Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	002	Finding:	The Department of Social and Health Services improperly charged $454,838 to the SNAP Cluster.
		Corrective Action:	The Department concurs with the finding. In response to prior audit findings, the Department had taken steps to correct the deficiencies identified by the auditors. As of March 2017, the Department's Economic Services Administration implemented a mandatory process for staff to include the month of service (MOS) to transactions processed in the Agency Financial Reporting System (AFRS). The Department utilizes the MOS to perform a monthly review of AFRS transactions to identify unallowable charges and move them to the proper grant year via the journal voucher process. However, at the time of this audit, the Department has not established a process to ensure staff were following procedures to meet period of performance requirements. As of December 2018, the Department had moved the improperly charged expenditures identified in the audit to the proper grant year via the journal voucher process. As of February 2019, the Department updated processes and procedures for management oversight to prevent future expenditures from being improperly charged to the wrong grant year. The Department: • Assigned backup coverage during staff absences. • Began reviewing and monitoring monthly expenditure reports, and taking action where appropriate. • Increased staff accountability through the use of a monthly task list. • Began meeting monthly with the Accounting and Internal Control Administrator to provide updates on corrective action status related to period of performance issues. If the grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in findings 2017-002, 2016-002, 2015-003, and 2014-022.
		Completion Date:	February 2019, 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 Status	
2018 F	021	Finding:	The Department of Social and Health Services did not have 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:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with eligibility timelines and required procedures. As of April 2019, the Department implemented the following procedures: • The Fiscal Compliance Manager conducts six-month review of eligibility extensions to identify cases that do not conform to policy and documentation requirements. These cases are sent to the respective supervisors for follow-up. • Supervisors' monthly case reviews now include mandatory follow-up activities to ensure reviews are effective and properly documented. • Rehabilitation Technicians review cases coming due within 30 days for eligibility determination and alert counselors of upcoming due dates. • Supervisors complete an on-line coaching tool monthly with Rehabilitation Technicians, as needed. As of June 2019, the Department: • Revised the eligibility extension letter to include a mandatory field for the extension end date. • Amended eligibility extension procedures to require follow-up with clients when extension letters are not returned. As of October 2019, the Department: • Enhanced the case management report to identify eligibility extension dates and determination completion dates. • Provided training to staff on updated procedural guidance that clearly define "exceptional and unforeseen circumstances." By December 2019, the Department will update the eligibility extension process in the case management system to auto-generate: • Case narratives • Client letters • Completion dates The conditions noted in this finding were previously reported in findings 2017-013 and 2016-012.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	021 (cont'd)	Completion Date: Corrective action is expected to be complete by January 2020 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 Status	
2018 F	022	Finding:	The Department of Social and Health Services did not have 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:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with timelines and required procedures. As of April 2019, the Department implemented the following procedures: • The Fiscal Compliance Manager conducts a six-month review of individual plans of employment (IPE) to identify cases that do not conform to policy and documentation requirements. These cases are sent to the respective supervisors for follow-up. • Supervisors correct any IPE that does not conform to policy and documentation requirements. • Rehabilitation Technicians review IPEs coming due within 30 days and alert counselors of upcoming due dates. • Supervisors complete an on-line coaching tool monthly with Rehabilitation Technicians as needed. As of May 2019, the Department revised the eligibility determination letter to include an appointment date with the client to begin the IPE process. As of June 2019, the Department amended procedures to require counselors to follow-up with clients when IPE extension letters are not returned, and to ensure both counselor and client properly approve the completed IPE. As of August 2019, the Department provided training to field staff on the new procedures. The conditions noted in this finding were previously reported in findings 2017-012 and 2016-011.
		Completion Date:	August 2019, 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 Status	
2018 F	023	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with federal requirements to ensure payments paid on behalf of clients for Vocational Rehabilitation were allowable.
		Corrective Action:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with allowable uses of program funds. As of March 2019, the Department issued a directive requiring case records to be reviewed prior to authorization of services. Staff perform reviews to ensure: • Services are properly documented in the individual plan for employment (IPE). • The IPE has been approved by the counselor and client. • Case actions are appropriately referred to the supervisor if necessary. As of May 2019, the Department: • Updated procedures to clarify that payments for any authorized services on an IPE cannot be made until the IPE is properly signed by client. • Created detailed procedures for supervisors to conduct monthly review of payments. • Enhanced the case management system's preventative controls to only allow authorizations of services that are included on the IPEs. If an emergency, non-authorized service is needed, supervisory approval is required to proceed. • Consulted with the grantor to determine whether any questioned costs need to be repaid. As of July 2019, the Department reviewed all service category requirements from the Department of Education and identified process improvements. The conditions noted in this finding were previously reported in findings 2017-014 and 2016-013.
		Completion Date:	July 2019, 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 Status	
2018 F	024	Finding:	The Department of Social and Health Services did not have adequate internal controls to ensure its federal financial reports for the Vocational Rehabilitation grant were accurately prepared.
		Corrective Action:	The Department concurs with the finding. As of September 2018, the Department established written procedures to require secondary reviews of the Federal Financial Report (SF-425). As of April 2019, the Department established written procedures to require secondary reviews of the Program Cost Report (RSA-2). The Finance and Budget Manager reviews completed reports for accuracy. The Department continues to strengthen internal controls over reporting to ensure program reports are complete and accurate.
		Completion Date:	April 2019, 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 Status	
2018 F	025	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional and National Significance and Block Grants for Prevention and Treatment of Substance Abuse programs received required audits.
		Corrective Action:	As of July 1, 2018, the Behavioral Health Administration's Division of Behavioral Health and Recovery was transferred from the Department to the Health Care Authority (Authority). The Authority assumed the responsibilities over the Block Grants for Prevention and Treatment of Substance Abuse and Substance Abuse and Mental Health Services Projects of Regional and National Significance. As of October 2019, the Authority established a work group to coordinate the efforts of multiple divisions across the agency and work on establishing an overall subrecipient monitoring process. By March 2020, the Authority will: • Evaluate the existing process in monitoring subrecipient audits and identify potential improvements. • Assess and update policies and procedures related to subrecipient monitoring. • Strengthen internal controls to ensure: o Subrecipients submit required audits. o Subrecipients take timely actions on all deficiencies identified from audits or onsite reviews. o All audit findings and corrective action plans are tracked and management decisions are issued promptly. The conditions noted in this finding were previously reported in findings 2017-016, 2016-014, 2015-016, and 2014-019.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager State Health Care Authority PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	026	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to ensure payments to child care providers paid with Temporary Assistance for Needy Families funds were allowable.
		Corrective Action:	The Department partially concurs with the finding. The Department works with the Department of Children, Youth, and Families (DCYF) to ensure payments to child care providers paid with Temporary Assistance for Needy Families funds were allowable. DCYF 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. In response to prior findings, the Department has implemented internal controls including: • Third-party reviews through the establishment of the Process Review Panel (PRP) to review and evaluate audit findings, explore options and recommend appropriate corrective actions. • Pre-authorization reviews on high-risk and/or high cost cases based on trend analysis discovered during the PRP. As of December 2018, DCYF requires all licensed providers who accept subsidy payments to use DCYF's electronic attendance system or an approved third party system to track attendance. DCYF's system enables accurate, real-time recording of child care attendance, tracks daily attendance, and captures data on child care usage. DCYF has since expanded the requirement to all families, friends and neighbor providers. Beginning July 1, 2019, the Department will transfer responsibility for administering all aspects of client eligibility determination and child care provider payment to DCYF. The Department will continue to conduct post-payment reviews where improper payments appear likely to have occurred, or refer to DCYF for review. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and take appropriate action. The conditions noted in this finding were previously reported in findings 2017-017 and 2016-019.
		Completion Date:	February 2019, 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 Status
2018 F	027	Finding: The Department of Social and Health Services did not have adequate internal controls over maintenance of effort requirements for the Temporary Assistance for Needy Families grant. Corrective Action: The Department partially concurs with the finding. In response to prior years' findings, the Department has taken actions to improve internal controls over the maintenance of effort (MOE) process for the Temporary Assistance for Needy Families (TANF) grant. As of February 2017, the Department developed manuals that outline the collaborative report preparation procedures among the Community Services Division, the Research and Data Analysis Division (RDA) and the Division of Finance and Financial Recovery. As of March 2018, the Department: • Hosted weekly workgroup meetings to review and update existing policies, procedures and manuals as necessary. The workgroup also focuses on improving the Department's ability to forecast and monitor the level of TANF program's MOE expenditures throughout the year. • Implemented a quarterly monitoring and reporting schedule for all MOE sources throughout the federal fiscal year to ensure MOE reported expenditures are allowable and accurate. • Established a process for reviewing future budgets on programs subject to MOE requirements by: o Performing trend analysis by comparing budget data to previous years to ensure there is no significant fluctuations. o Obtaining written confirmation from partnering sources at the beginning of the federal fiscal year that program operations and expenditure levels will be similar to the previous year. o Reviewing TANF MOE reports and monitor departmental expenditures on a quarterly basis to ensure MOE requirements will be met. The Department's RDA Division is also taking actions to improve internal controls for ensuring the TANF quarterly reports are accurate and complete. By January 2020, the Division will: • Track which employees make coding changes. • Require that supervisors review coding changes and document these reviews. • Add a section in the TANF MOE manual outlining the roles and responsibilities of employees who make coding changes and for management who review those changes. The conditions noted in this finding were previously reported in findings 2017-019, 2016-017 and 2015-020.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	027 (cont'd)	Completion Date: Corrective action is expected to be complete by January 2020 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 Status	
2018 F	028	Finding:	The Department of Social and Health Services did not have adequate internal controls in place to ensure quarterly reports for the Temporary Assistance for Needy Families Grant were submitted accurately.
		Corrective Action:	The Department partially concurs with the finding. The Department currently has processes in place to ensure the accuracy and completeness of quarterly reports for the Temporary Assistance for Needy Families Grant (TANF). Specifically, the Department: • Maintains extensive documentation on algorithms for deriving the items in the federal transmission, including specifications on tables and codes in the Automated Client Eligibility System and the Social Service Payment System, and how Statistical Analysis System processes use this data to comply with reporting requirements. • Runs a quality assurance process for each report that identifies potential fatal and warning edits, the results of which are reviewed by the Supervisor. The Department has documented the quarterly reporting processes in detail, and continues to extend and update documentation, written policies and procedures for this complex reporting process. While the Department may benefit from a more formal process, the review of both code and results is extensive and the process includes monthly dissemination of summary data to multiple partners for review and validation. The established process ensures quarterly reports required for meeting participation rates are accurate, complete and submitted timely. The Department believes that the controls for change requests, coding updates and the approval processes are adequate. As of October 2018, the Department began manual monitoring, reviewing, and testing of coding changes to ensure they were applied correctly. While no version control software was used, Department staff maintained copies of all old code versions using filename conventions. As of October 2019, the Department updated documentation to reflect automation enhancements to existing data set generation and reporting processes. By January 2020, the Department will • Implement the use of technical assessment forms and security review forms. • Conduct peer reviews and document results, testing, logging and approval prior to moving code changes into the production environment.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	028 (cont'd)	The conditions noted in this finding were previously reported in findings 2017-020 and 2016-016. Completion Date: Corrective action is expected to be complete by January 2020 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 Status	
2018 F	029	Finding:	The Department of Social and Health Services did not have adequate internal controls in place for submitting quarterly and annual reports for the Temporary Assistance for Needy Families grant.
		Corrective Action:	The Department does not concur with the finding. In response to prior years' findings, the Department has taken actions to improve internal controls over the reporting process for the Temporary Assistance for Needy Families (TANF) grant. As of March 2018, prior to the end of the audit period, the Department fully implemented the following process changes: • Hosted weekly workgroup meetings to review and update existing policies and procedures as necessary to strengthen internal control. • Implemented a quarterly monitoring and reporting schedule for all maintenance of effort (MOE) sources to ensure reported expenditures are allowable, accurate and submitted in a timely manner. • Established a process for reviewing future budgets on programs subject to MOE requirements: o Perform trend analysis by comparing budget data to previous years to ensure there is no significant fluctuations. o Obtain written confirmation from partnering sources at the beginning of the federal fiscal year that program operations and expenditure levels will be similar to the previous year. o Review TANF MOE reports and monitor departmental expenditures on a quarterly basis to ensure MOE requirements will be met. Additionally, the Department: • Reviews all reported expenditures to ensure they are accurate, verifiable, and not used for other federal matching purposes, • Maintains all supporting documentation locally and electronically for the reports submitted to the federal grantor. The Department maintains that current processes and procedures are adequate to ensure expenditures are verifiable and meet federal regulations. The conditions noted in this finding were previously reported in findings 2017-021, 2016-018, and 2015-021.
		Completion Date:	Not applicable
		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 Status	
2018 F	030	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 Working Connections Child Care program.
		Corrective Action:	The Department partially concurs with the finding. The exceptions identified by the auditor results from minor procedural errors or incorrect calculations that did not have an effect on the eligibility determinations. While some of these errors caused payment errors, the clients were eligible. In response to the fiscal years 2016 and 2017 findings, the Department has enacted major changes to improve internal controls over eligibility determination. Many of these changes were implemented during fiscal year 2018, while some were implemented at the beginning of fiscal year 2019. The Department of Children, Youth, and Families (DCYF), formerly the Department of Early Learning, established child care program policies. DCYF policy does not require secondary review or approval when determining eligibility, or authorizing benefits and payments. Beginning July 1, 2019, the Department will transfer responsibility for administering all aspects of client eligibility determination and child care provider payment to DCYF under the Child Care Development Fund. The Department has continued to employ the following controls to ensure child care subsidy payment authorizations are made correctly: • Require a supervisory review of payment requests that exceed certain parameters. The supervisor reviews the justifications for the need of additional payment and will deny the payment if the client is not eligible. A monthly report is generated and supervisor checks for any authorization that appears to have been approved without the required secondary review. • For authorizations with high cost special needs rates, a panel consisting of DSHS and DCYF staff review the request and supporting documentation prior to approval. The authorization is subsequently reviewed by a supervisor prior to payment. • Require one hundred percent of new employees' work be audited by a lead worker until they achieve proficiency. These reviews may be conducted before or after authorization. • Requires at least one percent of child care cases be audited monthly. • Participate in the Improper Payments Information Act audit required by the Federal Office of Child Care and conducted by the DCYF once every three years. As of August 2017, the Department: • Implemented enhancements in the Barcode system to automatically generate a sixty-day reminder letter requesting income verification of new employment.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	030 (cont'd)	• Created a 9-code avoidance report that identifies cases that may require supervisory approval. These cases are reviewed and returned to the employee for coaching and corrective action. As of February 2018, the Department implemented a child care process review panel within the Department's Division of Program Integrity. A child care quality team reviews cases, verifies circumstances and determines whether each sampled case has been correctly determined in accordance with state policy and procedure. As of March 2018, the Department: • Completed enhancements to the Barcode system to automatically flag cases when the household composition for child care is different than information entered in other state systems. Procedures were also updated to require comparison of household composition data reported for childcare against those reported for other programs when determining eligibility. • Updated appropriate state rules, procedures and trainings to strengthen: o Household composition rules including a new policy for single parent households. o Mandatory cross-matching with other state systems. o Required documentation for new employment wage verification. In preparation for the transfer of the child care program to DCYF, the Department has been collaborating with DCYF to update policies and procedures, and develop system enhancements to correct deficiencies and improve internal controls. As of October 2018, the Department: • Updated a combined policy manual which is accessible on the DCYF website to ensure consistent guidance is provided to staff. • Established an integrity review process for eligibility determinations that are made by a worker who was not assigned to the case through the automated workload assignment system. • Worked with DCYF to ensure family, friends, and neighbors providers receive DCYF's full portable background checks and are approved by DCYF as providers. Upon approval of a background check, DCYF assigns a vendor number, which together with the provider's eligibility information, is communicated to the Department for creating an authorization. As of January 2019, the Department and DCFY developed a policy that provides guidance on viewing documents/information for relative validity, and on the process of prioritizing the best information to obtain first to ensure determinations are supported. As of May 2019, the Department reviewed the fiscal year 2018 audit exceptions, established and referred the appropriate overpayments to the Office of Financial Recovery for collection.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	030 (cont'd)	If the grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs with the grantor and take appropriate action. The conditions noted in this finding were previously reported in findings 2017-026, 2016-023, 2015-026, 2014-026, 2013-017 and 12-30. Completion Date: May 2019, 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 Status	
2018 F	031	Finding:	The Department of Social and Health Services improperly charged payroll costs to the Child Support Enforcement Grant.
		Corrective Action:	The Department partially concurs with the finding. The Department does not concur that some timesheets were not processed. The timesheets in question were for employees whose time was spent processing negotiables for another Administration. For this work, the Department bills the other Administration for the work performed and records the revenue as a reduction to expenditures for the grant. The Department also does not concur with the auditor's determination of $29,733 questioned costs on this finding. The Department discovered a calculation error on the questioned costs cited in the fiscal year 2017 finding during the process of closing the prior finding with the cognizant federal agency. This discovery prompted the Department to review the auditors' testing and calculation of questioned costs in the fiscal year 2018 finding. Based on the review, the Department believes that $24,250 of the $29,733 questioned costs were allowable costs. The Department calculated the actual questioned costs to be $5,484. To address the audit recommendations, the Department has initiated actions to improve processes and controls. As of August 2018, the Department: • Created a new journal voucher template with correct formulas to perform calculations and allocate the payroll costs from the grant to other activities associated with work by these employees. • Implemented a supervisory review process prior to processing journal vouchers. • Began the process of separating journal vouchers by funding source to reduce the complexity and volume of journal vouchers. As of April 2019, the Department: • Reviewed current procedures for processing journal vouchers and strengthened controls as necessary to ensure they are all processed. • Corrected accounting records to reverse costs that were inappropriately charged to the Child Support Enforcement grant. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in finding 2017-023.
		Completion Date:	April 2019, subject to audit follow-up

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Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	031 (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

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	036	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to detect fraud in the Child Care and Development Fund program.
		Corrective Action:	The Department concurs with the audit finding. In response to prior audit recommendations, the Department took steps to include child care dollars as a risk factor in determining the priority of fraud referral investigations. In December 2017, the Department convened a workgroup to modify the Fraud Early Detection program (FRED) algorithm to address child care cases while not adversely affecting other medical programs that also use the FRED algorithm. In February 2018, the Office of Fraud and Accountability's (OFA) Senior Director issued a directive to managers that all cases rated as 1 or 2 should be assigned for investigations within 90 days after referral. As of April 2018, an algorithm was implemented in the Barcode system to include child care benefit payments and household composition. This enhancement increases the assigned point values in child care cases, resulting in a higher priority level for investigation. The Department will continue to: • Maintain a goal of completing as many of the fraud cases with highest risk as staffing and workload allows. • Monitor the monthly status of all FRED cases by OFA managers to ensure high priority cases are assigned timely. • Review monthly performance measurement reports. The conditions noted in this finding were previously reported in findings 2017-027, 2016-020 and 2015-025.
		Completion Date:	April 2018, 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 Status	
2018 F	037	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure it separately identified and reported demonstration project costs.
		Corrective Action:	The Department concurs with the finding. As of July 1, 2018, the Legislature created a new state agency that combined the Department's Children's Administration and the Department of Early Learning. The new agency is called the Department of Children, Youth and Families (DCYF) and is now responsible for managing the Foster Care program. DCYF assigned specific system coding in FamLink, the system used to track costs for service payments and contracts. The new codes track payments made for the demonstration project. The Department revised its reporting process to separately identify and report project costs for both the Title IV-E Foster Care program and the demonstration project. The Department will work with the grantor if revisions to prior reports are determined to be necessary.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison Department of Children, Youth and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	038	Finding:	The Department of Social and Health Services improperly charged $798,930 to the federal foster care grant.
		Corrective Action:	The Department partially concurs with the audit finding. The auditors determined that $797,740 of federal expenditures were not supported because this amount could not be reconciled between the Department's provider payment system (SSPS) and the State's accounting system (AFRS). While SSPS does interface with AFRS, it is not the only payment mechanism utilized when paying for eligible foster care services. As such, there will always be a difference in the total expenditures between the two systems. In response to the audit findings, the Department: • Provided training to accounting field staff on the invoice payment process, and emphasized the requirement of reviewing proper documentation when making invoice payments to vendors. • Informed providers of the requirement of providing adequate supporting documentation to align with the Department's internal procedure. • Strengthened the review process to ensure services are authorized prior to making payments. The Department will consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid. As of July 1, 2018, the Legislature created a new state agency that combined the Children's Administration of the Department and the Department of Early Learning. The new agency is called the Department of Children, Youth, and Families and is now responsible for managing the Foster Care program. The conditions noted in this finding were previously reported in finding 2017-028.
		Completion Date:	November 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison Department of Children, Youth, and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	039	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 concurs with the finding. In response to prior audit findings, the Children's Administration of the Department had improved internal controls and developed written policies and procedures to ensure the federal level of effort requirements are met for the Adoption Assistance program. As of July 1, 2018, the Legislature created the Department of Children, Youth, and Families (DCYF) by combining the Children's Administration and the Department of Early Learning. The new agency assumed the responsibilities of managing the Adoption Assistance program. To address the audit recommendations, DCYF has implemented appropriate corrective actions, which include: • Established written procedures for staff to identify and accurately report adoption savings expenditures. • Reviewed annual reports to ensure reported expenditures are accurate and supported by adequate documentation. • Provided training to staff on the policies and procedures. The conditions noted in this finding were previously reported in findings 2017-030 and 2016-026.
		Completion Date:	September 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison Department of Children, Youth, and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	050	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration made improper Medicaid payments to individual providers when clients were hospitalized or admitted to long-term care facilities.
		Corrective Action:	The Department partially concurs with the finding. As stated in the background of this finding, the auditor could not determine in the fiscal year 2017 audit whether the duplicate expenditures identified were caused by billing errors of the individual providers, or the hospital or long-term care facility. For this reason, the auditor did not issue a finding. For the fiscal year 2018 audit, the auditor used the same audit methodology and issued a finding. However, the auditor failed to provide a rationale as to how they were able to determine the source of the billing errors or why those errors were attributed to the Department. It is not known whether the payments were incorrectly claimed by the individual provider, or the hospital or nursing facility. The Department had developed a process to research and remediate payments made to in-home providers while a client was either hospitalized or admitted to a long-term care facility: • As of November 2018 , the Department: o Created a report to identify payments made to all provider types for in-home personal care and mileage services while the client was in the hospital or in a long-term care facility. o Hired an employee to perform payment analysis and coordinate remediation with field contacts. • As of January 2019, the Department began reviewing, processing and tracking the duplicate payments that were identified. As of June 2019, the Department worked with the Health Care Authority to analyze the duplicate payments found and identified the ones that the Department is responsible for. By February 2020 : • The Department will begin the process of issuing overpayments to the providers for any unallowable payments. • The overpayment functionality in the Department's Individual ProviderOne system is expected to be fully implemented. By June 2020, the Department will consult with the Department of Health and Human Services to discuss any remaining questioned costs. The conditions noted in this finding were previously reported in finding 2016-048.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	050 (cont'd)	Completion Date: Corrective action is expected to be complete by June 2020 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 Status	
2018 F	051	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration made improper Medicaid payments to individual providers when clients were hospitalized or admitted to long-term care facilities.
		Corrective Action:	The Department concurs with the finding. The Department is in the process of enhancing monitoring procedures for identifying unallowable payments. By January 2020: • The overpayment functionality in the Department's Individual ProviderOne system is expected to be fully implemented. • The Department will begin the process of issuing overpayments to the providers for any unallowable payments. The Department will work with the federal grantor to determine if any questioned costs identified in the audit and associated costs need to be repaid.
		Completion Date:	Corrective action is expected to be complete by January 2020
		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 Status	
2018 F	052	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 survey requirements for Medicaid intermediate care facilities.
		Corrective Action:	The Department partially concurs with the finding. The Department utilizes a survey-tracking tool to monitor survey due dates and completion, and has established internal controls to ensure survey requirements for Medicaid intermediate care facilities are met. The one recertification that was performed past its due date in April 2018 was not an indication of internal control deficiency, but rather a result of resource prioritization. The facility was non-compliant with a condition of participation from a prior recertification survey, and was imposed with a "Denial of Payment" penalty for new admissions. After receiving the facility's credible allegation of compliance letter in January 2018, the Department conducted two re-survey visits and subsequently placed the facility back in compliance in March 2018. The facility's recertification was performed in May 2018 due to the Department's executive decision to prioritize a recertification survey of another facility that had been out of substantial compliance and placed clients' safety and welfare at risk. As of April 2019, the Department requested assistance from: • Certified surveyors of other units within Residential Care Services as needed. • The federal grantor's contracted certified surveyors, if available, to meet compliance with survey intervals. The Department will continue to ensure survey requirements are met. The conditions noted in this finding were previously reported in finding 2017-042, 2016-037, 2015-045, and 2014-046.
		Completion Date:	April 2019, 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 Status	
2018 F	053	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure it complied with survey requirements for Medicaid nursing home facilities.
		Corrective Action:	The Department does not concur with the finding. In response to prior audit findings, the Department had implemented the Electronic Plan of Correction (ePOC), an electronic application that enables the Department to monitor compliance more effectively. The Department asserts that internal controls have been strengthened to ensure Statements of Deficiencies (SOD) are mailed by the tenth working day after survey exits, as evidenced by the steady decrease in audit exceptions since fiscal year 2016. The auditors reported two cases where the Department did not deliver SOD within ten working days as required. One case was due to the failure of the ePOC system on the provider end, resulting in the Department manually delivering the SOD to the provider on the eleventh day. The Department subsequently confirmed that the technical problem had been resolved for the provider in question. In the second case, an administrative review of the SOD caused a slight delay and resulted in the Department delivering the SOD to the provider on the eleventh day. In both cases, the SOD were delivered less than 24 hours beyond the federal requirement. The providers submitted their plans of correction timely with no impact from the one-day delay. System failures are beyond the control of the Department, and administrative reviews are essential to ensure SOD are complete and accurate. These should be considered acceptable reasons for providers not receiving their SOD within the required ten days. The Department will continue to use existing internal controls and quality assurance reviews to monitor the timeliness of SOD distribution to providers. The conditions noted in this finding were previously reported in finding 2017-043, 2016-036, 2015-044 and 2014-046.
		Completion Date:	February 2019, 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 Status	
2018 F	054	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 Medicaid payments to home care agencies were allowable.
		Corrective Action:	The Department partially concurs with the finding. The Department concurs that there were 25 instances when a daily payment was not supported by an electronic timekeeping record. These payments were made to a home care agency that subsequently closed and did not respond to the request for documentation. However, the Department does not concur that payments with no attached task sheets or missing signatures on task sheets should be included in questioned costs. Task sheets are used to document what tasks were completed during the provider's shift, as required by the home care agency contract. They are not a federal or state requirement. As of May 2019, the Department: • Issued an overpayment to the home care agency that did not respond to the request for electronic time keeping records to support the payment. • Reimbursed the federal questioned costs. As of June 2019, the Department: • Modified the tool provided to the Area Agencies on Aging (AAA) for monitoring home care agency's compliance with electronic timekeeping contractual requirements. • Worked with AAA's contract management staff to request corrective action plans from home care agencies that are noncompliant with contractual requirements. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action.
		Completion Date:	June 2019, 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 Status	
2018 F	055	Finding:	The Department of Social and Health Services did not ensure the federal portion of uncashed Medicaid checks was returned to its grantor.
		Corrective Action:	The Department concurs with the finding. The Department is implementing a process for the vendor to return uncashed checks to the Department. By January 2020, the Department and the vendor will: • Complete the development of an interface to identify uncashed checks older than 180 days. • Develop a report listing the uncashed checks that need to be returned to the Department. • Request the vendor to return uncashed checks that were issued from April 2016 through December 31, 2017. Thereafter, the vendor is required to submit a monthly report with any uncashed checks. By March 2020, the Department will return the federal share of all uncashed checks to the Center for Medicaid and Medicare Services.
		Completion Date:	Corrective action is expected to be complete by March 2020
		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 Status	
2018 F	056	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure all Medicaid Community First Choice individual providers had proper background checks.
		Corrective Action:	The Department partially concurs with the finding. The Department asserts that adequate internal controls are in place to ensure all Medicaid individual providers had proper background checks. Centers for Medicare & Medicaid Services require a minimum of 86 percent proficiency statewide related to compliance with individual provider background checks. The Department has monitored this requirement for many years and has consistently achieved over 90 percent proficiency statewide. The audit identified: • Five instances when fingerprint background check were not performed on Community First Choice (CFC) individual providers within the required timeframe. In all cases, the Department subsequently completed fingerprint background checks and found no disqualifying crimes. • One instance where a background check was not renewed after two years. Although this requirement is included in the Department policy, the State Plan does not require individual providers to complete background checks every two years to remain qualified. The State Plan only requires a state background check prior to contracting, and a federal background check, when required, within 120 days of being hired. The Department agrees that two of the three Area Agency on Aging (AAA) proficiency improvement plans did not address how the AAA would correct a background check deficiency. To address the audit recommendations, the Department will continue to follow established internal controls to materially ensure CFC individual providers have timely background checks. As of June 2019, the Department revised its internal process for approving proficiency improvement plans to ensure accuracy and completeness. The Department will identify associated costs related to unallowable payments for personal care services. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in finding 2017-049, 2016-040, 2015-040, 2014-049, 2013-40, 12-41, and 11-34.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	056 (cont'd)	Completion Date: June 2019, 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 Status	
2018 F	057	Finding:	The Department of Social and Health Services, Aging and Long-Term Support and Developmental Disabilities Administrations, did not have adequate internal controls over and did not comply with requirements to ensure some Medicaid providers were properly revalidated or screened, and fingerprint-based criminal background check requirements were met.
		Corrective Action:	The Department concurs with the finding. As of November 2017, the Department developed a process to screen and track each nursing facility contract to ensure validation and revalidation occurred within the five-year requirement. As of September 2018, the Department completed screening of all nursing facilities. As of October 2018, the Department implemented an automated process to screen providers in the Agency Contracts Database (ACD). The new process includes a built-in system edit in the ACD that prevents a new or renewal of Medicaid contract to be approved or signed unless the screening process has been successfully completed in ACD. The Department will continue to: • Verify and document proof of identity and authorization to work in the U.S. from individual providers before revalidating providers' contracts. • Perform quality assurance monitoring and remediation activities to ensure compliance with contracting requirements. By January 2020, the Department will complete a workload impact assessment and cost analysis for: • Monitoring provider risk levels for risk level reassignment due to overpayments or Medicaid fraud referral. • Implementing a process to conduct fingerprint-based criminal background checks for high-risk providers to meet additional fingerprint requirements. Once workload impact and cost analysis is complete, the Department will determine the best course of action to comply with screening and fingerprint requirements.
		Completion Date:	Corrective action is expected to be complete by January 2020
		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 Status	
2018 F	058	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and was not compliant with requirements to ensure Medicaid payments to supported living providers were allowable.
		Corrective Action:	The Department partially concurs with the finding. State law provides the Department the authority to authorize payments for individuals in community residential programs. The system is designed to allow supported living (SL) providers the resource flexibility needed throughout the year to meet the changing needs of the individual clients. The Department requires that clients receive all authorized Instruction and Support Services (ISS) hours over the course of the year. Providers are expected to provide hours in a flexible way within the year in order to address clients' individualized needs. SL providers are required to complete and certify annual cost reports, which reconcile hours and ISS dollars authorized to hours and ISS dollars provided. After reviewing cost reports, the Department establishes settlements when providers were paid for more direct service hours than they provided in a calendar year or when providers received more reimbursement (in dollars) for direct support costs compared with what was actually incurred during the year. <u>Cost Reports and Timesheets</u> The cost reports are not used to provide information to establish rates or allocate appropriate funds. Rather, rates are established through a rate setting process which includes a method to adjust for the sharing of service hours within households or clusters, and for needed supports that occur on an infrequent basis. All of these items are factored into calculating a daily rate for the individual client. The direct hours reported in the cost reports does not take into consideration the annual needs for support services, such as medical appointments and periodic essential shopping, The daily rates established through the rate setting process encompass these support hours. As such, looking at a snapshot of hours does not accurately reflect the cost of care provided and does not take into consideration that the rate assessment is based on a client's daily, weekly and annual needs for support services. Support services are evaluated and spread out over the entire year. The algorithm encompasses and factors in these support hours to determine the daily rate. The staffing plan is not intended to be a reflection of the daily hours provided, but rather a snapshot of the client's average assessed needs. During the cost settlement process, the Department's rate analysts verify accuracy of the reports and request additional documentation for support when necessary. The Department works with the providers to address any issues prior to the filing of cost reports.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	058 (cont'd)	Settlements The Department has the authority to reimburse the service provider for services delivered. Sometimes, overtime costs are necessary to adequately support clients, such as when: • The ISS cost exceeds the reimbursed rate. • A service provider has to fund the delivery of ISS by the use of overtime since there is an industry-wide staffing shortage. • High staff turnover and vacancy rate in the supported living industry necessitates the use of overtime. All ISS hours are documented initially in the cost report as delivered at the benchmark. During the cost settlement process, the Department can grant an exception to the benchmark rate for the hours purchased. The hours purchased at the higher benchmark may be adjusted for the total hours purchased. Categorization of Employees Department policy states that for staff who perform both administrative/non-staff functions and ISS, the service provider may include that portion of the employee's hours that are dedicated to ISS function. The Department relies on the function of the position, rather than the title of the position. The Department will continue to: • Follow current policy and monitoring activities to ensure individual client assessed support needs are met. • Use statistical sampling method and risk assessment to select a sample of agencies to verify that ISS cost information submitted by providers is accurate. • Grant exceptions to the payment rates if needed. • Work with the ProviderOne payment system partners to address system edits to prevent duplicate claims As of July 2019, the Department issued overpayments for the duplicate payments. As of October 2019, the Department consulted with the federal grantor and repaid the questioned costs identified in the finding. By July 2020, the Department will: • Increase the sampling size for cost report reviews to cover approximately one quarter of the supported living agencies. • Offer training to providers on maintaining adequate documentation to support ISS expenses. • Review a targeted sample of provider records to evaluate and determine whether supporting documentation is adequate.

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2018 F	058 (cont'd)	• Complete desk audits of selected providers and work with the providers to resolve any payment discrepancies identified. The conditions noted in this finding were previously reported in findings 2017-044, 2016-041, 2016-045, 2015-049, 2015-052, 2014-041, 2014-042, 2013-036, 2013-038, and 12-39. Completion Date: Corrective action is expected to be complete by July 2020 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 Status	
2018 F	059	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 Medicaid Community First Choice client service plans were properly approved.
		Corrective Action:	The Department partially concurs with the finding. While the Department agrees that person-centered service plans must be signed by the Department, client, and provider, the Department does not agree that improper payments can be assigned when a person-centered service plan is not signed by an individual responsible for its implementation. The Centers for Medicare and Medicaid Services (CMS) had previously provided guidance to the Department stating that the federal rules covering eligibility for services are separate from the rules on person-centered service planning. In all the cases reviewed by the auditors in the audit, the Department made payments to qualified providers for covered services delivered to eligible beneficiaries. The lack of a signed service plan does not render a client ineligible for services and therefore should not result in an improper payment. In January 2018, the Department updated the quality assurance procedures in monitoring compliance for obtaining client signatures on service plans. The Division's Quality Assurance team reviews client and Department signatures from a statewide sample, including documented attempts to obtain signatures. The review is part of an established annual audit cycle and measures statewide proficiency. If the annual review determines that the proficiency has fallen below the CMS standard of 86 percent, a quality improvement plan will be implemented to improve statewide performance. The Department also disagrees that any signatures received after 60 days should result in exceptions. Federal regulations require signatures, but not within a specified amount of time. CMS did provide guidance that in some cases it may be difficult to obtain signatures and gave direction on steps the Department can take to comply with the rules while still continuing services without the required signatures. Based on CMS guidance, effective December 2018, the Department changed its regulations to no longer require the termination of services should a client not return a signed service plan within 60 days of the completion of assessment. Since the previous rule was in conflict with federal guidance and has subsequently been revised, the Department disagrees with the auditor's determination that: • Improper payments resulted from seven service plans that were not signed by the clients within 60 days. • Seven Department signatures and two provider signatures received after 60 days were audit exceptions. The 60-day time frame for the Department and providers was not required by either federal or state regulations.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	059 (cont'd)	As of July 2019, the Department: • Revised its policies and procedures to add the requirement of provider signatures on person-centered service plans. This requirement was also added to the quality assurance monitoring process. • Provided training and outreach efforts to field staff on the new requirement and the alternatives for obtaining client's signature on person-centered service plans. As of November 2019, the Department: • Completed targeted reviews to measure compliance and determined that additional actions were needed to increase the proficiency rate with this requirement. • Began piloting technical upgrades in the Comprehensive Assessment and Reporting Evaluation assessment tool to allow clients to sign their service plans via an electronic method. The Department will consult with CMS to clarify if person-centered service plans that are missing signatures should result in unallowable payments, and if applicable, the associated costs related to any unallowable payments. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in finding 2017-045. Completion Date: November 2019, 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 Status	
2018 F	060	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 service plans were properly approved.
		Corrective Action:	The Department partially concurs with the finding. The auditors expanded the audit scope in fiscal year 2018 to include a review of provider signatures on person-centered service plans, in addition to Department and client signatures, for compliance with federal requirements. While the Department agrees that it must comply with federal regulations regarding obtaining signatures on clients' person-centered service plans, the Department does not agree that improper payments can be assigned when a service plan is not signed by an individual responsible for its implementation. The Centers for Medicare and Medicaid Services (CMS) had provided guidance to the Department stating that the federal rules covering eligibility for services are separate from the rules on person-centered service planning. In all the cases reviewed by the auditors in the audit, the Department made payments to qualified providers for covered services delivered to eligible beneficiaries. The lack of a signed person-centered service plan does not render a client ineligible for services or a provider unqualified to provide services, and therefore should not result in an improper payment. The Department also disagrees that any signatures received after 60 days should result in exceptions. Federal regulations require signatures, but not within a specified amount of time. CMS did provide guidance that in some cases it may be difficult to obtain signatures and gave direction on steps the Department can take to comply with the rules while still continuing services without the required signatures. Based on CMS guidance, effective December 2018, the Department changed its regulations for the Community First Choice Program to no longer require the termination of services should a client not return a signed person-centered service plan within 60 days of the completion of assessment. The Department has quality assurance processes in place to monitor compliance in obtaining client and Department signatures on person-centered service plans: • The Administration's Quality Compliance Coordination team reviews client and Department signatures from a statewide sample, including documented attempts to obtain signatures. The review is part of an established annual audit cycle and measures statewide proficiency. If the annual review determines that the proficiency has

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2018 F	060 (cont'd)	fallen below the CMS standard of 86 percent, a quality improvement plan will be implemented to improve statewide performance. • Case Manager Supervisors perform monthly monitoring of all staff for compliance with signature requirements. As of August 2019, the Department: • Updated policies and procedures to add the requirement of provider signatures on person-centered service plans. This requirement was also added to the quality assurance monitoring process. • Developed and implemented a training specifically designed to provide support and guidance to staff in obtaining required signatures on service plans in alignment with CMS guidance. By June 2020, the Department will: • Consult with CMS to determine if person-centered service plans that are missing signatures should result in an unallowable payment. If necessary, the Department will identify associated costs related to any unallowable payments. • Work with the U.S. Department of Health and Human Services to determine if any costs identified by the audit should be repaid. By September 2020, the Department will enhance the quality assurance process to monitor compliance with the signatures requirement. The conditions noted in this finding were previously reported in finding 2017-046 and 2016-043. Completion Date: Corrective action is expected to be complete by September 2020 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 Status
1024523	2018-001	Finding: The Department of Social and Health Services, Rehabilitation Administration, did not have adequate internal controls to ensure overtime at Naselle Youth Camp was properly authorized. Corrective Action: Effective July 1, 2019, the Juvenile Rehabilitation Division's programs, including the Naselle Youth Camp, were transferred to the Department of Children, Youth, and Families. The Department partially concurs with the finding. While a selection of employees' overtime authorization forms were not properly authorized before payday, the Department has the following established controls to ensure overtime hours for these employees were allowable and authorized: • The Administrative Officer of the Day (AOD) maintains an overtime log that records employee names and dates of overtime worked. The AOD performs the following procedures prior to approving any overtime: o Contacts other units to find out if they may have available staff who could fill in, therefore avoiding overtime charges. o Contacts on-call employees to find out if they can report to work, therefore avoiding overtime charges. o Approves overtime requests if the first two options are not available. o Records the approval in the AOD log. Entries from the log are reviewed every Monday. • After overtime approval is obtained from the AOD, additional requirements are in place to provide supporting documentation for overtime worked: o All approved overtime are required to be entered into the agency's timesheet system, Leave Tracker. o If an employee has over 40 hours for the week in Leave Tracker, the supervisor is required to reconcile the employee's timesheet with the unit's log where the overtime occurred to confirm the employee was on site. o Once the overtime hours are verified, the employee's timesheet is approved. The overtime hours for the employees included in the finding were recorded in the AOD logs, and were approved by supervisors in Leave Tracker prior to payment. In response to the finding, the Department will take the following actions: • Review and update policies and procedures for overtime approval. • Provide training to managers and staff on the overtime approval process. • Research options for simplifying overtime authorizations for juvenile rehabilitation facilities.

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Audit Report	Finding Number	Finding and Corrective Action Status
1024523	2018-001 (cont'd)	Completion Date: Corrective action is expected to be completed by June 2020 Agency Contact: Stefanie Niemela Audit Liaison Department of Children, Youth and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov