

AUDIT RESPONSE REPORT

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

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

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

The process of identifying the local WCD coordinators began in January 2009. A pilot program for the (primary vendor) districts began in June 2009. Initial pilot training on the new local review process occurred on July 21, 2009. WCD coordinators are in place and have been trained. As new coordinators are added, training is provided by the Statewide WCD Coordinator. Webinar coordinator training is being prepared and will be presented twice a year starting with the second quarter of 2012. Training covers all vendors.

The department began working with WCD vendors in February 2009 to start the process of creating sub-accounts and bundling minutes. The department worked closely with vendors to create the appropriate sub-accounts, establish local coordinator access and receive ordering system training. The use of sub-accounts for each District is an example of how invoices are broken out for each Local WCD Coordinator for review. Sub-accounts also provide roll up to one account allowing the agency to take advantage of volume

discounts. Vendors provide other methods to achieve the same goal. Invoices from all vendors are sent to Local WCD Coordinators for review. The department also worked with the vendors to reduce expenses by bundling minutes into a shared pool of minutes. These efforts are ongoing.

DHS Policy DHS-020-006 and procedures DHS-020-006-01 and 02 provide overarching roles and responsibilities for wireless communication devices (WCD); however, they do not discuss inventory process or procedure. Local WCD coordinators have been assigned the responsibility of ordering, inventorying and monitoring the wireless devices and usage for their districts. Regular updates to inventories are sent to IT Asset Management who maintains the Master WCD Inventory. WCD coordinators are responsible for examination of rate plans, zero use, and possible inappropriate use. The Statewide WCD Coordinator, with OIS IT Asset Management, is responsible to spot check that the local reviews take place. Individual spot checks are currently initiated as questions arise. This usually occurs every two to four weeks. A process to assure spot checks are completed on all local WCD coordinators at least twice a year was implemented by the end of the first quarter of 2012.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- *The Oregon State Hospital and Public Health have switched to weekly payment processing, allowing DHS/OHA to take further advantage of the rebates.*
- *We worked with DAS to start making payments to our bank by ACH instead of warrant. This will reduce the time it takes the payment to reach our bank.*
- *We worked with DAS to receive the interim rebate reports to help us analyze the spending trends.*

DHS/OHA have improved payment cycle time and received increased rebates since these steps have been implemented.

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

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

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

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

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

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

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

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

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

The department implemented a new Medicaid Management Information System (MMIS) in December 2008. This system replaced the department's former legacy system used to track, pay and report on a majority of the state's Medicaid eligible services. Operation of the MMIS is a joint effort between the Department of Human Services, who is responsible for the system, and our service provider, who has been contracted to implement it. Both the department and our service provider have experience designing and maintaining large information management systems. Under the current Operations and Maintenance contract, our service provider maintains control over the source code and is responsible for security of the code. Only our service provider's staff have update access for programming changes, implementing change orders, and correcting system defects. The department remains responsible for physical security of the system, for controlling user access, for updating reference tables and identifying errors in data entry and in output.

Over the course of the audit, the department provided a considerable number of documents outlining system operations and controls at both the department and our service provider. However, the department

acknowledges that further work is needed to adequately document, communicate and review MMIS internal controls and processes.

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

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

External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1, 2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, was completed in June 2012.

- Department management ensure accounting personnel have the requisite knowledge, skills, and abilities to accurately perform their assigned duties and ensure the resulting accounting records are in accordance with

GAAP. Management should emphasize the importance of understanding GAAP to personnel who are responsible for recording transactions, calculating year-end accruals, and making adjustments that cross fiscal years. Management should also create a better awareness of the differences between budgetary accounting and GAAP, and when each is applicable.

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

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

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

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

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

- Errors identified from the FY09 audit were documented and reviewed by staff.*
- Statewide Financial Reporting (SFR) team staff attended various trainings in FY 10 including the annual GAAP update training held by GASB.*
- The SFR team created an internal and external year-end task list for year-end closing activities. The internal task list was used by the SFR team to ensure that all of the necessary year-end activities were completed. During the FY 10 close period the SFR unit scheduled weekly meetings to review task, update and add to the task list and to problem solve issues. The external year-end task list was sent to OFS staff for the purposes of clarifying each unit's role in the year-end process and providing written guidance on required year-end tasks. SFR team members met with various staff and provided verbal guidance on GAAP required tasks including accruals, prior period adjustments, transferring completed assets, and appropriate backdating of payments and Balanced Transfers. These efforts resulted in reduced errors in FY 10 related to prior period adjustments, improved documentation of entries, and increased staff understanding of their entries related to GAAP requirements. The Lean Daily Management System adopted by DHS has also resulted in improved verbal communication of GAAP throughout DHS's fiscal units.*
- Development of the batch release check-list was completed in April 2010. In-person and V-Con training for batch releasers was completed on August 17, 2010. The purpose of the check-list is to set expectations and provide guidance on what to review prior to releasing a batch. The checklist is to be used as a reference guide and is not required to be completed with each batch.*
- Policy discussion on accrual recording level began in May, 2010. Accrual procedure has been updated and will be reviewed yearly for modification.*

We believe that ensuring that accounting personnel have the requisite knowledge, skills and abilities to accurately perform their accounting duties in this complex environment is an on-going process. During the last year we have taken steps to develop a more robust succession plan including more opportunities for

cross-training and job developmentals and rotations. We continue to use Lean methodologies to document and improve our processes. We have formed an internal training committee with the goal of increasing training on the unique aspects of accounting in DHS/OHA.

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

External audits of the Medicaid Management Information System have been completed by both the Oregon Secretary of State Audits Division (June 2011) and the Department of Health and Human Services Office of Inspector General (April 2011). The department has implemented many of the recommendations from these audits and is actively working on those recommendations not yet implemented. The system on-site Certification Review was also conducted by the Centers for Medicare and Medicaid Services (CMS) in January, 2011. In addition, in August 2011, the department entered into an agreement with a contractor to perform a series of SOC 1, Type 2 service organization control audits covering periods between July 1, 2010 and June 30, 2013. The first of these reports covering the period July 1, 2010 through June 30, 2011, was completed in June 2012. (Please refer to finding 09-01 response for further detail.)

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

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

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

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

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

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

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

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

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

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

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

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

Streamlining eligibility:

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

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

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

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

SSPAT CHIP reviews 2009:

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

Application changes:

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

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

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

Medical Quality Control:

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

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

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

- A total of 300 cases were sampled for the project.*

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

Third Party Liability:

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

The Health Insurance Group (HIG) routinely works MMIS report TPL-0689-M, which identifies clients who have had active third party liability (TPL) for the past six months. When they are reviewing the TPL they also check to see if the client is receiving CHIP medical. For individuals who are receiving CHIP medical coverage and have TPL, the case is referred to OHP Statewide Processing Center. The OHP Statewide Processing Center eligibility staff review the case to see if the individual is eligible for Medicaid. If there is not Medicaid eligibility, the medical case is closed.

SSP Training:

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

staff. Two Healthy KidsConnect focused skill challenges also helped SSP managers assess and support policy knowledge in local unit meetings.

Areas added to the curriculum Fall 2009

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

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

Self Sufficiency Modernization (SSM) efforts:

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

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

eligibility factors. The benefit calculator will review the eligibility factors for each medical category, including countable income, and assist the eligibility worker in making an eligibility determination. Income calculations will be automated. The new income calculation functionality will improve the accuracy of earned income calculations.

- *The modernization efforts will continue to be implemented in phases, continuing throughout 2011.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As previously noted, the department did create procedures to improve the monitoring and analysis of \$25,350 report. The finding 10-13 Oregon Department of Human Services Eligibility – System coding issues, found that the procedures were being completed accurately, however, services were still being claimed to TANF-EA after the eligibility was appropriately denied. As discussed in the 10-13 Oregon Department of Human Services Eligibility – System coding issues finding, Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds. In addition to the detailed service definitions, the OR-Kids financial batch processing should monitor the amount claimed within the 365 days and when the \$25,350 amount is achieved the system should automatically end claiming and send a notice to the Federal Revenue Specialist to close TANF eligibility.

The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services to design reports for Central and Field Offices to use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track all their workload including TANF eligibility determinations.

Due to the issues described above and the estimated schedule for accepting the OR-Kids system, the federal compliance unit will be completing the analysis of prior payments and complete a manual adjustment by March 31, 2013.

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

Child Welfare (Emergency Assistance Re-determinations)

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

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

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

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

Self Sufficiency (Pre-TANF Eligibility)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The department once again reinforced the narrative guidelines with field managers and staff in the Spring of 2012. Narration of financial eligibility continued to be the main area that needed reinforcement. For this

reason, the monthly accuracy newsletter, "On Target", for April included a reminder of the narration guidelines and the expectation of checking screens and of narrating the results of screen checks in the TRACS system. The April article also included examples of how the results of screen checks can be narrated. The department also issued another Informational Memorandum transmittal in April 2012 reinforcing the narration expectations as they apply to financial eligibility and verifying information through the various IEVS screens available to field staff.

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

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

A recent CDC Request for Applications specifically encouraged a shared approach to leveraging resources for chronic disease programs. Our methodology for managing the costs of shared staff across all the grants was based on our interpretation of this guidance from the CDC. We have initiated conversations with CDC about these audit findings. They agree that states, like Oregon, who have acted on their direction to integrate programs and leverage resources across multiple grants are in a difficult situation when it comes to time/activity reporting. The CDC Chronic Disease and Health Promotion Center has agreed to work with Oregon to find a mutually acceptable way to monitor personnel expenses for shared staff whose work

crosses multiple grants and cannot be easily dissected to individual grants, while still remaining in compliance with OMB Circular A-87.

The department agrees that a mistake was made in the second instance described above. The employees in the Office of Disease Prevention & Epidemiology who work on multiple grants or cooperative agreements included in the CDC Investigations and Technical Assistance Program are required to do time and activity reporting. They must meet this requirement by over-riding the default coding on the monthly electronic timesheet with the coding for the grants/activities where they worked during the month. Management does not shift payroll costs for employees from one grant to another disproportionately, without regard for which grant the individual actually worked on. The payroll adjustment that was made did not reflect actual grant activity for the month of May 2009. Rather, adjustments to time/activity reporting needed to have been done over several earlier months to reflect actual time spent on the Cancer Prevention and Control grant.

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

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

- Department management implement a procedure to completely review and detect whether assistance payments agree with the signed adoption agreements and to get any amended assistance agreements filed in

the case files. We further recommend that the department management work with the designated federal agency to determine the appropriate way to resolve any potential overpayments.

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

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

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

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

Adoption Program management has initiated contact with the Administration for Children and Families Children's Bureau, Region X Child Welfare Program Office regarding how to best resolve the issue. At this

point we estimate approximately \$28,000 in federal Title IV-E funds are within the total overpayment amount.

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

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

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

Children, Adults and Families (CAF) District 8 initiated a work group comprised of transfer clerks from each branch office and two Line Managers, all within District 8. The “case transfer workgroup” meets monthly and has developed a District-wide case transfer process and database, as their mechanism for tracking incoming and outgoing case files. The process and database are used for case file transfers within the district, or to another branch office in the state. The workgroup identifies and provides solutions to management of case file transfer issues that may arise.

The department has communicated the expectation of following established transfer procedures at various CAF statewide meetings including: Self Sufficiency Program Managers (April 14, 2010) and the Self Sufficiency Line Manager quarterly meetings (April 20-22, 2010). District Managers have also been engaged in the discussion (July 7, 2010). Case File transfer procedures (FSM MP-WG # 21) are located in the Family Services Manual (MP-WG # 21) and the Field Business Procedure Manual (XVI. Case Files, A. Interoffice Transfer of Case Files).

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

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

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

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

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

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

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

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

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

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

The eligibility process, including these standardized time frames, became a focus in the new counselor training module being conducted regionally throughout the state during 2010. OVRS administration staff

developed a worksheet to assist vocational rehabilitation counselors to better identify and track the salient elements required when completing an eligibility determination, i.e., the number of documented disabilities, and corresponding functional limitations when determining eligibility, and due dates. This new worksheet was distributed during the new counselor trainings.

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

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

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

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

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

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

6. DHS: Office of Vocational Rehabilitation Services: Save on Vocational Costs to Serve More Clients, audit #2010-31 (September 2010)
- Oregon's Office of Vocational Rehabilitation Services (OVRS) should take several actions that can help discontinue Order of Selection by serving more clients with its current state and federal resources. In order to save costs OVRS should:
 - Ensure counselors work with clients to approve realistic employment plans by better identifying impediments to future employment and discontinuing payments when clients show an inability to achieve the employment goal.

- Ensure counselors adhere to the employment plan and only approve expenses directed toward employment impediments and employment goal achievement.
- Consider using a fee schedule to ensure a reasonable cost to the program for commonly purchased services.
- Monitor counselor spending approvals to ensure the most prudent decisions are made.
- Establish realistic budgets for counselors and branch offices that are based on client types, economic conditions and other related factors.
- Consider reviewing and revising the client contribution policy.
- Continue with the addition of client maintenance system controls such as the current effort to link authorizations and payments to plan services.

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

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

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

- *Spending authority limitations are presently incorporated in ORCA, the program's case management system. The spending authority for counselors is \$5,000 per authorization, \$20,000 for branch managers, and \$50,000 for field services managers. ORCA will not permit the issuance of payment documents beyond one's authority.*

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

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

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

OVRs took the following additional actions relating to cost containment:

- *OVRs reviewed current spending approval levels and methodologies. The review included consideration of setting budgets for counselors and branch offices that are based on client types, economic conditions and other related factors such as prior budget management, average costs and rehabilitation rates. The review also looked at improving ways to efficiently monitor and analyze spending patterns and ultimately set a process for routine reviews of spending approval levels.*
- *Adjustments to spending levels were reviewed, however no changes were made.*
- *OVRs asked the State Rehabilitation Council (SRC) to partner with them in a review of the current participation contribution policy. OVRs developed the consumer's contribution policy with the SRC, and any change in the existing policy would require their approval. OVRs engaged the SRC in a discussion about the level of the participant's contribution as a percentage of income as well as the income threshold for contributing to the cost of services. The SRC moved to maintain current client contribution levels.*
- *OVRs explored options for a fee schedule that will maximize resources and ensure timely access to appropriate medical providers and make recommendations based on that research, as needed. In addition, it will track the implementation of healthcare legislation and the opportunities for the use of comparable needs to meet the rehabilitation related healthcare needs of the program's participants.*
- *OVRs reviewed and revised its Medical Restoration policy in order to provide more effective guidance on medical fees.*

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

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

- Ensure counselors address any prior issues when clients return.

OVRs has implemented a new case management data monitoring system to identify individual case management issues and program-wide reporting on open cases. This system strengthens monitoring consumer compliance to the mutually agreed benchmarks incorporated within the employment plans.

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

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

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

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

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

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

OVRS completed a significantly expanded revision of the program's policy manual in September 2011, to address the increased need for consistency in client expenditures across the state. Regional trainings will be conducted on the new policy manual beginning May of 2011.

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

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

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

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

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

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

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

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

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

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

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

In addition, an ad-hoc monitoring report has been created. This report, finalized in October 2011 is distributed monthly and is used to identify potential SSP and SPD employees who performed conflicting access functions and replaces the previous manual compensating controls process.

It should be noted that a statewide hiring freeze remains in effect. CAF received permission to fill some

previously vacant positions, however, this will only bring CAF staffing up to 70 percent of the need. Based on continued reduced staffing and limited resources, it is anticipated the need for staff to have conflicting access will continue.

Corrective action was completed by March 2012.

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

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

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

Eligibility staff are currently trained to pursue questionable information and utilize available resources including Oregon Birth Verification Records. The DHS Child Care Provider Listing form (DHS7494) also

asks the provider if they are related to the children. The form states that DHS will not pay the provider if they are the parent, step parent or legal guardian of the child. When processing the form, the Direct Pay Unit (DPU) reviews all open cases for the provider and client to see if all household members are included on the form. If DPU notices a birth father on the open case, they are prompted to further investigate.

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

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

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

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

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

DHS currently has one overpayment writer who works specifically on child care provider payments. This allows the department timely request and review of attendance logs and special reports for appropriate service payments and the writing of overpayments.

DHS is also moving to real time knowledge of child care usage rather than waiting for provider submission of paper billing forms for manual processing. This will be accomplished with the Child Care Billing and Attendance Tracking (CCBAT) project. This project is in development with a planned initial rollout beginning September 2012. The DHS Overpayment Unit has seen a workload decrease due to CCBAT system changes already implemented that reduce the risk of overpayments.

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

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

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

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

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

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

ISPO has been working with HP and MMIS to conduct an application vulnerability assessment in August 2012. The assessment will take several days due to the large number of servers and coordination with HP. In addition, the ISPO is working toward developing and implementing a formalized Risk Management

Framework that will include development of regularly scheduled risk assessments and security reviews. It is anticipated that this work will be completed in December 2012.

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

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

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

Children, Adults and Families federal compliance, contracts, budget and OR-Kids business analyst staff have completed detailed service definitions, which include appropriate budget and funding sources (federal or state general fund). This work was done with the knowledge of past audit findings and with particular attention to the appropriate use of federal funds.

The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues

mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services to design reports for Central and Field Offices to use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track all their workload including TANF eligibility determinations.

Due to the issues described above and the estimated schedule for accepting the OR-Kids system, the federal compliance unit will be completing the analysis of prior payments and complete a manual adjustment by March 31, 2013.

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

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

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

CAF Child Welfare:

A Federal Revenue Specialist (FRS) is responsible for completing Title XIX redeterminations every 12 months. The FACIS system creates a notice on the assigned FRS workload when a redetermination is due.

The notice date is based on the review due date captured on the IIS Individual Information screen. Based on conversations with the FRS and the data displayed on the IIS Individual Information screen, the redetermination was completed appropriately.

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

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

The OR-Kids system was implemented on August 29, 2011. While the OR-Kids system does maintain an electronic copy of the Title XIX determination, there is not adequate reporting functionality to monitor that eligibility determinations are being completed timely and accurately. This should be achieved by March 31, 2013.

The OR-Kids system has not been accepted at this time due to significant issues which have not been completely corrected. The OR-Kids Project Team and DHS Executive Team are working with the vendor to determine how and when all of these issues can be resolved. All eligibility, TANF, Title IV-E and Title XIX, have been significantly impacted by the issues mentioned above.

Also impacted by the implementation of the OR-Kids system is the ability to complete adequate queries of the data maintained in OR-Kids. In June 2012, we began working with the Office of Information Services and the Office of Business Intelligence to design reports for Central and Field Offices use. An Eligibility Report is still in the design stages and is proposed to be available in September 2012. The Eligibility Report will be the mechanism by which the Federal Revenue Specialists will track their workload including Title XIX eligibility.

Seniors and People with Disabilities:

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

CAF Self Sufficiency:

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

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

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

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

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

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

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

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

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

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

SSPAT:

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

MEQC:

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

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

On May 16th, 2011, the Child Welfare SFMA cross walk code file was updated to include 103 additional codes identifying child welfare cases paid with TANF funding that were previously left out of our reporting. As a result, the ACF-199 and ACF-209 for the 1st quarter (ending Dec. 2010) were re-transmitted on June 28, 2011 and included over 500 additional cases per month. Since that date, we have not transmitted any Child Welfare TANF funded cases. The OR-Kids system was implemented on August 29, 2011. The OR-Kids system has not been accepted at this time due to significant issues which have not been corrected. The OR-Kids project team and the DHS executive Team are working with the vendor to determine how and when these issues can be resolved. All eligibility for TANF, Title IV-E and title XIX has been impacted. We are

unable to complete queries of data maintained in OR-Kids . A new eligibility report is still in design and is currently being validated. Due to this issue we hope to have the report completed and ready to transmit soon. We expect this may take until March 31,2013 .

We have corrected the previously identified coding problem with the JOBS Plus cases. The PTF cases problems were also solved, although PTF cases were discontinued in March 2012.

In addition, although our reports were correctly reflecting our policies related to disability and domestic violence cases being excluded from mandatory participation and thus excluded from the participation reports; we agree that in cases where these clients are voluntarily participating in work activities, we could be including those cases. We made coding changes to also begin bringing those cases into the reports. The cases were retransmitted in June 2012.

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

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

Correcting transactions were completed in January 2011. Correcting journal entries were made to fix errors and to move funds from federal to other funds. An additional small correcting entry was made in January 2012. Implementation of the new OR-Kids system will restrict the ability to make manual coding adjustments in the future.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Once the MCO reconciliation process was finalized, then the last sequential step in the payment reconciliation plan began. This last step was to overlay the corrected MCO client enrollment onto the FFS claims payment history and determine the appropriateness of the FFS payments made for these enrollment-adjusted clients. This final reconciliation effort was successfully completed by the December 30, 2011, extended target date.

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

The department agrees with the recommendations provided in the confidential security letter provided to the department per ORS 192.501. We have taken and will continue to take corrective actions as discussed in our confidential response to the security letter. These efforts are not yet completed.

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

9. DHS and OHA: Statewide Single Audit Including Selected Financial Accounts and Federal Awards for the Year Ended June 30, 2011, audit # 2012- 08, (dated March 2012)

- We recommend department management develop controls to ensure all Supplemental Nutritional Assistance Program federal revenues are recorded and year-end financial statement adjustments to expenditures are appropriate.

DHS uses a third-party service provider to administer the Supplemental Nutritional Assistance Program (SNAP). This service provider draws revenue directly from the federal government as benefits are issued to clients. Each month the Office of Financial Services (OFS) receives a report from the service provider and records the federal revenue drawn in the state accounting system. At the end of the year Statewide Financial Reporting unit adjusts expenditures to match the revenue drawn for financial reporting.

The January 2011 revenue recording from the service provider in the amount of \$94,357,598 was missed due to lack of cross-training while an individual was on medical leave. At the end of the fiscal year, the expenditures were reduced by an equivalent amount. Since the discovery of this error, cross-training has been provided to OFS staff and an additional review has been established by the OFS Reconciliation unit to ensure each month's revenue transaction is posted. Additionally, the Statewide Financial Reporting unit reviews the SNAP program trial balances for reasonableness during the reporting year to identify anomalies and to implement needed corrections prior to year-end close.

- We recommend department management verify that the initial upload of pharmacy rates in MMIS are complete and accurate.

OHA changed our reimbursement methodology for all enrolled pharmacy providers that serve recipients of Medical Assistance Programs (MAP) from a "lesser of" methodology that reimbursed either a percentage discount off of the Average Wholesale Price (AWP); the Federal Upper Limit (FUL) or the pharmacy's Usual and Customary (U&C) to a "lesser of" methodology based on the Actual Acquisition Cost (AAC) of

individual drugs paid by pharmacies to wholesalers or the Wholesale Acquisition Cost (WAC) when an AAC has not been determined; the FUL or U&C. This “lesser of” methodology ensures that pharmacy rates in the MMIS are complete.

As an early adopter of a more transparent methodology, Oregon Medicaid hired a contractor in 2010 to perform data collection and rate setting functions for our more than 700 enrolled pharmacy providers, to implement the new AAC methodology which became effect on January 1, 2011, with the initial upload to the MMIS.

We agree to review the initial upload of pharmacy rates into the MMIS to ensure completeness and accuracy. Staff now review reports generated from the MMIS after each weekly rate load that identify both changes in rates for individual drugs and an error report that identifies whether the load was stopped or unsuccessful in any way.

OHA staff also compares the system generated reports against a weekly report from our rate setting contractor that identifies changes in rates for individual drugs from week to week including those for the initial load. This review allows us to verify that rates have been loaded into the MMIS correctly and resolve any issue or anomalies in the event a rate is loaded incorrectly and to monitor drugs with significant changes in cost from week to week.

The contractor Oregon Medicaid hired to establish the AAC rates is also responsible for addressing pharmacy disputes when reimbursement is below their respective acquisition cost which further serves as a safeguard to ensure accuracy.

- We recommend department management develop procedures to ensure that balance transfers pertaining to prior fiscal years are properly recorded and do not misstate current year fund balances.

In January 2010 Medicaid and CHIP Federal rules changed related to client citizenship documentation requirements. This change allowed the Department to reclassify expenditures from GAAP General Fund to GAAP Health & Social Services Fund for current and prior fiscal years.

These types of adjustments are often large and require complex analysis to determine the appropriate accounting in current and prior periods. OFS will continue to provide training opportunities to program and internal staff on the importance of thorough documentation and understanding correct period recognition of balance transfers that relate to prior periods. The Statewide Financial Reporting unit has updated the year-end task list to include a review of balance transfers that were entered during the accrual period that affect prior periods.

- We recommend department management strengthen controls to ensure documentation is maintained in the case files sufficient to demonstrate compliance with federal requirements.

One of the missing applications was for an Adoption Assistance case that began in 2002. Due to prior audit findings for Title IV-E in late 2009, the department instituted a process where the Adoptions Assistance Unit reviews the applications to ensure all documentation which supports the eligibility determination (Title XIX or Title IV-E) is attached. Although this process was not administered retroactively, due to the volume of cases and the lack of resources, cases moving forward should have appropriate documentation. The eligibility for this case was retroactively reviewed and found Title IV-E eligible, thus categorically eligible for Medicaid.

The second missing application was used to apply for Self-Sufficiency program benefits. The application was initially processed by a case worker who determined Supplemental Nutrition Assistance Program (SNAP) eligibility. The same application was used, by a different case worker, to determine Medicaid eligibility, however the application did not get returned to be filed in the case record. The case record was subsequently transferred to a different branch office, and the application could not be located. It has since been located. The DHS Family Services Manual provides procedures and outlines the steps for transferring

case files between branch offices. In addition, DHS Imaging and Records Management Services (IRMS) provides services including imaging of documents and “open archiving” of case records to reduce the volume of applications and case file documents retained in branch offices. DHS sent staff an Informational Transmittal reminding staff of the case file transferring procedures and providing a link to IRMS services information. In addition, DHS published an article in the “On-Target” newsletter for Self-Sufficiency staff about ensuring case files are complete prior to transferring to a different case worker or branch. DHS also added information to the Family Services Manual and Business Procedures manual regarding case file transfer processes internally within a branch. DHS will also research the questioned costs for the Adoption Assistance case and reimburse the Centers for Medicare and Medicaid Services (CMS) the appropriate federal funds. The department hopes complete this adjustment by June 30, 2012.

DHS will review the case with undocumented income verification and reimburse CMS any federal funds as appropriate based on this review. The department will also address documentation requirements at the next Area Agencies on Aging (AAA) / Seniors and People with Disabilities (SPD) Field Managers meeting and in the newsletter to field staff by June 30, 2012.

To reduce barriers to access and eligibility, the OHA Medical Programs (formerly DHS Medical Programs) have implemented policies that allow a medical program eligibility determination using a previously submitted application, whether or not the prior application was for medical benefits. During this time (the period under review), it was the case worker’s responsibility to remember and obtain any additional information, such as private health insurance, needed to determine medical program eligibility.

The department continues to proactively strengthen controls over the eligibility determination process. Within the past 17 months, updates have been made to the Legacy computer systems to revise a field in the Client Maintenance (CM) system. This is now a mandatory field, requiring data entry by the case worker when setting up the medical case. The purpose of this field is to identify whether or not an individual has third party insurance. Training for this systems’ change, along with other medical policy changes, was

delivered statewide to field staff beginning in the fall of 2010. In addition, the training material is posted on the Self-Sufficiency Program, Medical Program Staff Tools website.

Medical program eligibility worker training includes guidance on how to process eligibility decisions. In addition, instruction is given to participants on how to “interview” to ask questions to ascertain eligibility information not captured on the current application in the case file, including whether or not individuals have private health insurance. The new data field and purpose is also explained in detail during the trainings.

DHS also researched the questioned costs for both of the cases missing the private health care information and determined no reimburse to CMS was necessary.

DHS will review the case with the private dental insurance and reimburse CMS any federal funds as appropriate based on this review. The department will provide the case information to the Health Insurance Group (HIG) for entry into MMIS. The department will also address reviewing applications for insurance policy disclosure and the requirement to send the information to HIG at the next AAA/SPD Field Managers meeting and in the newsletter to field staff by June 30, 2012.

- We recommend department management implement controls to ensure correct rates are used when calculating the Medicare Part B buy-ins and reimburse the federal agency for the overdrawn ARRA funds.

In April 2011, the ARRA enhanced FMAP rate was reduced. The Medicare Part B buy-in calculations are performed in an excel spreadsheet. In April, the department inadvertently retained the prior quarter’s FMAP rate resulting in an over draw of the ARRA funds. We have since added a box to the excel spreadsheet used in calculating the buy-in and have it highlighted as a reminder to verify the rate being used prior to draw. We have refunded the overdrawn funds to CMS.

- We recommend department management use the standardized contract language and ensure contractors include the standardized contract language with subcontractors to ensure compliance with federal regulations.

Beginning in May 2011, the contract used in the renewal process for Child and Adult Foster Home providers was replaced by the Foster Home Medicaid Provider Enrollment Agreement (SDS0738). This agreement includes the federal and state disclosure requirements. These new agreements will be in place for all Foster Home Providers (child and adult) by August 31, 2012.

The department's contract and Intergovernmental Agreements (IGA) include standardized language with regards to compliance with federal regulations (exhibit G). The IGA or contract requires that exhibit G is attached to any sub-contract. The department will include review for this attachment with sub-contracts during field reviews with Community Developmental Disabilities Programs and Adult Support Services Brokerages. This updated process began with the field reviews scheduled in April 2012.

- We recommend department management ensure the review for suspension and debarment is documented in accordance with department policy.

The Office of Contracts and Procurement (OC&P) reviewed the internal procedure, "Federal Debarment and Suspension Confirmation" and the "OC&P File Checklist" to ensure they comply with the federal debarment requirements. The procedure is in compliance with these requirements. The importance of checking debarment was discussed at the OC&P Unit meeting February 22, 2012. An individual conference was held with staff that had a file without debarment documentation to discuss and document the issue. OC&P management staff enhanced the training regarding debarment for new OC&P staff. Debarment is listed on the OC&P File Checklist, included in the Contract Processing Standards and a link is included on the OC&P intranet site.

- We recommend department management ensure adequate review of the various calculations of the cost pool statistics is performed.

A portion of the cost allocation process has been performed in excel spreadsheets that required some manual entry of statistics each month. In September, the previous month's data had not been removed prior to processing the new data. As a result, the statistics became a blended two month average and was not calculated in accordance with the cost allocation plan. The review process in place did not and would not have picked up this error. The Office of Financial Services has analyzed the impact of the error and made adjustments as appropriate.

The Office of Financial Services implemented a new cost allocation model in July 2011 in which now only relies on one remaining spreadsheet that needs to be automated. The manual intervention of the remaining spreadsheet is to be eliminated by September 2012. The current model in use has eliminated the possibility of this human error happening again.

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

The prior year's corrective action was not accomplished for the period ending June 30, 2011 due to staff resource issues. However the department has implemented appropriate controls to ensure that conflicting access rights are removed where they can be and there is a detective control in place to specifically address those instances.

Our corrective action has multiple parts:

- 1) DHS has developed expectations that field managers review the monthly Resource Access Control Facility (RACF) report for conflicting access of employees. To assist in this review a cheat-sheet for managers has been developed and distributed,*
- 2) DHS has removed all access to perform any update capabilities from non-paid employees, i.e., volunteers and;*

3) DHS has developed and distributes monthly a Conflicting Access report. The report identifies employees who may have taken action using conflicting access on individual accounts for further review.

Corrective action was completed by March 2012.

10. DHS and OHA: Strategies to Better Address Federal Level of Effort Requirements, audit # 2012- 11, (dated April 2012)

- To maximize state resources, allocate General Funds strategically, and ensure continued compliance with Level of Effort requirements, we recommend management from Oregon agencies subject to federal Level of Effort requirements:
 - encourage program staff to work with their federal agency contact to understand possible financial sources available to meet Level of Effort requirements, including funds outside of those directly budgeted for that program;
 - work with the Legislative Fiscal Office to make information available to Oregon Legislative members explaining Level of Effort requirements and consequences for lack of compliance;
 - conduct regular communications among program, financial, and budget staff within each agency to discuss Level of Effort compliance and cross-program expenditure possibilities; and
 - strengthen certification procedures across programs to allow more cross-program expenditures while ensuring compliance with federal mandates.

While OHA and DHS generally agree that the recommendations are reasonable expectations, we are concerned that the report contains no specific analysis explaining if the additional efforts it recommends will generate benefits in excess of their anticipated additional costs. It is also unclear to OHA and DHS management how these recommendations should be prioritized amongst the other activities available to the agencies to improve efficiency and effectiveness. With that said, we do see opportunities to make

improvements to our communication and coordination processes within the two agencies and with our other state and federal partners.

As can be seen in the report, Level of Effort is a very complex subject due to all the different grants and specific rules each grant requires. As such it can be difficult to apply general statements and recommendation regarding Level of Effort (LOE) requirements to all of the grants listed in the audit. For some of grants administered by OHA and DHS some of the specific details of the above recommendation do not apply. For the Medicaid and the Children's Health Insurance Program, the LOE requirements are eligibility based and not expenditure level based. Another grant, the Senior Community Services Employment Program, only requires that placement of an enrollee not supplant normally budgeted positions or contract work at the host agency. There are also grants, such as the Block Grants for the Prevention and Treatment of Substance Abuse, that have historically only allowed expenditures from the recipient agency in determining compliance with the LOE requirement.

OHA and DHS agree that Oregon agency management (including program, fiscal and budget staff) need to understand their grant requirements. We also agree, and do, actively work with the Legislative Fiscal Office (LFO), and the Department of Administrative Services, Budget and Management Division (BAM) to communicate, maintain and ensure compliance with these grant requirements. While we also feel for many of the grants administered by OHA and DHS, we are currently engaged in these discussions at the level necessary, there may be some efforts that could be improved.

Both agencies will review our current communication and coordination efforts related to the individual grants identified in the report to determine if improvements are needed. This will include consideration of a more formalized internal and external meeting structure to discuss ongoing LOE issues and possible changes in other agency programs that may impact LOE (both opportunities and challenges when programs are reduced).

For some grants, such as TANF, we spend significant time analyzing funding opportunities and have put in place a "certification process" as a way to both have routine communications with partner agencies and document other agency LOE related expenditures. We continue to partner with non-traditional MOE programs such as the food banks to explore possible additional opportunities. We also agree there may be additional funding opportunities available and will work with BAM and LFO as necessary to resolve cross-agency issues as they arise.

We will review our programs to determine if there is funding that is in excess of current grant requirements that could help other programs or grants meet their LOE needs. We will continue to work with LFO and BAM to help facilitate the communication of new opportunities as they arise, keeping in mind sufficient analysis is always necessary prior to using any new LOE source to meet specific grant expenditure level requirements.

11. DHS: Child Welfare Program: Strategies to Help Caseworkers Reunite More Families, audit # 2012- 12, (dated April 2012)

- We recommend that Child Welfare district offices and branches share locally-developed practices or systems that support caseworkers, create efficiencies, and develop caseworker skills.
- We recommend the Department of Human Services Child Welfare Program:
 - Evaluate and set priorities among the expected caseworker duties contained in their Child Welfare procedures manual.
 - Routinely gather and share potential best practices among districts.
 - Consider assigning a program manager dedicated to returning children home at the central office to provide better direction and support to enhance caseworker practices. The manager's responsibilities could also include working with other Child Welfare Managers to evaluate and set priorities among current return home practices and ensure best practices are distributed among districts.

- Continue with efforts to implement a policy of annual employee performance evaluations to encourage professional development, improve working environments and better achieve the program's mission.
- Evaluate whether support staff could help alleviate caseworkers' workload burden by providing more assistance on administrative tasks. This should include determining if support staff need additional, but adequately controlled access to the program's OR-Kids system.
- We recommend federal reconsideration of current funding practices to determine whether alignment with the federal goal of returning children to their families would produce better outcomes.

As stated in the draft audit report, there are a number of competing demands on child welfare caseworkers as they navigate their day to day work with families. Other groups and agencies are involved in the decision making process that must be coordinated, and there has been an increase in the expected activities of a caseworker without adequate increases in resources. Child welfare is staffed at approximately 67% of the need given the current workload and there are tasks that go undone every day.

As also stated in the draft audit report, child welfare work is complex. Each family is unique and requires the expertise of the caseworker and supervisory support to craft the plan that will afford the best chance of success and reunification of the family. Despite this, Oregon returns children to their parents at a rate higher than the national average.

While Oregon has a state administered system, there is a differentiation of roles and duties between the Central Office child welfare staff and the field child welfare staff. The promulgation of rules and procedures, and the consultation that helps maintain fidelity in application of those rules and procedures is work done by staff in Central Office. The actual work with families occurs through state employees in 16 Districts around the state.

The department is in agreement with the recommendation that priorities need to be set among the expected duties contained in the Child Welfare procedures manual. Given the demands and expectations of the work

and the current staffing levels, prioritization is critical. The decisions regarding which tasks will be left undone must occur close to where the work with families is being done in order to take into consideration the uniqueness of the situations in each case. Caseworkers are required to have specific training to do their work and their expertise combined with the clinical supervision of their direct supervisor are needed to provide the case management that is required for families to be successful. It is in this relationship between a caseworker and their supervisor that the prioritization of work is done. A static list of priorities issued from Central Office will not serve families well and could leave children in unsafe settings. Each month at the District and Program Managers meetings, workload is an agenda item and there are a number of suggested areas where some changes in rule and procedure could result in workload reduction. Some have already been implemented and some will take longer to evaluate and implement. These meetings also provide a forum for the discussion between field managers and Central Office managers on practice innovations, efficiencies and caseworker skills assessments.

Potential best practices are also discussed at both the District and Program Manager meetings; however, there has not been a schedule for these conversations. In order to ensure a regular and timely discussion of innovations to practice, this topic will be added to the monthly meetings where District Managers and Child Welfare Program Managers meet jointly.

The department will continue these conversations and efforts and will be able to report to the legislature the progress made in this area.

The department recently implemented a change in the organizational structure of Central Office and focused all child welfare programs in one program area, the Office of Child Welfare Programs. Within this office, we are in process of repurposing resources we have to better align with the work in the field, including increasing our consultation resources focused on our return home practice. There is no additional program manager to dedicate solely to returning children home so this work will have to occur within the resources currently allocated, and will take some time. This will be especially challenging as the department takes

steps to implement House Bill 4131. The department anticipates this work will be fully implemented by January 2013.

As stated in the draft audit report, the department has begun the implementation of the Performance Feedback Model. The implementation and evaluation of that model is an outcome measure on the department's Fundamentals Map as well as the Child Welfare Fundamentals Map, and a topic of the department's and program's Quarterly Business Reviews.

In the development of the technology system that supports child welfare, OR-Kids, the documentation of activities done by the various staff that work with families was required to be entered by the individual that did the work. This resulted in an increase in the documentation activities of the caseworker that in the prior system, may have been entered by support staff. Because the OR-Kids system is a role based access system, support staff cannot enter material on behalf of the case worker. Since the implementation of OR-Kids, the department has been evaluating the design and actively looking for opportunities to improve on the design. One of these areas is the further evaluation of the role based assignments for entry of data. The department believes there are data entry activities that can be shifted back to support staff and is working to implement those changes.

Finally, the department is in agreement with the recommendation that the federal government align the funding for child welfare with the national priorities of safely reducing the number of children in the foster care system. Oregon has been involved in providing feedback on several proposals for federal finance reform for the child welfare system. As opportunity arises, the Department will continue to participate in this national conversation.