State of Washington
Office of Financial Management

2017
Audit Resolution Report

Accounting Division
December 2017

STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT

2017
Audit Resolution Report

ACCOUNTING DIVISION
DECEMBER 2017

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THIS REPORT SUMMARIZES the status of corrective actions taken by state agencies, in conjunction with the Office of Financial Management (OFM), to resolve exceptions to specific expenditures or financial transactions reported in audits performed under RCWs 43.09.310 and 43.09.340.

Washington State laws require post audits of every state agency. As part of the audit process, exceptions to specific expenditures or financial transactions become a matter of public record. OFM is required to ensure that agencies take corrective actions to address exceptions and to annually report on the status of these audit resolutions.

This annual report is required by RCW 43.88.160 which states, "The director of financial management shall annually report by December 31st the status of audit resolution to the appropriate committees of the legislature, the state auditor, and the attorney general. The director of financial management shall include in the audit resolution report actions taken as a result of an audit including, but not limited to, types of personnel actions, costs and types of litigation, and value of recouped goods or services."

This report summarizes the status of resolution of audit exceptions reported in conjunction with individual agency post audits and the statewide single audit, as well as other special State Auditor's Office (SAO) reports. These reports were issued between November 1, 2016, and October 31, 2017.

The audit reports issued during that period include:

- 50 federal compliance findings
- 9 non-federal findings
- 2 findings of fraud

Agencies are required to submit corrective action plans to OFM within 30 days of issuance of audit reports in which exceptions are taken. OFM participates in the corrective action process, which is subject to a follow-up review by SAO.

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Schedule 1 – Audit Findings by Agency

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Schedule 1 – Audit Findings by Agency

2016 F = Statewide Single Audit Report

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	001	Finding:	The State should improve internal controls over the processing and recording of Unemployment Insurance premium payment and wage information and accounting for program activities in the Guaranteed Education Tuition program's (GET) to ensure accurate reporting.
		Corrective Action:	The Office of Financial Management (OFM) has been working with the Employment Security Department (ESD) to improve internal controls over processing and recording of Unemployment Insurance premium payments. In response to the finding, ESD has established a Next Generation Tax System (NGTS) Interfaces and Data Quality Assurance project team comprising of representatives from the business and technology sectors to address concerns regarding the NGTS. The project team is working on improving the system's internal controls related to processing transactions, reporting, and reconciliations between systems. In addition, ESD has contracted with Microsoft to remediate technical issues with the NGTS system and work on eliminating any identified deficiencies. To address the recommendations related to the reporting of accounting activities of the Guaranteed Education Tuition program, the Student Achievement Council (SAC) provided training to agency accounting staff to ensure a better understanding of the year-end closing process with the state's Accounting and Financial Reporting System. The SAC Accounting Manager has also updated year-end accounting procedures to ensure they are complete and adequate. OFM will continue to provide year-end training classes to all state agencies on various topics related to the processing and reporting of financial activities. OFM has also improved the process for reviewing unusual events or unique program activities that are material to the state's financial reporting. Monitoring activities include performing analytical reviews and evaluating significant items to assess the overall statewide impact. For all special and unique transactions, OFM will work with responsible agencies to ensure the transactions are properly accounted for and correctly reported on the financial statements.
		Completion Date:	December 2016, subject to audit follow-up
		Agency Contact:	Brian Tinney Statewide Accounting Assistant Director PO Box 43127 Olympia, WA 98504-3127 (360) 725-0171 brian.tinney@ofm.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	028	Finding:	The Health Care Authority did not perform semi-annual data sharing with health insurers as required by state law.
		Corrective Action:	RCW 74.09A.020 requires the Authority to provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information, and requires health insurers to use this information to identify joint beneficiaries. The Authority meets the intent of the law by performing data matching with insurance carriers in the state of Washington on a regular basis. Data exchanges occur in real time using information and electronic data available to the state Medicaid program. In addition, the Authority implemented the national Payor Initiated Eligibility/Benefit (PIE) transaction standard in July 2013, which meets the intent of RCW 74.09A.005 by instituting "a transfer of information between the authority and health insurers." The Authority is continuing to refine the logic for loading PIE data from insurance carriers into the Medicaid Management Information System (MMIS). Some changes were made to the transaction logic in August 2016 and the Authority is continuing to work through the logic to ensure accurate automated loading of the files to the MMIS. The Authority will complete those refinements and will continue to work with carriers currently engaged in PIE transaction submissions. The Authority has continued to encourage health insurers to develop systems capable of participating in the PIE data exchange. As of August 2017, the Authority has submitted proposed legislation to align state law with current practice. The conditions noted in this finding were previously reported in finding 2015-030, 2014-034, 2013-020, 12-49, 11-38, 10-40, 09-19, and 08-25.
		Completion Date:	August 2017, subject to audit follow-up
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	030	Finding:	The Health Care Authority made improper Medicaid payments to Federally Qualified Health Centers and Rural Health Clinics.
		Corrective Action:	By December 2017, the Authority will recoup the overpayments made to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics. The Authority will consult with the U.S. Department of Health and Human Services regarding resolution of the questioned costs. The conditions noted in this finding were previously reported in finding 2015-033. The prior finding numbers for FQHCs alone are 2014-036, 2013-026, and 12-45.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	031	Finding:	The Health Care Authority did not repay the federal government for improper payments made to Medicaid Managed Care Organizations.
		Corrective Action:	As noted by the auditors, the Authority identified the duplicate premium payments reported in this finding. The Authority has recouped the duplicate payments.
		Completion Date:	September 2017, subject to audit follow-up
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	032	Finding:	The Health Care Authority did not establish adequate internal controls and did not comply with requirements to ensure it sought reimbursement for all eligible Medicaid outpatient prescription drug rebate claims.
		Corrective Action:	In response to the audit finding, the Authority has implemented the following corrective actions: • As of September 2016, identified and corrected the system issue concerning the Medicaid eligibility code. • As of February 2017, corrected the system issue concerning the managed care plan coding errors. The Authority has also strengthened its review process by: • Preparing a checklist of steps for staff to consider when a new code is added to the ProviderOne System. • Implementing quarterly monitoring reports designed to validate the completeness and accuracy of each invoicing cycle. On May 31, 2017, the Authority invoiced the unclaimed rebates identified by the auditors. The Authority and U.S. Department of Health and Human Services have discussed the resolution of questioned costs. The conditions noted in this finding were previously reported in finding 2015-034 and 2014-031.
		Completion Date:	May 2017, subject to audit follow-up
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	033	Finding:	The Health Care Authority did not have adequate internal controls over its Medicaid inpatient hospital rate setting process and made overpayments to inpatient hospitals.
		Corrective Action:	The Authority has implemented additional internal controls to prevent errors from occurring in the hospital rate setting process, which include: • Adding calendar reminders for significant action items in the process. • Notifying providers in a timely manner when errors are identified. • Conducting a final review of rates after they are entered into ProviderOne. By February 2018, the Authority will amend WAC 182-550-3830 to eliminate the contradiction between it and WAC 182-550-3800. The Authority will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs
		Completion Date:	Corrective action is expected to be complete by February 2018
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	034	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Children's Health Insurance Program funds were claimed for eligible Medicaid expenditures.
		Corrective Action:	As of July 2017, the Authority updated eligibility status during the post eligibility review process. For cases that were determined to have been placed in an incorrect eligibility category by self-attestation, their status was updated to reflect the most appropriate eligibility category. The Authority will refund the questioned costs following the process established by the U.S. Department of Health and Human Services.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	035	Finding:	The Health Care Authority did not notify Medicaid providers of revalidation requirements as required by the Center for Medicare and Medicaid Services.
		Corrective Action:	By December 2017, the Authority will: • Notify providers of the revalidation requirement. • Complete revalidations of all providers who enrolled with Medicaid prior to December 2012. To meet federal compliance, the Authority will continue to revalidate providers every five years from their date of enrollment or date of last revalidation.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov

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State Health Care Authority **Agency 107**
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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	029	Finding:	The Health Care Authority and the Department of Social and Health Services did not have adequate internal controls and did not comply with requirements to ensure Medicaid service verifications were performed for all eligible claims.
		Corrective Action:	The Department of Social and Health Services (Department) completes an annual Client Service Verification survey that includes a statistically significant sample of clients to verify whether services billed by providers were received. Although it is a manual process, this method satisfies the verification requirement as outlined in federal regulations. The Health Care Authority (Authority) questions the auditor's interpretation that federal regulations require additional verifications be done through ProviderOne. Nonetheless, the Authority has expanded the ProviderOne verification process in May 2017 to include social service payments in the universe from which samples are selected in the Medicaid service verification survey process. By January 2018, an automated verification process through ProviderOne will be implemented. This will include establishing a written agreement between the Authority and the Department detailing each of their roles and responsibilities regarding the Medicaid service verification survey process. The Department's manual survey process will continue until this written agreement is in place. The conditions noted in this finding were previously reported in finding 2015-032, 2014-039, 13-031, 12-54 and 11-39.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Kathy E. Smith Audit & Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-0937 kathy.smith2@hca.wa.gov Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Enterprise Services **Agency 179**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	008	Finding:	The Department of Enterprise Services did not have adequate internal controls over and was not compliant with federal wage rate requirements for the Grants to States for Construction of State Home Facilities program.
		Corrective Action:	In response to the finding, the Department took the following corrective actions: • Immediately communicated auditors' finding and recommendations to agency program representatives and management. • Reviewed all current program contracts subject to similar requirements to identify potential non-compliance. From this review, three federally funded contracts were identified and amendments were completed to clarify the Davis-Bacon Act requirement of submitting weekly-certified payroll reports by contractors and subcontractors to the Department. • Initiated and completed a program-wide verification with each client agency to identify contracts with federal funding. The Department ensured all contracts complied with the provisions under the Davis-Bacon Act and defined specific responsibilities by each party. The project supervisors overseeing the contracts are responsible for ensuring compliance with the provisions stipulated in the contracts. • Required a section of the supplemental conditions related to prevailing wages and certified payrolls drafted by the Attorney General's Office (AGO) and accepted by Department's management to be included in all federally funded contracts. • Provided a team-wide project services management training conducted by the AGO regarding the federal requirement. • Provided training to Contract Specialists to emphasize the need to verify that contractors and consultants meet all applicable federal requirements during the contract development process. As part of process improvement, eight forms used in the contract development process were revised and are being used to ensure compliance in the contract development process. • Included the review of the Federal Davis Bacon requirements in weekly management team meetings. In addition, supervisors and project managers hold monthly scheduled meetings to verify on-going compliance. • Ensured the corrective action process is monitored by the Department's Internal Audit where assistance will be provided as needed.
		Completion Date:	June 2017, subject to audit follow-up
		Agency Contact:	Francis McElroy Internal Audit Manager PO Box 41408 Olympia, WA 98504-1408 (360) 407-8285 francis.mcelroy@des.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	002	Finding:	The Department of Social and Health Services improperly charged $4.6 million to multiple federal grants.
		Corrective Action:	The Department partially concurs with this finding. The Department notes that the transactions identified in the audit were accruals and does not agree that accruals always result in charges to federal grants. All of the Department's accruals automatically reverse in the following fiscal month, which will be followed by appropriate payments processed during the same or future period. For federal grants, the Department's Economic Services Administration, Division of Finance and Financial Recovery (DFFR) has processes in place to reverse and move payments that are improperly charged to the appropriate grant year. The auditors identified the payroll for the pay period ending September 30, as the only payroll cycle that was charged to the incorrect grant year. DFFR identified these charges when payments were processed on October 10, and researched all other related administrative charges and disbursements based on the processing dates. Reversals were subsequently processed to move charges to the appropriate grant year. For the Supplemental Nutrition Assistance Program (SNAP), DFFR identified and processed more than $3 million of reversals consisting of payroll, benefits, and goods and services charged to the wrong grant year. However, the Department does not agree that this program should be included in the finding as the related amount substantially increased the final questioned costs from the original $2.8 million. DFFR also reversed all the accruals for the Refugee and Entrant Assistance (REA) grant and properly charged them to the correct grant period. However, another administration inadvertently posted an accrual transaction on the following day resulting in improper charges of $14,628. DFFR has not yet completed reversals for the Temporary Assistance for Needy Families (TANF) program due to its focus on completing the higher-risk TANF claims. The Department acknowledges that additional controls are needed to ensure compliance with the period of performance requirement for the SNAP, REA and TANF grants. As of March 2017, the "Month of Service" was added to transactions in the agency's accounting system to help DFFR identify expenditures charged to the incorrect grant year. In addition, accounting staff are now required to include month of service in processing all agency payments from the accounting system. The Department will continue with the manual process via journal vouchers to move disbursements to the correct period as needed.

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	002 (cont'd)		Additionally, DFFR will take the following actions by November 2017: • Move the process of updating the Automated Cost Allocation Plan from October to November. • Update procedures to include a checklist developed for staff responsible for administering the SNAP, REA and TANF grants. By February 2018, the Economic Services Administration's Internal Control Administrator will implement procedural changes to include the new requirements. Accounting staff will be required to review and research improperly charged costs monthly and make corrections as needed. If the grantors contact the Department regarding questionable costs that should be repaid, the Department will confirm these costs with the grantor and will take appropriate action. The conditions noted in this finding were previously reported in finding 2015-003 and 2014-022, where the improper charges were determined to be centralized costs that are allocated throughout the Department.
		Completion Date:	Corrective action is expected to be complete by February 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	004	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with public assistance cost allocation plan requirements.
		Corrective Action:	The U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, Region 10, Division of Cost Allocation (DCA) was in possession of the Department's fiscal year 2012, 2013, and 2014 cost allocation plans. While DCA was in possession of those three plans, they were working with the Department to ensure the 2012 plan was approved. The Department was provided verbal directions from DCA's negotiator to stop submitting plans until DCA finished approving the previous years' plans. Therefore, the Department stopped submitting new plans. The federal partners are aware of where the Department stands with its plans as they are actively working with the Department on approvals of the previously submitted plans. The Department has since received written directions from DCA. As of June 2017, fiscal year 2016, 2017, and 2018 public assistance cost allocation plans were submitted to DCA.
		Completion Date:	June 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	011	Finding:	The Department of Social and Health Services failed to establish adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.
		Corrective Action:	To address the auditors' recommendations, the Department conducted internal compliance reviews of the Individual Plans of Employment (IPEs) to determine if they were in compliance with the 90-day requirement from the date the clients were determined eligible. The Department will continue to conduct reviews on an on-going basis. To more effectively monitor the timeliness of IPEs completion, the Department has transitioned from using the monthly reports generated in the Supervisory Case Review Module of the case management system. The Department's Division of Vocational Rehabilitation has enhanced a web-based report that refreshes daily to include cases that are approaching or have exceeded the 60-day eligibility or the 90-day IPE development timeframe. In June 2017, the Director of Vocational Rehabilitation issued a directive to staff to communicate the 90-day requirement for IPEs. As of September 2017, the Department: • Provided statewide training to staff on the federal requirements of establishing timely IPEs. • Developed a tool for Vocational Rehabilitation counselors to create reports from the case management system. This capability allows counselors to identify cases that are nearing the 90-day limit for appropriate actions. By January 2018, policies and procedures will be updated to ensure IPE's are created in a timely manner, including documentation requirements for the IPE extensions.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	012	Finding:	The Department of Social and Health Services did not establish adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility within a reasonable period of time for the Vocational Rehabilitation program.
		Corrective Action:	To address the auditors' recommendations, the Department has revised procedures to include: • Conducting monthly internal compliance reviews by Area Managers to ensure eligibility determinations have been completed timely. • Maintaining required documentation of exceptional and unforeseen circumstances for cases requiring extension. To more effectively monitor the timeliness of eligibility determination, the Department has transitioned from using the monthly reports generated in the Supervisory Case Review Module of the case management system. The Department's Division of Vocational Rehabilitation has enhanced a web-based report that refreshes daily to include cases that are approaching or have exceeded the 60-day eligibility or the 90-day IPE development timeframe. In June 2017, the Director of Vocational Rehabilitation issued a directive to field staff communicating applicable federal requirements and the updated procedures relating to client eligibility determination. As of October 2017, the Department improved its monitoring process by developing a tool for Vocational Rehabilitation counselors to create reports from the case management system. This capability allows counselors to identify cases that are nearing the 60-day limit for appropriate actions.
		Completion Date:	October 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	013	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to ensure payments paid on behalf of clients and staff time and effort for Vocational Rehabilitation were allowable.
		Corrective Action:	The Department concurs with the finding. Although time certification for six months of the year were completed during fiscal year 2017, rather than 2016, the direct payroll and benefit charges were appropriately charged to the grant and subsequently certified. The Department is now following policies to ensure payroll certifications are accurate and submitted timely. Per federal regulations, the Department's Vocational Rehabilitation Division must ensure the following types of services are not interrupted or delayed: • Progress of an employment outcome. • An immediate job placement. • Services to an individual who is determined to be at extreme medical risk. For the above services, the Department is allowed to verbally authorize and/or purchase client services prior to the Individual Plan for Employment (IPE) approval. The Department will ensure adequate follow-up is done to update and sign the IPE as required. To address the auditors' recommendations, the Department is taking the following actions to ensure client employment services are included in the approved IPE before they are purchased or paid for. The Department has: • Issued a directive to field staff communicating the federal requirements that client employment services must be included in the IPE along with the counselor and client signatures. • Implemented a monitoring process to ensure compliance. The Fiscal Compliance Manager will run reports from the Service Tracking and Reporting System (STARS) and conduct quarterly internal compliance reviews to ensure services were included in appropriately approved IPEs. Any issues identified are forwarded to management and counselors for corrective actions. • Developed tools to assist staff in ensuring IPEs are complete and properly approved before services are paid for. • Consulted with the Department of Education regarding resolution of questioned costs. By January 2018, the Department will enhance the STARS system so staff will be alerted when services are purchased which are required to be in the IPE.
		Completion Date:	Corrective action is expected to be complete by January 2018

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	013 (cont'd)	Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	014	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional Significance and Block Grants for Prevention and Treatment of Substance Abuse programs received required audits.
		Corrective Action:	Since fiscal year 2015, the Department had been working on establishing new sub-recipient monitoring policies and procedures for the Behavioral Health Administration. In September 2016, the Department formalized the monitoring procedures by issuing a management bulletin. The bulletin communicated the need to: • Ensure compliance with the federal regulations. • Adhere to the Department's administrative policy on subrecipient monitoring. • Implement corrective actions to address audit exceptions identified in this finding. The management bulletin also outlines the subrecipient monitoring procedures, which include: • Conducting risk assessments. • Ensuring subrecipients obtain their required audit. • Following up on all subrecipient audit findings related to the program and to issue management decisions timely. • Ensuring accurate reporting by subrecipients of federal funds received. In addition, the Department assigned two staff the roles and responsibilities of subrecipient monitoring. The conditions noted in this finding were previously reported in finding 2015-016 and 2014-019.
		Completion Date:	September 2016, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	015	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to sanction Temporary Assistance for Needy Families program participants who were not cooperative with the Department regarding child support issues.
		Corrective Action:	All issues identified by the auditors were for clients served by both Division of Child Support (DCS) and the Community Services Division (CSD). The system glitch between the two divisions identified in a prior year's audit affected cases through September 1, 2016, some of which were included in the current audit test sample. As a response to the prior audit finding, DCS immediately fixed the glitch and sent all potentially affected cases to CSD for review. The Department recognizes it did not properly apply sanctions for 18 clients who did not cooperate with child support requirements which led to overpayments to seven clients. As of February 2017, the Department reviewed these cases and established overpayments as appropriate. In response to the finding, CSD now prioritizes non-cooperation notices received from DCS to ensure sanctions are applied timely and accurately. As of August 2017, the Department: • Developed and provided online refresher training of existing CSD policies and procedures on reducing benefits for clients in non-cooperation status. • Continued to pursue a long-term, automated solution to ensure all cases in non-cooperation status are properly sanctioned. • Consulted with U.S. Department of Health and Human Services regarding resolution of questioned costs. As of September 2017, the following monitoring process has been implemented: • DCS runs monthly reports on clients that were non-cooperative. • Based on the non-cooperation documents received, CSD Quality & Compliance Team at headquarters performs post audits of a random sample of clients. • Forwards post audit results to the policy administrative unit to determine if additional training or guidance for staff is needed. CSD and DCS will continue to work together to identify and eliminate potential gaps in appropriately sanctioning a client in non-cooperation status. The conditions noted in this finding were previously reported in finding 2015-018.
		Completion Date:	September 2017, subject to audit follow-up

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2016 F	015 (cont'd)	Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	016	Finding:	The Department of Social and Health Services did not have adequate internal controls in place for submitting quarterly reports for the Temporary Assistance for Needy Families Grant.
		Corrective Action:	The Department partially agrees with this finding. The Department currently has the following processes in place: • Maintain extensive documentation on algorithms for deriving the data contained in the Automated Client Eligibility System and the Social Service Payment System as needed in federal reporting. Staff run a quality assurance process that identifies potential fatal and warning edits which are reviewed by the Supervisor. • Monitor, review, and perform manual testing of coding changes to ensure they were applied correctly. While no version control software is being used, Department staff is keeping systematic copies of all old code versions using filename conventions, duplicating most of the functionality of version control software. The Department is not aware of any federal regulations that require the use of version control software. • Run data files through an error checking process when compiling reports. Results are reviewed by the Research and Data Analysis unit before files are transmitted. • Disseminate monthly summary data to other divisions and other state agencies for review prior to submission of quarterly reports to ensure they are complete and accurate. By January 2018, the Department's Research and Data Analysis Division will: • Ensure all proposed coding changes are documented, approved by the supervisor, and reviewed after implementation. This process will be formally documented for each major change. • Research version control software packages to determine feasibility. • Document current source code archiving processes. • Ensure policies and procedures are updated to reflect these changes.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	017	Finding:	The Department of Social and Health Services did not have adequate internal controls in place to ensure compliance with the maintenance of effort requirements for the Temporary Assistance for Needy Families grant program.
		Corrective Action:	The Department partially concurs with the finding. In response to a prior year finding, the Department created a collaborative work group to develop written policies and procedures as part of the effort to strengthen internal controls specific to complying with maintenance of efforts (MOE) requirements. As of February 2017, the Department finalized new policies and procedures and identify the steps and processes for staff to ensure accurate and timely reporting of MOE. Specific procedures include: • Ensuring adequate documentation is collected and reviewed to support all MOE expenditures. • Using attestations between the Department and other state agencies to meet federal requirements. However, an improved protocol will be developed to review final expenditure data from outside agencies to ensure they were allowable, supported, and accurate. • Using an adequate and structured monitoring protocol to facilitate management review of MOE expenditure data to ensure federal requirements are met. The Department currently monitors, reviews and performs manual testing of coding changes to ensure they were applied correctly. While no version control software was used by the Department, staff is keeping systematic copies of all old code versions using filename conventions, duplicating most of the functionality of version control software. By January 2018, the Department's Research and Data Analysis Division will: • Ensure all proposed coding changes are documented, approved by the supervisor, and reviewed after implementation. This process will be formally documented for each major change. • Research version control software packages to determine feasibility. • Document current source code archiving processes. • Ensure policies and procedures are updated to reflect these changes. The conditions noted in this finding were previously reported in finding 2015-020.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	018	Finding:	The Department of Social and Health Services did not have adequate internal controls in place and was not compliant with requirements for submitting quarterly and annual reports for the Temporary Assistance for Needy Families grant.
		Corrective Action:	The Department partially concurs with the finding. The Department acknowledges that existing policies and procedures in place were not adequate to ensure financial reports for the Temporary Assistance for Needy Families (TANF) grant were submitted completely and accurately. In response to the prior year finding, the Department created a work group comprising of staff from the Department's Division of Finance and Financial Recovery (DFFR), Community Services Division (CSD), and Research & Data Analysis Division (RDA). As of February 2017, the work group developed and adopted additional written procedures to strengthen internal controls to ensure federal reporting requirements are met. Due to timing of the audit, the corrective actions taken by the Department were not included in the current audit period. The Department ensures that state agencies' expenditures are verifiable and allowable by reviewing the agencies' reporting methodologies and record maintenance protocols, and analyzing the agencies' expenditure data to the extent allowable under state regulations and policies protecting confidentiality. The Department does not agree with the auditors' assertion that federal regulations require the state to verify the amounts of spending by other non-state organizations before including those expenditures toward the state's basic Maintenance of Effort (MOE) requirement. Federal regulations stated that an expenditure may be counted and reported if it "is verifiable and meets all applicable requirements" and if there is "an agreement between the state and the other party allowing the state to count the expenditure toward its MOE requirement." The Department maintains that obtaining attestations from other organizations is sufficient to meet federal requirements. As of May 2017, the Department: • Convened and led a TANF MOE workgroup consisting of representatives from CSD, DFFR and RDA. The workgroup will continue to hold quarterly meetings to review the MOE projection data. • Developed a quarterly report review checklist to ensure sufficient documentation is maintained for the quarterly and annual reports currently in use. Written policies and procedures were updated to include this new process. • Initiated a meeting with the auditors to discuss the interpretation of the federal regulations and obtain feedback on the newly developed written policies and procedures.

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2016 F	018 (cont'd)	The conditions noted in this finding were previously reported in finding 2015-021. Completion Date: May 2017, subject to audit follow-up Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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2016 F	019	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers for the Temporary Assistance for Needy Families program were allowable.
		Corrective Action:	The Department partially concurs with the finding. The Working Connections Child Care program policy and guidance, as maintained by the Department of Early Learning (DEL), does not require staff to verify employment or school schedule as a condition of eligibility. The Individual Responsibility Plan (IRP) outlines the approved activities for Temporary Assistance for Needy Families (TANF) clients participating in the Department's WorkFirst program. The IRP also lists the number of hours the client is required to participate, which determines the client's authorization for full-time or part-time child care. The WorkFirst program staff and contractors maintain a client's schedule, and regularly track and report actual hours of participation. The Department acknowledges that adequate attendance records are necessary in the reconciliation process to determine allowable payments. DELs policy requires providers receiving subsidy payments to maintain attendance records and provide them upon request. However, because attendance records are paper-based, it is not feasible for staff to request, review and reconcile all records before subsidy payments are made. The Department will continue to conduct post-payment reviews of cases where an improper payment appears likely to have occurred, such as when providers bill the maximum authorization each month. For these cases, staff will review the case specifics and perform verification, to include, requesting attendance records to determine if an overpayment has occurred. The review will also determine if it is a provider or a client overpayment, the amount of the improper payment, and establish an overpayment if appropriate. The Department plans on implementing major changes to improve internal controls, while minimizing impact to the clients. The Department will seek to add 25 additional full-time employees and necessary resources to staff the business-process redesign and support the information technology initiatives necessary to improve our internal controls. The Department will also explore other options to strengthen our processes including third-party reviews and pre-authorization reviews on high-risk and/or high cost cases. These initiatives focus on improving accuracy in eligibility and authorization determinations, which will reduce the risk for improper billings from providers.
		Completion Date:	Corrective action is expected to be complete by March 2018

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2016 F	019 (cont'd)	Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	023	Finding: The Department of Social and Health Services did not have adequate internal controls over and did not comply with client eligibility requirements for the Child Care Development Fund. Corrective Action: The Department partially concurs with this finding. The Department thoroughly reviewed each of the 50 exceptions identified by the auditors, and agrees that 26 of them were exceptions on eligibility determination. The Department's review indicated one case of likely fraud when the client failed to accurately report household composition and 18 cases where overpayments occurred. The Department referred the fraud case for prosecution and the 18 overpayments to the Office of Financial Recovery for collection. The Department does not concur with the remaining 24 audit exceptions. The disagreement centers on two primary policy interpretations: • Allowing self-attestation of work schedules. • Allowing 60 days for verification of new or changed employment. The U.S. Department of Health and Human Services (HHS)'s Administration of Children and Families Administration (ACF) encourages states to adopt family-friendly policies in determining child care subsidy eligibility. The Department of Early Learning (DEL), the lead agency for the Child Care and Development Fund (CCDF), has embraced this philosophy when addressing a prior year's finding on the same issue. DEL clarified and ratified these two policies and highlighted them in the Fiscal Year 2016-2018 CCDF Washington State Plan. The State Plan was approved by HHS in June 2016, but was made effective as of March 2016. The Department also had concerns with the auditors' sampling methodology and associated extrapolation of questioned costs. In May 2017, the Department and other agencies met with the auditors but agencies' concerns have not been resolved. In response to the audit recommendations, the Department is taking the following actions: (1) Eligibility determination reviews: The Department will continue to use the following criteria in child care authorization audits: • At least one percent of child care caseloads are audited monthly. • Exceptional payment authorizations are reviewed and approved by a supervisor before payments can be made. • 100 percent audit of pre and post-authorizations made by new child care eligibility staff until they attain proficiency. • Review cases where an improper payment appears likely to have occurred, such as when providers bill the maximum authorization in each month. For these cases, staff review case specifics and perform verification, including requesting attendance records to

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2016 F	023 (cont'd)	determine if an overpayment has occurred. The review will also determine if it was a provider or client overpayment, the amount of the improper payment, and will establish an overpayment if appropriate. By January 2018, the Department's Community Service Division (CSD) will optimize usage of Audit Plus for child care reviews. The program is an auditing tool designed to randomly sample case actions based on a pre-determined criteria and support manually added case actions. Requests for enhancements to the program have been made to: • Update the auto-add sampling criteria to ensure appropriate cases are randomly selected for review. • Add a new review type for child care cases with a higher risk of errors. • Add child care reports to review error trends. These reports will be used to determine areas selected for accuracy focus review. The Department is also working on identifying high risk cases where care was authorized more than full time. These cases have separate coding indicating supervisory review is required prior to authorization. As of July 2017, CSD started generating a monthly report listing these cases. The reports are submitted to the child care leadership team in the field for supervisory review and determination of next steps. CSD will work with the Department's Economic Services Administration Division of Program Integrity and DEL to implement a third party review process. By February 2018, CSD will use the third party review to identify categories that have a potentially high risk of error and based on their findings may institute additional categories of pre-authorization review. The Department will also participate in the Improper Payments Information Act audit conducted by DEL every three years in accordance with the Federal Office of Child Care requirements. For the audit conducted in federal fiscal year 2013, less than one percent of the total amounts of payments for the sampled cases were found to be made in error. (2) Employee training: As of May 2017, the CSD Child Care Program Manager compiled and submitted training work requests. Training focus includes ensuring staff review and compare client eligibility documents with available source documents. The Child Care Program Manager will work with Child Care Operations and the division's training and development team to determine if existing training and desk aids need to be updated for child care workers. New training will also be created as needed to ensure understanding of existing policies and systems used in eligibility determination.

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2016 F	023 (cont'd)	Relevant training has been developed and the Department anticipates the accompanying handbook will be completed by December 1, 2017. Once the handbook is completed, the Department has an expectation for staff to complete training within 30 days, and strives to achieve at least 95 percent as a successful completion rate by December 2017. (3) Segregation of duties: By March 2018, CSD will initiate the process of gathering information technology (IT) requirements to support changes in the child care subsidy procedures to separate the eligibility determination from the authorization process. These include IT and CSD staffing changes needed for segregation of duties, and for pre-authorization review of highest cost cases and high risk cases. The Department's consideration of potential solutions will include weighing the associated adverse impact to timeliness of service delivery. By April 2018, the Department will transition the responsibility to approve Family Friends or Neighbor providers to DEL, segregating a part of the approval process for these license exempt providers where the potential for fraud has historically been above average. CSD staff will not be able to authorize payments until DEL approves these providers. (4) System Enhancements: As of August 2017, CSD completed the enhancement to Working Connections Automated Program (WCAP) to automatically generate and send notifications to clients specifying the due dates for their income verification, and that their benefits will be terminated if verification is not received by the due date. As of October 2017, the Department enhanced WCAP to actively alert a worker when the household composition in WCAP is different from the household composition for other Department administered programs. This feature ensures workers review and assess all available information prior to making an eligibility determination. If HHS contacts the Department regarding questionable costs that should be repaid, the Department will work with them and will take appropriate action. DEL concurs with this finding and the auditors' recommendations. In collaboration with the Department, DEL will prioritize internal control improvements on eligibility determinations. DEL has already adopted rules and policy changes and aligned supporting guidance and documentation to simplify and clarify eligibility determination and payment authorization within the bounds of federal and state law and regulations. In April 2016, DEL revised WAC 170-290-0012 and created WAC 170-290-0014 outlining the specific information that must be verified before

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2016 F	023 (cont'd)	making a payment to a provider. The rules specifically allow for self-attestation of work schedules. In July 2016, DEL revised WAC 170-290-0095 that included language to allow 60 days for verification of new employment. Specific rules and policy changes included the following: • Model household composition determination requirements after those of the Supplemental Nutrition Assistance Program, requiring questionable client statements of household composition be supported with additional third party verification. • Clearly define "new employment" so that client attestation of income for the first 60 days of new employment is unambiguous. • Eliminate the requirement to use three months of wages for income determination. Provide flexibility in income counting rules and income verification requirements to allow use of income documentation that most accurately reflects the consumer's economic situation and allows income eligibility determination to be completed. • Standardize authorization amounts for all families across all provider types, including those with parents participating in approved activities, such as: ▪ full time and part time, ▪ traditional and non-traditional, ▪ variable working schedules, ▪ school age and non-school age children. • Clarify and simplify rules and policies as to how parent and child schedules may impact the authorization. • Clarify rules and policies regarding work schedules to specify circumstances where schedule information and third party verification may be required. Specify acceptable forms of documentation and timelines for submission. • Create rules and policies describing consequences for client and provider intentional program violations, including potential ineligibility for client benefits and provider payment. Intentional program violations in this context will be defined and will likely include intentional acts that knowingly result in an unallowable payment but exclude fraud. In addition, DEL will support the Department's commitment in the planned actions on increasing reviews, continuing monitoring protocols, segregating eligibility determination and payment authorization duties, and implementing necessary system enhancements. The conditions noted in this finding were previously reported in finding 2015-026, 2014-026, 2013-017, and 12-30. Completion Date: Corrective action is expected to be complete by April 2018

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2016 F	023 (cont'd)	Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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2016 F	024	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with foster care payment rate setting and application requirements for the Foster Care program.
		Corrective Action:	During the current audit, the Department's Children's Administration (CA) did not have a policy that defined the time period required to perform a periodic review of foster care payment rates since current federal regulation did not specify a time table for states to comply with the requirement. During fiscal year 2015, the Family First Act was introduced to Congress, which included setting time parameters for foster care payment rate review to be done every three years. The Act failed to pass and was later incorporated into the 21st Century Cures Act and reintroduced to Congress in fiscal year 2016. The 21st Century Cures Act passed in December 2016. The Department intended to create new Department policy that aligns with potential new federal regulations resulting from implementation of the Act. However, the Family First Act was subsequently dropped along with the three-year rate review requirement. The Department will review the maintenance payment rate again in 2019, based upon an economic analysis, to determine if the rate needs to be adjusted. If an increase is necessary, the Department will submit a decision package for additional funding. Reviews after 2019 will occur every four years. By June 2018, the Department will update the policy to include that the economic analysis be completed every four years after 2019. This policy will be included in the Title IV-E State Plan submission. The conditions noted in this finding were previously reported in finding 2015-028 and 2014-027.
		Completion Date:	Corrective action is expected to be complete by June 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	025	Finding:	The Department of Social and Health Services did not have adequate internal controls over federal eligibility requirements for the Foster Care program.
		Corrective Action:	The Department does not concur with the finding. The Department verified that all providers included in the auditors' test sample had background checks completed prior to payment for the period under review. Nevertheless, the Department will continue to communicate to staff the requirement of properly conducting background checks for providers. With regard to documentation for income eligibility, the Department contends that it is not a federal rule or requirement that documentation be printed and placed in clients' files. The Department uses FamLink as the official case management system and source for Title IV-E income verification information. The Department prints income source documentation when the information contains amounts over zero dollars and places the information in the Title IV-E eligibility folder, which is a part of the client's file. The Department also makes note of the zero dollar resource information in FamLink. The Department will continue to ensure proper documentation is maintained to support eligibility determination.
		Completion Date:	February 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	026	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal level of effort requirements for the Adoption Assistance program.
		Corrective Action:	The Department partially concurs with the finding. Given this is a new program requirement along with the delay in federal guidance; the program was at a disadvantage in setting up the structure to track expenditures within this audit period. While the Department could account for and identify the savings expenditures, the Department agrees that improvement can be made to the process. As of October 2017, the Department's Children's Administration established a coding structure to track expenditures specifically related to Adoption Savings spending which will also support expenditures reported. By June 2018, the Department will establish policies and procedures specifying how to determine adoption savings, and reporting annually to the grantor.
		Completion Date:	Corrective action is expected to be complete by June 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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2016 F	027	Finding:	The Department of Social and Health Services did not have adequate internal controls over federal eligibility requirements for the Adoption Assistance program.
		Corrective Action:	The auditors found the Department did not complete background checks for the providers of one child. While the Department cannot produce the physical document showing a cleared background check conducted in 1995, there is a notation by the case worker in the case management system that a background check did occur at that time, which was prior to the adoption. There was also a notation of a background check occurring in early 1997. It should be noted that in the event a background check was not conducted prior to adoption, the Department has no legal authority to run a background check retroactively on the adoptive parent. The Department maintains adequate internal controls to ensure background checks of providers and prospective providers are performed in accordance with state regulations and program rules. This is evidenced in the audit testing result that only one 20-year old case was identified as an exception. To address the auditor's recommendation, the Department will continue to communicate the importance of the background check requirement to staff responsible for eligibility determination. As of October 2017, the Department provided the U.S. Department of Health and Human Services (HHS) documentation showing that the background check was indeed completed and discussed any necessary repayment of the questioned costs. By January 2018, the Department will confirm with HHS if the noted questioned costs need to be repaid.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	036	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over requirements to ensure surveys for Medicaid nursing home facilities were completed in a timely manner.
		Corrective Action:	The Department partially agrees with this finding While the Department surveyed nursing homes within the required timeframes, documentation for nursing homes with deficiencies was not sent or received in a timely manner. The Department recognized that the Plans of Correction (POCs) were not always received within ten calendar days from issuance of the Statement of Deficiencies (SOD). However, the Department used the POC receipt date as its metric whereas the auditors used the date POC was determined acceptable by the Department. The Department follows the Centers for Medicare and Medicaid Services (CMS) State Operational Manual (SOM) guidelines for receiving POCs. If deficiencies are noted on the initial POC, it will not be accepted. Sometimes, the process may require more than ten calendar days to complete an acceptable POC. During the current audit, the Department requested and received clarification from the CMS Technical Director for Enforcement and Certification for the Division of Nursing Homes. Email correspondences with CMS supported and confirmed the Department's interpretation of the CMS policy, which was consistent with the current practices of other states when initial POCs are not acceptable. The Department agreed with the Statement of Deficiency (SOD) finding based on the auditors' testing methodology. While the CMS SOM does not require formal tracking, the Department did develop an internal tracking spreadsheet for SODs and POCs in January 2016 for use by field offices statewide. The Department will continue to enhance its ability to distribute SODs in ten working days and receive POCs in ten calendar days. As of March 2017, the Department's Residential Care Services Division worked with Management Services Division to finalize a tracking website for SODs requiring enforcement review and action. This website enables daily tracking of SOD processing between field managers and headquarters enforcement staff to ensure electronic SOD delivery within ten working days of survey exit date. As of April 2017, the Department implemented the web-based electronic Plan of Correction (ePOC) system. The system: • Electronically communicates and time-stamps distribution of SODs to providers and submission of POCs from providers. • Tracks and monitors the sending and receipt of documents through reporting functions.

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2016 F	036 (cont'd)	• Notifies Residential Care Services (RCS) headquarter and regional offices when surveys have been completed, but not posted to the ePOC website. • Notifies facilities and RCS Field Managers that a SOD is issued. Email notification is sent ten calendar days after the date of SOD issuance and every other day thereafter until the facility submits a POC. • Notifies RCS headquarter and regional offices when a POC has been submitted and has not been reviewed within five business days after submission and every other day thereafter until it is reviewed. The conditions noted in this finding were previously reported in finding 2015-044 and 2014-046. Completion Date: April 2017, subject to audit follow-up Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	037	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure surveys for Medicaid intermediate care facilities were completed in a timely manner.
		Corrective Action:	The Department partially agrees with this finding. The Department has established internal controls to ensure Statement of Deficiencies (SODs) are mailed out to providers within ten working days and Plans of Correction (POCs) are received from providers within ten calendar days. The Department did not agree with the auditors' finding that four facilities submitted their acceptable POCs after ten calendar days. The Department received the initial POCs from the providers within the required time frame, which were then deemed not acceptable by the Department. The Department recognizes that the POCs were not always received within ten calendar days from issuance of the SODs. However, the Department used the POC receipt date as its metric whereas the auditor's testing used the date POC was determined acceptable by the Department. The Department follows the Centers for Medicare and Medicaid Services (CMS) State Operational Manual (SOM) guidelines for receiving POCs. If deficiencies are noted on the initial POC, it will not be accepted. Sometimes, the process may require more than ten calendar days to complete an acceptable POC. During the current audit, the Department requested and received clarification from the CMS Technical Director for Enforcement and Certification for the Division of Nursing Homes. Email correspondences with CMS supported and confirmed the Department's interpretation of the CMS policy which was consistent with the current practices of other states when initial POCs are not acceptable. The Department agrees with the SOD finding based on the auditor's testing methodology. The Department's Residential Care Services Unit was fully staffed by July 2016, which improved the Department's ability to meet survey timeframes. As of September 2016, additional data elements were added to enable tracking due dates and receipt dates on a shared document located on the Department's SharePoint site. As of September 2017, procedures were updated to direct staff to forward SODs to the provider by facsimile when necessary and retain supporting documentation on file to meet compliance requirements. The Department also agreed that surveys were not performed in accordance with the frequency required by state and federal laws of 12.9

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2016 F	037 (cont'd)		months. This was attributable to providers' non-compliance with the federal Conditions of Participation (COPs) identified in subsequent surveys conducted in the prior fiscal year. Under this condition, the Department cannot conduct annual surveys unless the Department conducts credible allegation surveys to verify the facilities have met the COPs. This condition caused delays in conducting the annual recertification surveys. In April 2016, the Department conducted informal training to four facilities to provide proper interpretation of the regulations and to assist them in meeting compliance with COPs. Additional training requests from other facilities were also completed as of July 2017. The Department has initiated actions to amend the State Plan. As of September 2017, three alternative sanctions were added to strengthen the Department's ability to impose sanctions on non-complying facilities. The conditions noted in this finding were previously reported in finding 2015-045 and 2014-046.
		Completion Date:	September 2017, subject to audit follow-up
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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	038	Finding:	The Department of Social and Health Services did not have adequate internal controls over its examinations of Medicaid nursing home cost reports.
		Corrective Action:	The Department partially agrees with the finding. While there was adequate documentation when cost report examiners determined an adjustment was needed for unallowable costs and account code reclassification reason codes, the Department did not have a process for examiners to document their reviews when no issue was found. As of March 2017, the Department implemented the following corrective actions: • Added a description in the cost report examination manual to clarify the minimum requirement in the review of the unallowable costs and account code reclassification reason codes, particularly when no adjustments are necessary. • Updated the electronic cost report examination guide to include designated areas for reviewer's initials and date. In addition, a new statement was added to the exam guide for examiners' comments and notes. • Updated the examination manual to instruct cost report examiners to initial and date all reason code pages reviewed. • Provided training and communicated to all cost report examiners on the requirement of properly documenting examination for all reason codes. • Established an official policy including a secondary review requirement for all nursing home cost report examinations. A copy of the new policy was distributed to all staff in the unit.
		Completion Date:	March 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	039	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure complaints of abuse and neglect of clients at Medicaid residential facilities were responded to properly.
		Corrective Action:	The Department partially agrees with this finding. As of April 2016, the Department added additional staff to assist with processing complaints. The Department has also been authorizing overtime as a temporary measure to ensure that complaints are responded to within 24 hours of receipt. As of May 2016, the on-call staffing program was implemented to help improve the timeliness of field investigations. As of July 2016, the Tracking Incidents of Vulnerable Adults (TIVA) case management system reporting tool was completed which provides all required information for reliable tracking and monitoring. Since then, the Complaint Resolution Unit (CRU) implemented weekly monitoring using the TIVA 2016 report for complaints that require responses within 24 hours and those that need two working days response time. Management reviews all complaints that exceed the required response time and correct errors or discuss timeliness issues with the CRU staff. The weekly reports and statistics are also communicated to staff to show performance compared to required benchmarks. As of August 2016, CRU implemented the public online reporting system which is a shared system with Adult Protective Services. The online reports are imported into TIVA and the process takes less time than phone complaints. The hotline script was updated in the following month informing callers that an online option is available for providers and the public. As of April 2017, the Department implemented enhancements to the TIVA database to eliminate input errors. CRU staff are no longer able to link a nursing home or intermediate care facilities complaint to the field without prior review by a clinical triage nurse. Additionally, a message will appear if the complaint time exceeds 24 hours from the time of receipt. As of October 2017, CRU developed an additional Standard Operating Procedure to define extenuating circumstances for non-immediate jeopardy complaints. In addition, a TIVA system enhancement was completed to only allow supervisors to link a complaint that falls into one of the approved extenuating circumstances. This enhancement does not allow any complaint to be linked over two working days without supervisor override.

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2016 F	039 (cont'd)		These actions taken by the Department have helped reduce the backlog of complaint investigations, improved the timeliness of investigations, as well as improved the timeliness of complaint processing at intake. To improve response times to initiate complaint investigations, the Department will: • continue to work on filling vacancies and ensure new hires complete the federally required basic surveyor training for Nursing Home and Intermediate Care Facilities for Individuals with Intellectual Disabilities surveys. • continue to pursue TIVA design and processing enhancements to mitigate the need for overtime and to meet timeliness requirements. • perform ongoing monthly monitoring of timeliness of complaint investigations to provide the Department with information for leveraging resources to meet required timeframes. The conditions noted in this finding were previously reported in finding 2015-047, 2014-045, and 2013-033.
		Completion Date:	October 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	040	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure Medicaid Community Options Program Entry System and Community First Choice in-home care providers had proper background checks.
		Corrective Action:	The Department does not concur with the finding. The Department disagrees with the auditors' statement that there were inadequate internal controls to ensure in-home care providers (IP) had proper background checks. Of the 200 IPs sampled and tested by the auditors, four were found to have errors with their background checks ranging from a data entry mistake to a missing fingerprint check. This represented 98 percent proficiency rate which reflected the strong internal controls established by the Department to ensure that IP had proper background checks. As noted by the auditors, due to the Washington Service Employees International Union Training Partnership lawsuit, the Department was not able to access provider documents held by the Partnership. Due to this reason, the Department did not complete its quality assurance IP review until August 2016 when a work around was put in place to access the data. The auditors determined that IP monitoring and file review was not performed during the audit period. However, there is no federal requirement stipulating that file reviews must be completed by fiscal year rather than calendar year. The Department also disagrees with the auditors' determination that providers for whom a background check or a character, competence, or suitability (CCS) was not renewed every two years are unqualified. WAC 388-71-0510 states that the provider must complete a background check to become an IP, but does not state that the IP will become unqualified if another background check is not completed within two years. WAC 388-71-0513 states an IP must not have a disqualifying crime or be determined unqualified based on a CCS. There is no state or federal regulations requiring that a background check or CCS be repeated every two years. As such, the Department does not agree that the findings should be tied to questioned costs. In December 2016, the Department submitted the change request to modify the Department's Agency Contract Database and the Background Check Central Unit's data feed for better monitoring and tracking of IP background check compliance. In May 2017, the Department sent a letter to the U.S. Department of Health and Human Services regarding the disagreement with repayment of questioned costs, but have not yet received a response. By July 2018, the Department will develop a report from the contract database that will include IP background check due dates. Field staff will be able to access the report as a tool to monitor contracted providers to ensure ineligible providers do not have access to vulnerable Medicaid clients.

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Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	040 (cont'd)	The conditions noted in this finding were previously reported in finding 2015-040, 2014-049, 2013-040, 12-41, and 11-34. Completion Date: Corrective action is expected to be complete by July 2018 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016	041	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements for cost of care adjustments paid to Medicaid supported living providers.
		Corrective Action:	The Department partially concurs with this finding. The Department agrees that two payments were made to providers when clients were in a hospital and that one payment was inaccurately calculated. However, the Department disagrees that justification forms were inadequate. The Department believes that the exceptions identified in the finding are based upon the auditors' subjective analysis of the justification information contained in the cost of care adjustment (COCA) requests. The auditors did not give consideration to the resource managers' knowledge or expertise of the program. Furthermore, they did not consider the review of other related documents performed by resource managers while processing the COCA requests. Department staff who are responsible for reviewing and approving COCA requests have in-depth knowledge of the policies and of the instructions that are given to providers. The Department believes the instructions are concise and clear. The Department will continue to communicate the justification requirements to staff in accordance with Department policies. In addition, instructions will be provided on accurately completing the COCA forms to the residential providers and to the resource managers. As of July 2017, the Department reviewed the policy as part of contract negotiations with stakeholders and it was determined changes to the policy were not necessary. However, the Department will continue to monitor and assess the need for policy changes. Any updates will be submitted as part of the waiver renewal or amendment in January 2018. The Department will communicate changes and provide on-going training to staff and providers. The Department will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs. The conditions noted in this finding were previously reported in finding 2015-052, 2014-041, and 2013-038.
		Completion Date:	Estimated January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	042	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration did not ensure two Medicaid Community First Choice in-home care providers had proper background checks.
		Corrective Action:	The Department concurs with the audit finding. The Department recognizes client safety as a top priority and will ensure background checks are completed as required. Employees are trained throughout the year and the Department has found training employees in the area of background checks has proven to be effective. The Department confirmed the two individual providers identified in the finding have completed and passed the background checks, including the fingerprint check for the one individual. By January 2018, the Department will implement a new system that will provide an automated solution to prevent and/or cancel active service authorizations to individual providers who fail to meet or comply with background check requirements. The Department will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	043	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client support plans were properly approved.
		Corrective Action:	The Department concurs with the finding. The auditors' review found 18 person-centered service plans that did not have signatures or signatures were not received timely. The auditors also identified one case relating to financial eligibility. The Department acknowledges that the target for timely signatures and accurate financial eligibility determination is 100 percent and seeks to reach that mark. To ensure person-centered service plans are signed timely in accordance with federal requirements, the Department provides training to staff responsible for obtaining the signatures. Training is also provided to the compliance monitoring team who are responsible for annual monitoring. As of June 2017, the Department has provided additional statewide training regarding signature requirements to ensure client support plans are properly approved. As of September 2017, the Department: • Clarified written policies regarding signature requirements. • Conducted an enhanced, targeted review to monitor adherence to policies and compliance with signature requirements. The Department will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs.
		Completion Date:	September 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	044	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls and did not comply with regulations to adequately monitor Adult Family Home providers to ensure Medicaid providers and their employees had proper background checks.
		Corrective Action:	The Department partially concurs with the audit finding. The Department agrees with the number of audit exceptions. The following actions have been taken to address adult family homes' (AFH) noncompliance with background check licensing requirements: • As of November 2016, the Department updated the AFH provider orientation and AFH provider administration training to include the requirement of timely completion of background checks and the possible penalties for not meeting the requirement. • As of December 2016, the Department: o Revised the online training on the Department's Residential Care Services Division internet site to include information on the background check renewal process. o Worked with the AFH provider association to share information about background checks through the association's newsletters and intranet site, as well as the Department's Background Check Central Unit's project communication plan. The Department also ensured that all providers have access to the information. • As of January 2017, the Department added language to the provider contract renewal letter and the annual license renewal statement reminding providers that they need a current background check to renew the contract. • As of April 2017, the Department created a report that will proactively identify providers with background check renewals coming due. The Department will send reminder notices to providers 60 days prior to the expiration dates of their background checks. The following actions have also been taken to improve internal controls to ensure compliance with background check requirements: • As of July 2017, the Department reviewed and revised the State Plan to consistently reflect the minimum AFH provider qualifications as stated in state law. • As of August 2017, the Department started the process of addressing overdue checks listed and assigning staff to send out reminders to providers with balance due within the next 60 days. The Department does not agree the exceptions should be tied to questioned costs. The auditors' finding did not identify any providers who did in fact have a disqualifying crime or negative action. Neither RCW 70.128.120 nor RCW 74.39A.056 requires the Department or the provider to conduct additional background checks after the initial screening.

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2016 F	044 (cont'd)		While the AFHs identified in the finding did not comply with the Department's licensing requirements by not having current background check results in their files, and are therefore subject to corrective action and sanctions by the Department, the providers are not unqualified to provide Medicaid paid services. Thus, the payments to the providers were proper. In January 2017, the Department sent a letter to the U.S. Department of Health and Human Services regarding the disagreement with repayment of questioned costs, but have not yet received a response. The conditions noted in this finding were previously reported in finding 2015-051, 2014-048, and 13-37.
		Completion Date:	October 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	045	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid payments to supported living providers were allowable.
		Corrective Action:	The Department does not concur with this finding. State law provides the Department the authority to authorize payments for individuals in community residential programs. The Department uses the annual cost reporting process that requires payments for the total annual contracted Instruction and Support Services (ISS) hours to be reconciled to the actual hours provided. The supported living (SL) provider attests to the accuracy of their cost reports. The Department may request additional evidence to verify the ISS hours were provided. The Department seeks recovery through an overpayment if the cost report indicates that either the hours or the funds provided for the ISS hours were not used by the agency for ISS purposes. The approved system is designed to allow resource flexibility for the SL provider throughout the year to meet the changing needs of the individual client. It also enables more efficient use of taxpayer resources by allowing additional staffing for peak demands. The Department requires that clients served by the agency receive all authorized ISS hours for the year. Providers are given the calendar year to address client instructions and support needs. As such, audit reviews based on a fiscal year timeframe do not accurately capture the entire delivery of service, or any corresponding annual underpayment or overpayment. The Department also believes the audit inappropriately treated cost settlements as overpayments. Cost settlements are based on reimbursement methodologies defined in policy, rule and contract, and are typically done in the aggregate on an annual basis, rather than on a client-by-client or case-by-case basis. As of July 2015, the Department revised its policy to: • Clarify the expectations that the service provider's payroll system must adequately document ISS hours delivered. • Outline acceptable margins of flexibility of ISS hours delivered. • Require additional schedules to report ISS hours in a format reconcilable to payroll records. The Department provided training on the revised policies over the summer and fall of 2015. As of January 2017, the Department removed the two-year settlement request option from policy when the existing approvals expired. The Department already discontinued the approval of this option in calendar year 2014.

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Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	045 (cont'd)	In June 2017, the Department updated the policy again as part of contract negotiations. The new policy was effective July 1, 2017. The Department also: • Conducts reviews on approximately 20 percent of residential providers' ISS hours. Scope of this compliance review includes reconciling hours in the contract by households with employee payroll records delivered to the household. Consultation and training to service providers related to the tracking and documentation of ISS hours is provided at the time of review. • Performs cost report reconciliations annually. The following additional measures are in place to audit provider cost reports: o The Department's Residential Care Services performs a cursory review of hours provided as part of the certification evaluation process. If concerns are identified, the Department will conduct an additional review of the SL provider. o Review a sample of 24 agencies per year. Technical assistance and training are provided to SL providers during these reviews. By January 2018, the Department will consult with the U.S. Department of Health and Human Services regarding resolution of questioned costs. The conditions noted in this finding were previously reported in finding 2015-049, 2014-042, 2014-043, 2013-036, and 12-39. Completion Date: Corrective action is expected to be complete by January 2018 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	046	Finding:	The Department of Social and Health Services did not accurately claim the federal share of Medicaid payments processed through the Social Service Payment System.
		Corrective Action:	The Department concurs with the audit finding. During the implementation and data conversion for Community First Choice, not all data converted correctly from the Social Service Payment System (SSPS). Due to accounting and staff workload related to the implementation of ProviderOne and Individual ProviderOne (IPOne), it took longer than anticipated to obtain data reports from SSPS and to process corrections in the state's accounting system. For cases where incorrect cost allocation social service codes were authorized by case managers resulting in incorrect federal matching rates, Department staff notified accounting and expenditures were subsequently corrected. Although this is normal business practice, the auditors included these transactions in the amount of questioned costs. As of March 2016, with the exception of some minor prior authorization corrections, services are no longer authorized in SSPS. With the implementation of ProviderOne and IPOne, additional controls are in place to limit the selection of service codes by case managers when authorizing services. The Department's Home and Community Services Quality Assurance Unit continues to monitor payment authorizations for compliance with requirements. As of October 2016, the questioned costs were returned to the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services.
		Completion Date:	October 2016, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	047	Finding:	Medicaid funds were overpaid to a supported living agency that contracted with the Department of Social and Health Services, Developmental Disabilities Administration.
		Corrective Action:	The Department partially concurs with finding. As of February 2017, the Department processed the payment notice to the Department's Office of Financial Recovery (OFR). Per federal regulations, the Department is not required to refund the federal share of an overpayment made to a provider to the extent that the Department is unable to recover the overpayment because the provider has been determined bankrupt. The agency in question has filed for bankruptcy. The Department has submitted the required information to the bankruptcy court for the amount owed. The Department will work with OFR to follow the federal and state regulations for financial recovery that pertain to bankruptcy proceedings. By December 2017, the Department will confirm with the U.S. Department of Health and Human Services that the funds do not need to be repaid.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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2016 F	048	Finding:	The Department of Social and Health Services, Aging and Long-Term Care Administration, made improper Medicaid payments to individual providers.
		Corrective Action:	The Department partially concurs with the audit finding. The auditors used payment data to identify payments made to individual providers who claimed payment for personal care and mileage services on the same date of service that payment was made to a hospital or long-term care facility. The Department concurs that unallowable payments were made, but it is not known whether payments were incorrectly claimed by the individual providers, rather than the hospital or long term care facility. The audit work was performed during the first three months after the Department's new billing system, Individual ProviderOne (IPOne), went live. During this time, providers were experiencing a learning curve in using the new system, which may have contributed to incorrect claims made during this time period. Since the implementation of the IPOne system, internal controls have been strengthened in processing payments to individual providers. It is now easier for the Department to discover incidents when providers are claiming hours for a time period in which a client is in a hospital, long-term care facility, or other institutional setting. By March 2018, the Department will develop a process to research and remediate occurrences of payments made for personal care and mileage services while a client was either hospitalized or admitted to a long-term care facility. The Department will consult with the U.S. Department of Health and Human Services regarding the resolution of the questioned costs.
		Completion Date:	Corrective action is expected to be complete by March 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	049	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid payments made through the Social Service Payment System to individual providers were allowable.
		Corrective Action:	The Department partially concurs with this finding. The Department concurs that there were 48 payments not supported with timesheets or other documentation for hours worked or mileage claimed. However, the Department does not concur with all of the questioned costs associated with duplicate payments. To address the audit recommendations, the Department has taken the following corrective actions: • With the implementation of Individual ProviderOne system in March 2016, provider timesheets are now submitted electronically by providers as supporting documentation prior to payment. • As of June 2016, a portion of the duplicate payments were submitted for overpayments and were returned to the federal government. • As of January 2017, the Department's Developmental Disabilities Administration started verifying providers' services by phone calls to a random sample of clients each month. • As of May 2017, the new system automatically sends letters to a random sample of clients to verify services as part of the quality assurance review process. As of July 2017, overpayments have been submitted to the Office of Financial Recovery for recoupment from individual providers. The Department will consult with the U.S. Department of Health and Human Services regarding the resolution of the other questioned costs.
		Completion Date:	July 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	050	Finding:	The Department of Social and Health Services did not have adequate internal controls over the level of effort requirements for the Block Grants for Prevention and Treatment of Substance Abuse.
		Corrective Action:	The Department agrees with the finding. The Department formalized a written procedure to ensure established policies are followed in monitoring and managing level of efforts requirement for both treatment services for pregnant women and women with dependent children, as well as for tuberculosis services. The procedure references the data sources necessary for monitoring expenditure levels; frequency of monitoring efforts; and the appropriate actions to be implemented if expenditures are below the level of effort levels. The formal procedure was communicated to responsible staff across the agency. The Department collaborated with the Department of Health and the Health Care Authority to capture tuberculosis data quarterly and developed a methodology to determine and document the percentage of expenditures spent on individuals in substance abuse disorder treatment. The conditions noted in this finding were previously reported in finding 2015-053 and 2014-051.
		Completion Date:	May 2017, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019974	2016-001	Finding:	The Department of Social and Health Services' Children's Administration did not establish adequate internal controls to ensure volunteer drivers met requirements to transport clients.
		Corrective Action:	In response to the auditors' recommendations, the Department will take the following corrective actions: • By December 2017, the Department will establish a Department-wide policy regarding volunteers that will require each field office to create procedures for monitoring its specific type of volunteers. • By January 2018, the Department will: o Implement a process for field offices to track volunteer driver's licenses and auto insurance documents annually. Supporting documentation, such as an tracking spreadsheet, will be maintained to show the annual review of these documents. o Remove the language requiring volunteers to have first-aid certification from the Volunteer Handbook. While the Department agrees that first-aid certification of volunteers is a great recommendation, it is not a requirement of any RCW or WAC. The Department recognizes that it is a good practice to perform background checks on volunteers on a regular basis, even though there is no current statutory or agency requirement. If the Legislature determines volunteer background checks should be performed on a consistent basis, the Department will implement additional processes to ensure they are completed.
		Completion Date:	Corrective action is expected to be complete by January 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019974	2016-002	Finding:	The Department of Social and Health Services Children's Administration did not establish adequate internal controls to ensure deliverables for a contract with the University of Washington were received before making payment.
		Corrective Action:	The Department executed the Master Agreement with the University of Washington (UW) in December 2011, with a performance period through 2021. The Department followed the same contracting process for the Annual Plans under this Master Agreement. This finding was issued for the fiscal year 2016 Annual Plan, which was not signed prior to the start of the performance period. The Department has initiated the fiscal year 2017 Annual Plan and has been working with UW to reach an agreement on the deliverables. As of October 2017, UW has not signed the Annual Plan despite mediation efforts by the Governor's Office. The Department will continue to work with UW and the Governor's Office and hopes to complete the process by December 2017. In the event that an agreement is reached, the Department will ensure that a properly executed agreement is in place before the performance period begins and no payment will be made prior to that. Once the signed 2017 Annual Plan is in place, the Department will implement a monitoring protocol where monthly or quarterly progress reports will be reviewed to determine if deliverables are completed before payments are made.
		Completion Date:	Corrective action is expected to be complete by March 2018
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Health **Agency 303**

Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	003	Finding: The Department of Health did not have adequate internal controls over and did not comply with requirements to monitor local agency operations timely and at the minimum percentage. Corrective Action: In response to the finding, the Department implemented the following corrective actions: • Completed monitoring visit of the one local agency that did not have monitoring at least once every two years as identified in the finding. This agency was monitored on February 7, 2017. • Obtained clarification from the federal grantor that all sites for each local agency should be included in the calculation to meet the requirement for monitoring at least 20 percent of the clinics in each local agency. The Department added three additional on-site monitoring visits for the current monitoring cycle to meet the 20 percent requirement. Two were added in 2017 for the Public Health -Seattle King County, and one was added in 2018 for Sea Mar Community Care Center. • Developed a spreadsheet for 2017–2018 monitoring schedule. Monitoring visits have been planned quarterly for all local agencies, which may be subject to changes when schedules are finalized with the agencies. • Developed a process for yearly planning of on-site monitoring to be completed by October 1 of each year. Planning work include: o Assessing changes in the local agencies with funding from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). o Verifying the current number of clinics for each agency that has multiple sites. o Ensuring WIC program staff review the schedule and verify the accuracy of the list of grant subrecipients. The list will be used to develop a fiscal monitoring schedule for all subrecipients at least once every two years. o Scheduling all monitoring visits by the end of the calendar year. o Developed a process for supervisors to perform quarterly assessment of the monitoring plan to ensure staff are meeting the requirement to complete all scheduled visits. Contingency plans will be developed to address any unforeseen circumstances that require the need to adjust the planned schedule. Completion Date: February 2017, subject to audit follow-up Agency Contact: Lynda Karseboom Internal Auditor PO Box 47890 Olympia, WA 98504-7890 (360) 236-4536 lynda.karseboom@doh.wa.gov

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Department of Veterans' Affairs **Agency 305**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019447	2016-001	Finding:	The Department lacked adequate internal controls over the issuance of gift cards to veterans, increasing the risk of misuse, abuse and theft of public funds.
		Corrective Action:	The Department concurs with the finding. To address the auditors' recommendations, the Department: • Updated the recently implemented Gift Card Purchasing Policy to include documenting unique identifier numbers for all gift cards. • Maintained a gift card master log to track the issuance of gift cards. • Obtained signed memorandums from clients acknowledging receipt of gift cards and the intended use. • Provided case managers additional training on the processes. The Department's Gift Card Purchasing Policy has been updated to reflect current practices and expectations. The Department will educate clients to ensure that they understand the updated requirements. Case managers will ensure clients are informed of the intended use of the gift card when issued, and sign the memorandum acknowledging receipt of the gift card and agreeing to use it only for the intended purposes.
		Completion Date:	September 2017, subject to audit follow-up
		Agency Contact:	Mike Kashmar Chief Financial Officer PO Box 41150 Olympia, WA 98504-1150 (360) 725-2171 Mikek@dva.wa.gov

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Department of Services for the Blind **Agency 315**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	009	Finding:	The Department of Services for the Blind failed to establish adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable period of time.
		Corrective Action:	In December 2016 and January 2017, the Department held meetings with management and staff to identify and address the common reasons causing delays in eligibility determinations. Training was also provided at these meetings on the required elements on clients' case notes justifying a delay, which include circumstances, expected completion date and client agreement. Previously, management had been relying on reviewing monthly reports from the case management system to identify delayed eligibility determinations. These reports were reviewed by Regional Area Managers to assist counselors in meeting the 60-day deadline for each case. For the cases that were overdue, Regional Area Managers review justification for the delay to ensure it was adequately and properly documented in the client's case notes within the case management system. The completed monthly reviews were sent to the Deputy Director to be filed. However, the exceptions identified by the audit revealed the limitations of monitoring by monthly reports. Since the reports only showed a snapshot in time, they did not include those delayed eligibility determinations that had been resolved before the date the reports were generated. Consequently, management was not alerted and were missing the required justification and documentation. As of August 2017, the Department completed the testing of an actions-due feature called a dashboard in the case management system, and determined that the data values provided by the dashboard were sufficiently reliable to be used as a tool to monitor compliance. Case managers had since received appropriate training to use the tool weekly to manage their caseloads on a real-time basis. With the implementation of this new process, the Department discontinued the use of monthly reports as a monitoring tool. As of September 2017, management had also implemented a process to identify eligibility determinations nearing the 60-day deadline for the upcoming week and to remind counselors of the required components for documenting a delay justification if a determination is not expected to be made within the 60-day timeframe. Managers also perform weekly monitoring of the use of the dashboard tool by the team. The Department has informally communicated to Regional Managers a target of less than ten percent overdue eligibilities for the agency, by region and counselor. As of October 2017, performance data showed that agency-wide delayed eligibility determinations decreased to less than ten percent compared to the previous fiscal year. In addition, there were improvements

Department of Services for the Blind **Agency 315**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	009 (cont'd)		in the number of days taken to complete eligibility determination. The Department may consider adding the performance expectations to the Regional Managers' 2018 performance evaluation process. The Department is in the final stage of revising the Washington Administrative Code (WAC) to align with the new Workforce Innovation and Opportunity Act of 2014 which will include the requirements of delay justification documentation. As of October 2017, the policy revision has been sent out to external partners and stakeholders for initial feedback. The revised WAC is expected to be published by December 2017 for public comments before being adopted as final policy. By December 2018, the Department will update sections of the Vocational Rehabilitation Procedures Manual including eligibility determination and related requirements, which will occur in tandem with the implementation of a new case management system. The updated procedure manual will reflect the internal controls in place for the eligibility determination process.
		Completion Date:	Completion date is estimated to be complete by December 2018
		Agency Contact:	Michael Mackillop Deputy Director PO Box 40933 Olympia, WA 98504-0933 (206) 906-5520 Michael.mackillop@dsb.wa.gov

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Department of Services for the Blind **Agency 315**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	010	Finding:	The Department of Services for the Blind failed to establish adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.
		Corrective Action:	As of January 2017, the Department has provided training to management and agency field staff on the required elements justifying an Individual Plans of Employment (IPEs) extension past 90 days, including client agreement and a specific expected completion date. Previously, management had been relying on reviewing monthly reports from the case management system to identify delayed IPEs. These reports were reviewed by Regional Area Managers to assist counselors in meeting the 90-day deadline for each case. For the cases that were overdue, Regional Area Managers review justification for the delay to ensure it was adequately and properly documented in the client's case notes within the case management system. The completed monthly reviews were sent to the Deputy Director to be filed. However, the exceptions identified by the audit revealed the limitations of monitoring by monthly reports. Since the reports only showed a snapshot in time, they did not include those delayed IPEs that had been resolved before the date the reports were generated. Consequently, management was not alerted of delayed IPEs that were missing the required justification and documentation. As of August 2017, the Department completed the testing of an actions-due feature called a dashboard in the case management system, and determined that the data values provided by the dashboard were sufficiently reliable to be used as a tool to monitor compliance. Case managers have since received appropriate training to use the tool weekly to manage their caseloads on a real-time basis. With the implementation of this new process, the Department discontinued the use of monthly reports as a monitoring tool. As of September 2017, management had also implemented a process to identify IPEs nearing the 90-day deadline for the upcoming week and to remind counselors of required components for documenting a delay justification if an IPE is not expected to be developed within the 90-day timeframe. Managers also perform weekly monitoring of the use of the dashboard tool by the team. The Department has informally communicated to Regional Managers a target of less than ten percent overdue IPEs for the agency, by region and counselor. As of October 2017, performance data showed a decrease in agency-wide overdue IPEs compared to the previous fiscal year though not within the target range. Nonetheless, the average number of days taken to complete IPEs for all individuals has fallen to less than the required 90 days.

Department of Services for the Blind **Agency 315**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	010 (cont'd)		The Department may consider adding the performance expectations to the Regional Managers' 2018 performance evaluation process. The Department is in the final stage of revising the Washington Administrative Code (WAC) to align with the new Workforce Innovation and Opportunity Act of 2014 which will include the requirements of delay justification documentation. As of October 2017, the policy revision has been sent out to external partners and stakeholders for initial feedback. The revised WAC is expected to be published by December 2017 for public comments before being adopted as final policy. By December 2018, the Department will update sections of the Vocational Rehabilitation Procedures Manual including IPE development and related requirements, which will occur in tandem with the implementation of a new case management system. The updated procedure manual will reflect the internal controls in place for the IPE development process.
		Completion Date:	Corrective action is expected to be complete by December 2018
		Agency Contact:	Michael Mackillop Deputy Director PO Box 40933 Olympia, WA 98504-0933 (206) 906-5520 Michael.mackillop@dsb.wa.gov

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Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	021	Finding:	The Department of Early Learning did not have adequate internal controls over and was not compliant with requirements to ensure payments to child care providers for the Child Care and Development Fund program were allowable.
		Corrective Action:	The Department of Early Learning (Department) and the Department of Social and Health Services (DSHS) continue to make consistent progress in actively auditing and recovering overpayments. To address the auditors' recommendations, the Department has taken the following actions: • As of August 2016, began auditing providers based on month of payment rather than month of service in an effort to improve the timeliness of audit reviews. • Finalized changes to all program guidance and documentation, including the Child Care and Development Fund (CCDF) Plan, to align with federal and state regulations. Provider billing guides were updated and training provided to staff on the updates. • Improved internal controls and implemented preventative controls to assist in the detection of unallowable provider billing and reduce the risks of unallowable payments, including: o Recruited a Subsidy Policy Analyst tasked with monitoring the CCDF program compliance with state and federal laws. The incumbent: ▪ Acts as the lead on system implementation and training. ▪ Provides input on risk-based categories of pre-authorization review at DSHS. ▪ Works with DSHS to implement internal controls on eligibility determination and provider payments. ▪ Assists with implementing system changes at DSHS to alert staff when household composition differs between systems. ▪ Acts as the lead for corrective action plan implementation to address audit findings. o Clarified subsidy program rules and policies. Obtained provider feedback to improve training and to develop standardized record-keeping templates. o Began the development of rules and implementing policies to include the Department's definition of other intentional program violations, in addition to fraud, as well as consequences for clients and providers. • Developed a risk-based approach to audit providers' billings and payments that include selecting providers' billings in excess of licensed capacity and providers billing the limit of their authorizations. • Implemented a process where Subsidy Quality Assurance staff review provider billings by verifying parents' work schedules in Barcode to determine if the authorization is appropriate, and that the amount billed does not exceed the total authorized amount.

Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	021 (cont'd)	• Expanded auditor examinations when significant provider overpayments are found to determine if the issue is isolated or systemic. Thresholds by provider type have been determined for expanding review with training provided to staff. The Department also continue to work with DSHS to: • Review and process overpayments as required for questioned costs identified. • Coordinate the review of staff training, desk aids and communications, and jointly develop policies and procedures to ensure field staff understand and interpret eligibility policies correctly. • Address internal and external audit issues, and improve internal controls over client eligibility and directing payments to child care providers. • Ensure they are addressing known problems with the initial eligibility process for the CCDF program as a top priority. • Collaborate through the Working Connection Childcare reframe workgroup and the Child Care Audit Committee with focus on aligning and clarifying state rules and requirements with the reauthorization of the CCDF grant. The Department reinstituted a quarterly meeting of the Departments' Quality Assurance staff to discuss issues identified in the quality assurance process. The Department will continue to: • Improve the reconciliation process by following Department policies, and ensure the policies meet all federal and state regulations when reviewing provider payments. • Finalize the procurement and implementation of an electronic time and attendance reporting system that will maintain electronic copies of attendance records and potentially reduce provider errors. This system is scheduled to go live in July 2018 and will enable the Department to perform data analysis and audit of all payments to significantly increase fraud detection and referral. • Request additional funding from the Legislature to replace the 40-year-old mainframe-based authorization and payment processing system, Social Services Payment System. The new payment system will be capable of providing a robust provider interface and creating a rules engine solution that validates authorizations with attendance and billing data. Once these projects are complete, the combined systems will be able to generate accurate invoices and payments to providers. The conditions noted in this finding were previously reported in finding 2015-023, 2014-023, 2013-016, 12-28, 11-23, 10-31, 09-12, and 08-13. Completion Date: Corrective action is expected to be complete by July 2018

Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	021 (cont'd)	Agency Contact:	Mike Steenhout Chief Financial Officer PO Box 40970 Olympia, WA 98504-0970 (360) 725-4920 mike.steenhout@del.wa.gov

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Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	022	Finding: The Department of Early Learning did not have adequate internal controls over and did not comply with health and safety requirements for the Child Care and Development Fund program. Corrective Action: The Department concurs with this finding. To address the audit recommendations, the Department has implemented the following corrective actions: • Initiated emergency rulemaking and updated policies to clarify that licensors do not need to inspect inactive licensees. • Implemented new monitoring and compliance policies and procedures in July 2016, and provided training to licensing staff. • Created five new positions to address the workload increase created by the new federal regulations requiring the Department to monitor non-relative family, friend, and neighbor caregivers. • Restructured licensing regions in January 2017, to enable more efficient and effective management of licensing staffing and workload. • Launched an electronic caseload management system, WA Compass, in June 2017. The system allows licensing staff to make timely updates, improve data integrity, streamline staff work processes, and provide electronic reminders to licensing staff and supervisors. The new system also provides electronic tools for tracking the ten-day health and safety rechecks requirement. • Worked with the Department of Social and Health Services to review and process overpayments as required for questioned costs identified. The Department is also taking the following actions: • Rewriting all licensing policies and procedures to ensure that they align with current state and federal rules and regulations. Final implementation date is targeted for May 2018. • Requesting additional funding from the Legislature for additional employees needed to satisfy the licensor-to-childcare provider staffing ratio requirements of the Child Care and Development Fund Block Grant for fiscal year 2017. • Creating an objective enforcement system by weighing all licensing standards based on the level of risk to children. The system will connect licensing infractions with the level of risk to children and provide more information and clarity about the risk of each standard and the consequences for violations. This process is currently taking place and should be completed by end of October 2018. • Developing training for staff on the new system and new weighted licensing rules, and will create an on-going training plan for licensing staff. The conditions noted in this finding were previously reported in finding 2015-024.

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Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	022 (cont'd)	Completion Date:	Corrective action is expected to be completed by October 2018
		Agency Contact:	Mike Steenhout Chief Financial Officer PO Box 40970 Olympia, WA 98504-0970 (360) 725-4920 mike.steenhout@del.wa.gov

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Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019659	2016-001	Finding:	The Department of Early Learning did not establish adequate internal controls to ensure Needs-Based Grants recipients were eligible and used grant funds only for allowable purposes.
		Corrective Action:	The Department concurs with this finding. To address the auditors' recommendations, the Department has taken the following steps: • Established written policies and procedures for staff to follow when determining grant eligibility. • Updated the grants application to strengthen language regarding allowable uses and the requirement of proper record retention by grant recipients. • Implemented a dual approval process to ensure that applicants are eligible, have not already received a grant, and that they are receiving the proper grant amount. • Strengthened the Department's reconciliation process by the fiscal team with information recorded in the financial system to help ensure accurate payments are made to providers and to avoid duplicate payments. • Strengthened the Department's reconciliation process between payments processed by the fiscal team and the grants database. • Reviewed documentation to process an overpayment for the funds that were improperly granted to the in-home provider identified in the audit. • Created and implemented a process and procedures for selecting a valid sample from the population of program recipients to perform post-payment audit.
		Completion Date:	October 2017, subject to audit follow up
		Agency Contact:	Mike Steenhout Chief Financial Officer PO Box 40970 Olympia, WA 98504-0970 (360) 725-4920 mike.steenhout@del.wa.gov

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Department of Early Learning **Agency 357**
Department of Social and Health Services **300**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	020	Finding:	The Department of Early Learning and the Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to identify and detect fraud in the Child Care and Development Fund program.
		Corrective Action:	The Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) have taken the following actions: • As of January 2016, DEL implemented formal procedures for agency staff when potential fraud is suspected and reported to DSHS Office of Fraud and Accountability (OFA). A formal policy was also subsequently developed to address other overpayment issues not related to fraud findings. • DEL delivered fraud training, in collaboration with the DSHS OFA, to audit and licensing staff. The training took place in April and June 2016, and covered procedures for referring cases to the Subsidy Policy and Audit Manager, or designee, who makes the final decision to refer to OFA for action. • Conducted targeted training for licensing regional administrators to review recent referrals and identify best practices in recognizing and reporting suspected fraud. • Actively engaged in partnership with OFA to ensure more timely response and review of cases referred for investigation. DEL has also taken the following actions: • Developed and provided specific training to Subsidy Quality Assurance staff on identifying intentional program violations and suspected fraud. Training also included expanding review of provider attendance records in cases of program violations and suspected fraud to support investigation. • Recruited a Subsidy Policy Analyst responsible for developing an agency-wide fraud detection and referral system including risk-based fraud detection methods and case development. A process has been developed which ensures all incidents of suspected child care subsidy fraud are referred to OFA, as required. • Updated program rules such as reducing authorizations to Family, Friends and Neighbor providers under the 110-hour rule. • Developed rules and guidelines specifying consequences for attendance record deficiencies and other intentional program violations. • Employed a risk-based approach to audit providers billing and payments by assigning audit caseloads on a regional basis so that Subsidy Quality Assurance staff can foster better working relationships with providers to ensure compliance. • In July 2017, the Legislature required DEL to adopt rules to define intentional program violations and progressive sanctions. To meet this budget proviso requirement, rules have been drafted, filed, and will become effective on December 8, 2017. • Refined the formal policy and procedures to incorporate the newly adopted rules.

Department of Early Learning **Agency 357**
Department of Social and Health Services **300**

Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	020 (cont'd)	By March 1, 2018, DEL will begin sanctioning providers who repeatedly and intentionally violate program rules. DEL will continue to: • Provide statewide fraud trainings as needed and provide targeted training to licensing regional administrators on a quarterly basis. • Improve communication with DSHS and collaborated efforts to ensure accurate eligibility determination and authorization. • Finalize the procurement of an electronic time and attendance reporting system that will maintain electronic copies of records and potentially reduce provider errors. This system is expected to go live in February 2018 and will enable DEL to perform data analysis and audit of all payments to significantly increase fraud detection and referral. • Request additional funding from the Legislature to replace the 40-year-old mainframe-based authorization and payment processing system, the Social Services Payment System. The new payment system will be capable of providing a robust provider interface and creating a rules engine solution that validates authorizations with attendance and billing data. Once these projects are complete, the combined systems will be able to generate accurate invoices and payments to providers. DSHS has also taken the following actions: • The aged-out fraud referral cases that were identified in the audit were requests for current eligibility issues known as Fraud Early Detection (FRED) cases. Under the current system, referrals are assigned priority based upon an approved algorithm for fraud. These FRED cases are time sensitive and, if not completed timely, will be sent back to financial services workers. As of October 2017, OFA worked with the Economic Service Administration and designed the Intentional Overpayment Investigations (IOI) Priority Tool. The tool was implemented in Barcode and allows for appropriate adjustments to be made to the algorithm to include FRED cases, • Continued to follow up on open criminal fraud cases beyond the audit period since many child care fraud cases involve lengthy investigations. OFA shifted personnel resources within DSHS to work on the IOI backlog of cases received since 2016. The special project resulted in a significant decrease of backlog from 4,000 to 1,700 cases and $5.5 million in overpayments completed. • Performed cleanup of data contained in the DSHS's current case management system, and completed substantial upgrades and improved the functionality of the system. By December 2017, the strategic partnership with the developer will be extended for another two years. • OFA has been investigating all of the anticipated monthly DEL provider fraud referrals as resources permit without aging out the cases. DSHS will continue to review and improve its referral process.

Department of Early Learning **Agency 357**
Department of Social and Health Services **300**

Audit Report	Finding Number	Finding and Corrective Action Plan
2016 F	020 (cont'd)	• DSHS's Office of Financial Recovery is implementing a new case management system which will improve both the tracking and collection of fraud referrals by program types. The new system is expected to go live in January 2018. The conditions noted in this finding were previously reported in finding 2015-025. Completion Date: Corrective action is expected to be complete by March 2018 Agency Contact: Mike Steenhout Chief Financial Officer PO Box 40970 Olympia, WA 98504-0970 (360) 725-4920 mike.steenhout@del.wa.gov Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Department of Transportation **Agency 405**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	007	Finding:	The Department of Transportation did not have adequate internal controls over and did not comply with federal wage rate requirements for the High-Speed Rail Corridors program.
		Corrective Action:	As of November 2016, the Department requested and received the missing weekly-certified payrolls from Sound Transit, and has received certified payrolls for each subsequent Sound Transit invoice submitted. As of February 2017, the Department strengthened its invoice review process to include two independent reviews to verify that rail owners attach certified payrolls to invoices covering construction related activities.
		Completion Date:	February 2017, subject to audit follow-up
		Agency Contact:	Steven Meyeroff External Audit Liaison 310 Maple Park Avenue SE PO Box 47320, Olympia, WA 98504 360-705-7035 MeyeroS@wsdot.wa.gov

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Department of Ecology **Agency 461**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019361	2016-001	Finding:	The Department did not establish adequate internal controls to ensure wastewater discharge permit fees were properly assessed and billed.
		Corrective Action:	The Department concurs with this finding. To address the audit recommendations, the Department will take steps to improve internal processes and procedures for the Water Quality Permit Fee program. As of June 2017, the Department: • Followed up on permits that were found to be improperly assessed. • Refunded the customers who had overpayments identified in the audit. By February 2018, the Department will: • Establish policies and procedures over the billing process to: o Verify the accuracy of fees and ensure they are assessed in accordance with the fee schedule. o Reconcile between the permitting system and the billing system. o Determine when accounts can be adjusted or fees can be written off. o Ensure required documentation is obtained and reviewed. • Enhance the Department's billing system to allow effective reconciliation between permit issuances and collection of fees, and to monitor billings and adjustments. • Develop billing system reports to enable reconciliation with the fee system.
		Completion Date:	Corrective action is expected to be complete by February 2018
		Agency Contact:	Lisa Darnell Fiscal Manager PO Box 47615 Olympia, WA 98504-7615 (360) 407-7052 Lisa.darnell@ecy.wa.gov

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Department of Fish and Wildlife **Agency 477**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019710	2016-001	Finding:	The Department of Fish and Wildlife did not adequately monitor wildlife damage prevention contracts.
		Corrective Action:	The Department concurs with the audit finding. To address auditors' recommendations, the Department is taking the following corrective actions: • Create standardized "Range Rider" field journal templates for vendors to include the required elements. The templates will be posted on the Department's website to ensure consistency. • Reconcile the number of hours or days invoiced by vendors to field journals. • Ensure contract cost share provisions are properly accounted for on each invoice payment. • Ensure only properly documented costs are eligible for reimbursement. The Department will also take the following actions: • Request repayment from vendors for the known material overpayments identified in the audit. • Clearly describe the Statement of Work on future contracts with vendors, and specify whether vendors are authorized to bill for services by daily rates or hourly rates.
		Completion Date:	Corrective action is expected to be complete by June 2018
		Agency Contact:	Mario Cruz Internal Audit Manager 1111 Washington Street SE Olympia, WA 98501 (360) 902-2420 Mario.cruz@dfw.wa.gov

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Department of Natural Resources **Agency 490**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1017809	2015-001	Finding:	The Department of Natural Resources did not establish adequate internal controls over its orchard and vineyard leases.
		Corrective Action:	To address the auditor's recommendations, the Department is taking the following corrective actions: • Revise the procedure related to orchard and vineyard leases to improve accountability on costs and production. • Develop a procedure for program staff to provide guidance on performing required field inspections for all Agriculture Program leases. • Continue to transition share-crop leases to cash leases. • Ensure Harvest Reports are submitted timely and entered into the Department's data system. Reports will be generated on a regular basis to monitor compliance. • Provide training to staff on the updated and new program procedures, including field inspections, orchard and vineyard revenue reconciliations and lessee expense deductions. • Review the leases with unsupported expense deductions identified by the auditors and perform revenue reconciliation.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Jennifer Woods Department Auditor PO Box 47001 Olympia, WA 98504 (360) 902-1040 Jennifer.woods@dnr.wa.gov

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Employment Security Department **Agency 540**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	005	Finding:	The Employment Security Department made unsupported payments to Trade Readjustment Allowance program participants under the Unemployment Insurance program.
		Status:	Corrective action in progress
		Corrective Action:	As of October 2016, the Department established new procedures over the Trade Readjustment Allowance program which includes payment documentation and retention requirements, and managerial oversight and review processes. As of December 2016, manuals were developed to provide guidance to staff on the newly implemented policies and procedures to ensure program compliance and payment accuracy. As of January 2017, the Department implemented the Unemployment Tax and Benefit (UTAB) system to help automate and improve payment accuracy. UTAB is also used by the Trade Readjustment Allowance programs for maintaining payment documentation and record retention. By December 2017, the Department anticipates receiving the final determination letter from the U.S. Department of Labor and will determine what, if any, costs need to be repaid. The conditions noted in this finding were previously reported in finding 2015-008.
		Completion Date:	Corrective action is expected to be complete by December 2017
		Agency Contact:	Ben Hainline Director of Internal Audit PO Box 46000 Olympia, WA 98504-6000 (360) 902-9276 bhainline@esd.wa.gov

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Employment Security Department **Agency 540**

Audit Report	Finding Number	Finding and Corrective Action Plan	
2016 F	006	Finding:	The Employment Security Department did not establish adequate internal controls over its Next Generation Tax System, which led to improper computations of employer unemployment insurance tax rates.
		Corrective Action:	The Department has established a Next Generation Tax System (NGTS) Interfaces and Data Quality Assurance project team, which comprised of 29 employees and 44 contractors from the business and technology sectors. The team is dedicated to addressing the concerns over improper computations of employer insurance tax rates and billings in NGTS. The project team is also working on improving the system's internal controls related to processing transactions and reporting. In addition, the Department has contracted with Microsoft to remediate technical issues with NGTS and work on eliminating any identified deficiencies. The Department has also implemented a reconciliation process between the Employer Account Management system and NGTS to ensure wage and payment information transmitted between the two systems is complete and accurate. The Department has established improvement goals and tracking its progress on correcting issues associated with improper tax rates. Since May 2017, the Department has made consistent improvement in meeting established goals. As of October 2017, the Department continued to make good progress on process improvements and meeting data accuracy goals that led to increase in overall billing and tax rate accuracy. The Department also anticipates making frequent incremental progress throughout 2018. The conditions in this finding were previously reported in finding 2015-002.
		Completion Date:	Corrective action is expected to be complete by December 2018
		Agency Contact:	Ben Hainline Director of Internal Audit PO Box 46000 Olympia, WA 98504-6000 (360) 902-9276 bhainline@esd.wa.gov

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Lower Columbia College **Agency 657**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1018662	2015-001	Finding:	The College should improve internal controls over its financial statement preparation.
		Corrective Action:	The errors identified by the auditors were corrected in the College's final financial statements In response to the audit findings of the fiscal year 2014 financial statements, the College had already implemented some vital changes to improve internal controls in financial statements preparation and submission. As a result, the misclassifications that were identified during the prior year's audit were not repeated in the current year's financial statements. To address the audit recommendations, the College has also taken the following actions: • As of September 2017, a new Finance Director was hired to continue providing expertise and oversight over the prepartion of financial statements. • Contracted with a CPA firm to assist with the completion of the fiscal year 2017 financial statements, which include: o Performing a review of year-end adjusting journal entries to ensure they are accurate and complete. o Conducting a final review of the financial statements to ensure they comply with all applicable Governmental Accounting Standards Board requirements and generally accepted accounting principles. o Providing technical training to the Finance Director and Accounting Manager related to financial statement preparation. To prepare for the fiscal year 2018 financial statements cycle, the College has also incorporated outside education and training resources recommended by the auditors into the training program for staff.
		Completion Date:	Corrective action is expected to be complete by June 2018
		Agency Contact:	Nolan Wheeler Vice President of Administration 1600 Maple Street Longview, WA 98632 360-442-2201 nwheeler@lowercolumbia.edu

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Lower Columbia College **Agency 657**

Audit Report	Finding Number	Finding and Corrective Action Plan	
1019948	2016-001	Finding:	The College's internal controls over financial statement preparation were inadequate to ensure complete and accurate reporting.
		Corrective Action:	The errors identified by the auditors were corrected in the College's final financial statements. The College experienced some turnover in key positions during the financial statements preparation which impacted the level of oversight over the process. To address the audit recommendations, the College has taken the following actions: • As of September 2017, a new Finance Director was hired to continue providing expertise and oversight over the prepartion of financial statements. • Contracted with a CPA firm to assist with the completion of the fiscal year 2017 financial statements, which include: o Performing a review of year-end adjusting journal entries to ensure they are accurate and complete. o Conducting a final review of the financial statements to ensure they comply with all applicable Governmental Accounting Standards Board requirements and generally accepted accounting principles. o Providing technical training to the Finance Director and Accounting Manager related to financial statement preparation. To prepare for the fiscal year 2018 financial statements cycle, the College has also incorporated outside education and training resources recommended by the auditors into the training program for staff.
		Completion Date:	Corrective action is expected to be complete by June 2018
		Agency Contact:	Nolan Wheeler Vice President of Administration 1600 Maple Street Longview, WA 98632 360-442-2201 nwheeler@lowercolumbia.edu

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Schedule 2 – Fraud Findings by Agency

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Department of Social and Health Services **Agency 300**

Audit Report	Finding Number	Finding and Resolution	
1018397	001	Finding:	There were insufficient internal controls at Western State Hospital to adequately monitor a psychiatrist's presence at his assigned workstation during regular and extra-duty hours.
		Fraud Amount:	None
		Amount to be Recovered:	None
		Recovery to Date:	Not applicable
		Resolution/ Status:	As of March 2016, the Department implemented a new process for tracking and monitoring psychiatrists and physicians work times: • Requiring physicians to attest for their presence at work on Accountability Forms and submit to their immediate supervisors on a weekly basis for review. • Requiring supervisors to forward the reviewed Accountability Forms to the Medical Director's Office for additional review. • Reconciling the Accountability Forms and timesheets by the Medical Director's Office, if discrepancies exist, employees are required to submit leave slips and correct their timesheets accordingly. • Requiring the Medical Director's Office to approve monthly timesheets before they are forwarded to the payroll office. As of June 2016, the Department: • Notified all psychiatrists and physicians by email of the new time and attendance directives. • Required physicians who arrange cross coverage for regularly scheduled shifts to obtain prior approval from their respective supervisors. Physicians will record their work time on the new Accountability Forms.
		Personnel Action Taken:	None
		Criminal Action Taken:	None
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

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Community Colleges of Spokane **Agency 676**

Audit Report	Finding Number	Finding and Resolution	
1019179	001	Finding:	The College investigated and reported a potential loss of public funds from an employee who made questionable purchasing card activity that occurred between July 2009 and June 2015.
		Fraud Amount:	$33,654
		Amount to be Recovered:	$38,451
		Recovery to Date:	$0
		Resolution /Status:	To address the auditors' recommendations to strengthen internal controls over the heating, ventilation and air conditioning (HVAC) division's purchasing card activities, the College's Facilities Maintenance Department has taken the following immediate actions: • Requires each purchase card purchase be supported by an original receipt and attached to the purchase card transaction log. • Requires Department supervisors to perform regular review of the transaction log and purchase receipts to determine if the purchases were made for work-related purposes. • Requires work orders to be closed simultaneously by supervisor, administrative staff and craftsman/employee assigned to the work orders to prevent purchases made against closed work orders. The Director of Facilities Maintenance will also increase oversight and monitoring to include detailed review of all receipts and identify any suspicious activities that are incongruent with the HVAC division purchases for open work orders. Any suspicious activities will be followed up with the employees responsible for making the purchases. In addition, the College's Accounting Department maintains administrative procedures for the purchasing card program which detailed responsibilities of the: • Cardholders • Card statement reconcilers • Approving officials • Expense accounting department staff The administrative procedure also require the: • Purchase cardholders, card custodians and reconcilers to complete required training as provided by the purchase card unit. • Cardholders to have current user agreements in place. • Expense Account Supervisor to monitor and track training status. • Department Administrator to approve spending limits and approval signature on all new card applications. • Cardholders to make purchases according to purchasing policy and procedures.

Community Colleges of Spokane **Agency 676**

Audit Report	Finding Number	Finding and Resolution	
1019179	001 (cont'd)	Personnel Action Taken:	The employee was terminated on September 30, 2015.
		Criminal Action Taken:	The College has filed a report with the Spokane Police Department, and is waiting on notification from the Spokane Prosecuting Attorney's Office as to whether charges will be filed against the former HVAC Supervisor. Upon notification, the College will assist the Prosecuting Attorney's Office in the prosecution and recovery of questionable transaction amounts.
		Agency Contact:	Lisa Hjaltalin Chief Financial Officer/Risk Manager 501 N. Riverpoint Blvd. Spokane WA 99217 (509) 434-5275 Lisa.Hjaltalin@ccs.spokane.edu

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