 2012

prescribed health and safety standards for Medicaid providers. The Department of Health did not conduct a survey within the required timeframe for 43 of the 99 nursing home facilities in Utah receiving Medicaid payments. On average, the past due surveys had not been performed for almost 4 months beyond the requirement, with the longest just over 8 months beyond the requirement. This is a result of changes in survey staffing and the survey process. If surveys are not conducted in the prescribed manner, including the frequency, health and safety violations may go undetected.

Recommendation:

We recommend that the Department of Health strengthen existing controls over surveys regarding health and safety standards at nursing homes to ensure that they are done with the frequency required.

Department of Health's Response:

The Department of Health concurs with the audit finding and recommendation. Two important changes have resulted in this finding. First, our survey program has been short-staffed due to the large growth in providers in our state coupled with an actual decrease in the number of survey staff. Second, in January of 2011 the Centers for Medicare and Medicaid Services (CMS) mandated that the Utah State Survey Agency change the long-term care survey process to a computer-assisted survey process – Quality Indicator Survey (QIS). The new QIS survey process has shown to require more staff resources. The Department is currently seeking a budget request to address this issue.

Contact Person: Joel Hoffman, Bureau Director, Health Facilities Licensing Certification and Resident Assessment, 801-538-6279

Anticipated Correction Date: State Fiscal Year 2014, if receive budget request.

5. INCORRECT RATE CHARGED

Federal Agency: **DHHS**

CFDA Number and Title: **93.283 Centers for Disease Control and Prevention –
Investigations and Technical Assistance**

Federal Award Number: **5U58D0000774-05**

Questioned Cost: **\$24**

Pass-through Entity: **N/A**

During our review of 40 cancer screening payments for the National Cancer and Control Program, we noted that the incorrect rate was charged for one payment, resulting in an

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overpayment and questioned cost of \$24. The incorrect rate was charged due to a data entry error when entering the CPT coding.

Recommendation:

We recommend that the Department of Health take greater care when entering coding for cancer screening payments.

Department of Health's Response:

The Utah Department of Health concurs with the finding and recommendations. The incorrect rate for cancer screening payments was entered in error. The manager will review the documentation to ensure the correct rate is used in the future. The questioned cost of \$24 will be returned to the CDC by December 2012.

Contact Person: Bob Kuhn, Administrative Services Manager, 801-538-6887

Anticipated Correction Date: December 31, 2012