2018
Audit Resolution Report

FOR THE FISCAL YEAR ENDED JUNE 30, 2018

State of Washington
Office of Financial Management
December 2018

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STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT

2018
Audit Resolution Report

ACCOUNTING DIVISION
DECEMBER 2018

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State of Washington
Status of Audit Resolution
December 2018

Table of Contents

Audit Resolution Report 1

Schedule 1 – Audit Findings by Agency 3

Status of Resolution of Audit Findings
- State of Washington 5
- Office of Financial Management 10
- State Health Care Authority 11
- Traffic Safety Commission 23
- Military Department 26
- Department of Social and Health Services 28
- Department of Health 78
- Department of Children, Youth, and Families 79
- Department of Services for the Blind 82
- Department of Early Learning 91
- Washington State University 95
- The Evergreen State College 96
- Eastern Washington State Historical Society 97
- Department of Ecology 100
- Employment Security Department 102
- South Puget Sound Community College 103
- Wenatchee Valley College 105

Schedule 2 – Fraud Findings by Agency 109

Status of Resolution of Reported Fraud Findings
- Department of Social and Health Services 111
- Washington State Parks and Recreation Commission 116

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State of Washington
Status of Audit Resolution
December 2018

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, 2017, and October 31, 2018.

The audit reports issued during that period include:

- 52 federal compliance findings
- 20 non-federal findings
- 5 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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State of Washington
Status of Audit Resolution
December 2018

Schedule 1 – Audit Findings by Agency

AGENCY NUMBER	AGENCY	AUDIT REPORT	FINDING NUMBER	PAGE
Multiple	State of Washington	2017 F	001	5
105	Office of Financial Management	1022023	2018-001	10
107	State Health Care Authority	2017 F	031	11
107	State Health Care Authority	2017 F	032	12
107	State Health Care Authority	2017 F	033	13
107	State Health Care Authority	2017 F	034	14
107	State Health Care Authority	2017 F	035	15
107	State Health Care Authority	2017 F	036	17
107	State Health Care Authority	2017 F	037	18
107	State Health Care Authority	2017 F	038	19
107	State Health Care Authority	2017 F	039	20
107	State Health Care Authority	2017 F	040	21
107	State Health Care Authority	2017 F	041	22
228	Traffic Safety Commission	1022086	2018-001	23
228	Traffic Safety Commission	1022086	2018-002	25
245	Military Department	2017 F	052	26
300	Department of Social and Health Services	2017 F	002	28
300	Department of Social and Health Services	2017 F	004	29
300	Department of Social and Health Services	2017 F	012	30
300	Department of Social and Health Services	2017 F	013	31
300	Department of Social and Health Services	2017 F	014	32
300	Department of Social and Health Services	2017 F	015	34
300	Department of Social and Health Services	2017 F	016	35
300	Department of Social and Health Services	2017 F	017	36
300	Department of Social and Health Services	2017 F	018	38
300	Department of Social and Health Services	2017 F	019	40
300	Department of Social and Health Services	2017 F	020	42
300	Department of Social and Health Services	2017 F	021	44
300	Department of Social and Health Services	2017 F	022	46
300	Department of Social and Health Services	2017 F	023	47
300	Department of Social and Health Services	2017 F	026	48
300	Department of Social and Health Services	2017 F	027	52
300	Department of Social and Health Services	2017 F	028	53
300	Department of Social and Health Services	2017 F	029	54
300	Department of Social and Health Services	2017 F	030	55
300	Department of Social and Health Services	2017 F	042	56
300	Department of Social and Health Services	2017 F	043	58
300	Department of Social and Health Services	2017 F	044	59
300	Department of Social and Health Services	2017 F	045	62
300	Department of Social and Health Services	2017 F	046	64
300	Department of Social and Health Services	2017 F	047	66
300	Department of Social and Health Services	2017 F	048	67
300	Department of Social and Health Services	2017 F	049	68
300	Department of Social and Health Services	2017 F	050	69

State of Washington
Status of Audit Resolution
December 2018

Schedule 1 – Audit Findings by Agency

AGENCY NUMBER	AGENCY	AUDIT REPORT	FINDING NUMBER	PAGE
300	Department of Social and Health Services	2017 F	051	71
300	Department of Social and Health Services	1021987	2017-001	72
300	Department of Social and Health Services	1021987	2017-002	74
300	Department of Social and Health Services	1021987	2017-003	75
300	Department of Social and Health Services	1021987	2017-004	76
303	Department of Health	2017 F	003	78
307	Department of Children, Youth, and Families	1022030	2017-001	79
307	Department of Children, Youth, and Families	1022030	2017-002	81
315	Department of Services for the Blind	2017 F	006	82
315	Department of Services for the Blind	2017 F	007	84
315	Department of Services for the Blind	2017 F	008	86
315	Department of Services for the Blind	2017 F	009	87
315	Department of Services for the Blind	2017 F	010	88
315	Department of Services for the Blind	2017 F	011	89
315	Department of Services for the Blind	1021626	2017-001	90
357	Department of Early Learning	2017 F	024	91
357	Department of Early Learning	2017 F	025	93
365	Washington State University	1020905	2017-001	95
376	The Evergreen State College	1021189	2017-001	96
395	Eastern Washington State Historical Society	1021710	2017-001	97
395	Eastern Washington State Historical Society	1021710	2017-002	99
461	Department of Ecology	1020673	2017-001	100
461	Department of Ecology	1021796	2017-001	101
540	Employment Security Department	2017 F	005	102
675	South Puget Sound Community College	1020970	2017-001	103
686	Wenatchee Valley College	1021995	2016-001	105
686	Wenatchee Valley College	1021995	2016-002	106
686	Wenatchee Valley College	1020770	2015-001	107

2017 F = Statewide Single Audit Report

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	001	Finding:	The State should improve internal controls over specific areas of processing, recording, monitoring and reporting of financial activity included in the State's financial statements.
		Corrective Action:	The Office of Financial Management (OFM), with the collaboration of state agencies, strives for the highest standards in the preparation of the state's financial statements. OFM has discussed the issues with the agencies included in this finding and provided assistance in developing their respective corrective action plans. Response from each agency is listed below: ***Employment Security Department*** The Department partially agrees with the finding. In 2016, the Department established a Next Generation Tax System (NGTS) Interfaces and Data Quality Assurance project team comprised of representatives from the business and technology sectors to address concerns regarding the NGTS. The project team has been working on improving the system's internal controls related to processing transactions, reporting, and reconciliations between systems. In addition, the Department contracted with Microsoft to remediate technical issues with the NGTS system. <u>System Processing</u> The finding incorrectly states adjustments can be entered and processed in NGTS without review and approval of a second person. The Department did have a process in place at the time of audit; however, the process was not documented. Prior to the end of the audit, management had begun documenting the process of reviewing and approving adjustments. The auditors took exception that the Detailed Benefit Charges within NGTS do not consistently match the Summary of Benefit Charges. It is normal business practice to expect varying discrepancies between assessed and paid premium amounts, especially for large employers. When audit testing of a selected sample found a percentage of employer receivable balances at year-end varied from the employer paid amounts recorded in NGTS, it should not be construed as a misstatement on the financial statements. <u>System Report Issues</u> The Department agrees that some experienced-rated employers with delinquent accounts had at least one rate within the audit period that was incorrect resulting in an immaterial misstatement. However, the Department does not agree with the other system report issues as described in the condition of the finding. As stated in the prior audit finding responses, the Department does not rely on NGTS reports for financial reporting. The auditors have neither communicated to Department management what specific system reports they referred to, nor explained how they were used or their impact on

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	001 (cont'd)	financial reporting. Based on Generally Accepted Government Auditing Standards, the audit failed to identify any clear logical link of the effect to the system report issues that led to this misstatement. <u>Reconciliations</u> The Department agrees that NGTS has not been reconciled to the bank and has subsequently established a monthly reconciliation process between the bank (and other supporting documents) and the NTGS sub ledger. The Department has since enhanced the reconciliation process. As of August 2018, the Department completed all reconciliations with the bank for fiscal year 2018. The Department agrees that there are no reconciliations between systems to ensure information transmitted by interfaces is accurate and complete. However, the auditor did not communicate what constitutes adequate controls over interfaces between internal and external systems. As of September 2018, the Department implemented a file comparison interface that corrected the deficiencies identified in the audit. The Department will continue to identify and implement necessary controls over interfaces to ensure information transmitted is accurate and complete. ***Health Care Authority*** The Authority recognizes the significance and priority of internal controls over recording and reporting financial transactions. Currently, the ProviderOne vendor provides an independent service organization control audit every other calendar year. In 2015, the Authority requested funding from the Legislature to contract for a service organization control audit report on an annual basis so each state fiscal year will be covered. This request was not funded. The estimated additional cost to purchase an annual service organization control audit report is $470,000. The Authority will re-submit a request for funding to obtain the annual audit report. ***State Board for Community and Technical Colleges*** The Board implemented the PeopleSoft system in 2015 to replace the existing legacy software, and Community Colleges of Spokane (Spokane) and Tacoma Community College (Tacoma) were the first to go live with the new system. Since its implementation, there have been ongoing efforts to improve data accuracy and correct deficiencies. At the time of the 2017 audit, these two colleges were still in the process of identifying and correcting financial records for fiscal year 2016. It is the Board's priority to ensure accurate financial data is interfaced into the Agency Financial and Reporting System (AFRS), the state's accounting system. To address the audit recommendations, the Board has taken the following corrective actions:

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	001 (cont'd)	• The Director of Accounting and Business Services has been leading a support team of up to 10 accounting and project staff dedicated to assist these two colleges in closing fiscal years 2016 and 2017. Since September 2017, the Board has provided assistance both on-site and remotely in reconciling all accounting records. As of June 2018, Tacoma has closed both fiscal years 2016 and 2017 and the financial statements were audited for both years. Tacoma is currently working on closing fiscal year 2018. By November 2018, the Board expects both colleges to fully reconcile their accounts and close all prior fiscal years. • Staff on the support team provides assistance to the colleges in: o Reviewing, reconciling and making adjustments in all balance sheet general ledgers. Currently, the colleges are reconciling between funds, program indexes and organization indexes. o Reconciling cash with the new system. As of June 2018, reconciliation with bank statements was almost complete for both colleges. o Monitoring and reconciling data in the Asset Management module of the new system prior to uploading to AFRS to ensure accurate tracking and recording of capital assets and depreciation. Reconciliation of assets is expected to be complete by November 2018. o Providing training to college accounting staff in using the new system and implementing internal controls. • Additional technical staff were also assigned to develop customized programs and enhance the Financial Pillar module of the new system to facilitate more efficient account reconciliation and year-end closing process. The Board has developed numerous reports and processes to assist the colleges in reconciling and closing prior fiscal years and will continue to provide support when the needs arise to expand reporting capabilities. The Board anticipates the data clean-up process of the new system be completed by December 2018. Additionally, the Accounting and Business Services Director will continue to monitor and assist the other 32 colleges in their accounting and reporting of financial data. ***Department of Licensing*** To address the audit recommendations, the Department will: • Perform monthly monitoring and review, in addition to the monitoring by the Office of Financial Management (OFM). • Provide OFM with updates of material revenue increases and decreases of more than 10 percent as they occur. OFM will work with the Department to determine potential impacts and appropriate actions.

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	001 (cont'd)	• Perform analytical review at year-end to identify and correct accounting errors, and follow up to ensure they are appropriately addressed. ***Office of Financial Management and the Guaranteed Education Tuition Program*** The Office of Financial Management (OFM) prepares the state's financial statements in accordance with generally accepted accounting principles and recognizes the importance of internal controls over recording and reporting financial transactions. OFM has procedures in place to monitor and identify significant agency activities that may affect the state's financial reporting, as follows: • Perform quarterly and year-end analytical reviews on revenues, in addition to the analytical review by line items performed at year-end. As of January 2018, an analytical review by fund is also performed at mid fiscal year. These analytical reviews are used to help detect unusual or questionable transactions. • Monitor and review unusual events or unique program activities related to legislative changes or other mandates, and assess the overall statewide impact. • Perform necessary accounting research for all special and unique transactions and work with responsible agencies to ensure the transactions are properly accounted for and correctly reported in the Agency Financial Reporting System (AFRS), the state's accounting system. When interpretation of standards are not definitive, OFM will seek guidance from the Governmental Accounting Standards Board. • Perform monthly monitoring of agencies' financial data by running reports from AFRS to identify incorrect transactions and questionable balances. • Require agencies to complete year-end disclosure forms to collect vital information which have significant impact on the state's financial reporting. Agency chief financial officers are also required to certify the accuracy and completeness of their financial data. • Maintain ongoing communication with agencies to emphasize the need to contact OFM for guidance regarding reporting unique accounting activities. • Conduct meetings with all agencies prior to fiscal year-end close to provide important reminders and review outstanding issues. • Continue to provide ongoing training classes to all state agencies on various topics related to the processing and reporting of financial activities. As of March 2018, OFM procured a financial reporting program for preparing the state's Comprehensive Annual Financial Report. The new program will improve efficiency and accuracy, and allow OFM to dedicate more resources at year-end for review.

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	001 (cont'd)	OFM will continue to work with the Employment Security Department, Department of Licensing, Health Care Authority, and the State Board for Community and Technical Colleges to strengthen their internal controls over processing and reporting of financial activities. The conditions in this finding were previously reported in findings 2016-001 and 2015-002. Completion Date: Corrective action is expected to be complete by December 2018 Contact: Brian Tinney Statewide Accounting Assistant Director PO Box 43127 Olympia, WA 98504-3127 (360) 725-0171 brian.tinney@ofm.wa.gov

Office of Financial Management — Agency 105

Audit Report	Finding Number	Finding and Corrective Action Status	
1022023	2018-001	Finding:	The Office of Financial Management did not have sufficient internal controls in place to ensure it accurately reported its allocation schedules and notes.
		Corrective Action:	The Office of Financial Management (Agency) is responsible for the preparation of the state's financial statements. It concurs with the finding and has corrected the misstatements identified in the audit. In response to the audit recommendations, the Agency will implement the following processes to strengthen internal controls over the preparation of allocation schedules and notes: • Develop written procedures when implementing new Governmental Accounting Standards Board standards. • Incorporate the check figures tool used in the preparation of the state Comprehensive Annual Financial Report to identify and correct any variances or discrepancies. • Formalize an official review process to enhance the quality control protocol.
		Completion Date:	Corrective action is expected to be complete by March 2019
		Agency Contact:	Brian Tinney Statewide Accounting Assistant Director PO Box 43127 Olympia, WA 98504-3127 (360) 725-0171 brian.tinney@ofm.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	031	Finding:	The Health Care Authority did not perform semi-annual data sharing with health insurers as required by state law.
		Corrective Action:	The Authority does not concur with the finding. This finding is based on a specific data exchange method which most insurance carriers have chosen not to participate in and which the Authority has no legal authority to enforce. The auditor recommended the Authority seek and obtain the legal authority through legislation. However, it is not within the Authority's scope of responsibilities to regulate insurance companies. In June 2018, the auditor submitted this finding to the appropriate committees of the legislature in accordance with the requirements of the amended RCW 43.09.312 when the auditor determines that the audited agency has not made substantial progress in remediating its noncompliance. Currently, the Authority regularly employs several other methods of data sharing to achieve the goal of identifying third party liability. The Authority has prepared legislation to present in January 2019 that modifies the specific method and timing of data exchange with insurance carriers. The Authority anticipates the finding will be resolved through the request legislation and/or the decision of the legislative committees regarding resolution. The conditions noted in this finding were previously reported in findings 2016-028, 2015-030, 2014-034, 2013-020, 12-49, 11-38, 10-40, 09-19, and 08-25.
		Completion Date:	Corrective action is expected to be complete by June 2019
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	032	Finding:	The Health Care Authority overpaid a tribe for Medicaid chemical dependency treatments.
		Corrective Action:	The Authority submits an annual State Plan to the Centers for Medicare and Medicaid Services (CMS) for approval. The plan includes tribal health care facilities that deliver health care services to Medicaid-eligible clients. In August 2017, the State Auditor's Office published a whistleblower investigation (report number 1019566) that reported the Authority overpaid a tribe for chemical dependency treatments. Since the language in the State Plan is not conclusive and more than one tribe has challenged the conclusions in the whistleblower report, the Authority requested guidance from CMS in September 2017 on whether the payments identified in the audit report are overpayments. The Authority also requested an amendment to the State Plan to provide clear language that would prospectively preclude the type of findings published in the whistleblower investigation and that is consistent with language approved by CMS for other states' tribal health programs. CMS approved the requested amendment effective September 29, 2017. On January 29, 2018, CMS directed the Authority to Section 4320 of the State Medicaid Manual issued by the Health Care Financing Administration (predecessor agency to CMS). In particular, paragraph C of the Section states: "If a State elects to cover clinic services, it may choose the type of clinics or clinic services that are covered, provided that the services constitute medical or remedial care." In light of this CMS guidance and based on various mitigating factors, the Authority has determined that it would be inappropriate to seek recovery of payments based on the sole reason that service was rendered by a provider not listed in the State Plan which was in effect prior to the amendment in September 2017. If the U.S. Department of Health and Human Services determines the payments identified in the audit are in fact overpayments, the Authority will follow the normal audit resolution process to resolve the questioned costs.
		Completion Date:	June 2018, subject to audit follow-up
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	033	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid medical providers were revalidated every five years and screening requirements were met.
		Corrective Action:	The Authority is aware of the current situation with provider revalidation and is closely monitoring with routine reports. Currently, the Authority is working on a long-term solution by developing an automated process that will conduct all necessary data matches. The new process is expected to significantly reduce the amount of manual effort required and ensure provider revalidation is performed timely. Until the new automated process is fully implemented, the Department conducts other activities to mitigate the risk of paying ineligible providers. The Authority has prioritized revalidation work, and is making progress towards revalidation compliance. By March 2019, the Authority will be in compliance with this requirement, and will have notified providers who enrolled with the Authority prior to March 31, 2014, of the revalidation requirement. In addition, the Authority noted that federal regulations require providers to be re-categorized as high risk under very specific, limited circumstances. Currently, there are approximately two dozen providers, out of 98,000, that meet the specific criteria and require to be re-categorized as high risk. By March 2019, the Authority will: • Implement the process of re-categorizing high-risk providers. • Formally adjust the risk level of this group of providers. • Update procedures to include the new process. When the new fingerprint requirement is implemented, the Authority will conduct fingerprint-based criminal background checks on the providers identified under this re-categorization process. The conditions noted in this finding were previously reported in finding 2015-035.
		Completion Date:	Corrective action is expected to be complete by March 2019
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	034	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid service verifications were performed for all eligible claims.
		Corrective Action:	To address the audit recommendations, the Department has taken the following actions: • As of May 2017, Medical Service Verifications (MSVs) were expanded in ProviderOne to include social service claims. • As of November 2017, a Service Level Agreement was signed with the Department of Social and Health Services (DSHS). The agreement detailed the roles and responsibilities of the Authority and DSHS for processing and investigating leads from MSVs. The Authority does not agree that the exclusion of nursing homes in the survey population is an indication of a control deficiency. The Authority strategically excluded nursing homes in order to conduct targeted, risk-based verifications with high return rates. From a compliance standpoint, the Authority believes federal regulations allow flexibility for grantees to adopt a more effective approach. The Authority will continue to consult with the federal grantor to obtain clarification. As of March 2018, nursing homes are included in the universe of ProviderOne claims until definitive federal guidance is obtained. The conditions noted in this finding were previously reported in finding 2016-029, 2015-032, 2014-039, 13-031, 12-54, and 11-39.
		Completion Date:	March 2018, subject to audit follow-up
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	035	Finding: The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it sought reimbursement for all eligible Medicaid outpatient prescription drug rebate claims. Corrective Action: The Authority disagrees, in most respect, with the Description of Condition, Cause of Condition, Effect of Condition and Questioned Costs, as stated in the finding. Details of the disagreements and concerns were outlined in the Authority's response to the finding. The following are exceptions identified by the auditors with which the Authority concurs and will take corrective actions: (1) Emergency medical eligibility This issue was limited to medical claims and affected 119 specific clients in the ProviderOne system. As of March 2018, the Authority started using a report that allows staff to preemptively identify these specific scenarios and make eligibility updates as appropriate. This review is performed on a weekly basis, which also allows the Authority to reprocess any affected claims prior to invoicing. (2) Procedure code configuration ProviderOne allows numerically sequential procedure codes with like requirements to be configured in ranges or 'groups.' However, unintended gaps were created in certain ranges during the process of uploading new and changed codes, which caused the National Drug Code (NDC) requirements on certain codes to be temporarily bypassed. In April 2018, the Authority corrected the drug rebate system errors by: • Removing the grouping configuration • Reviewing the current list of codes • Maintaining codes individually (3) Healthcare Common Procedure Coding System to NDC conversion errors This was a condition known to the Authority from prior audit findings. A ProviderOne change request has been initiated to add configurable fields to facilitate unit conversions on the more complex physician-administered drug claims. As of April 2018, this change was implemented. In addition, the Authority will: • Contact the Centers for Medicare and Medicaid Services to fully explain the audit results and determine if the questioned costs identified by the audit should be repaid. • Initiate work to invoice drug manufacturers for rebates that should be requested.

State Health Care Authority **Agency 107**

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	035 (cont'd)	The conditions noted in this finding were previously reported in findings 2015-034 and 2014-031 for fee-for-service Medicaid claims, and 2016-032 for managed care Medicaid claims. Completion Date: Corrective action is expected to be complete by January 2019 Agency Contact: Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	036	Finding:	The Health Care Authority overpaid Medicaid hospitals for outpatient services.
		Corrective Action:	The Authority agrees that some claims were missed during the original mass adjustment of claims affected by incorrect Enhanced Ambulatory Patient Group weight assignment in the ProviderOne system. As of November 2017, the Authority identified all the missed claims and processed the majority of the adjustments. As of January 2018, the Authority completed the processing of the remaining two percent of the claims that did not get adjusted in November 2017. All corrections had been completed at that time and there were no outstanding questioned costs.
		Completion Date:	January 2018, subject to audit follow-up
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	037	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with suspension and debarment requirements for Medicaid medical fee-for-service providers.
		Corrective Action:	As of December 2016, the Authority began conducting monthly checks on Medicaid providers with the List of Excluded Individuals/Entities database. The Authority is not currently conducting monthly checks with the Excluded Parties List System (EPLS). The System Award Management (SAM) system, which replaced the EPLS in November 2012, only has the ability to look up a single individual. There is also a price associated with uploading more than one individual provider at a time. Due to the volume of providers and the resources it requires, it is not feasible for the Authority to conduct monthly EPLS checks on providers. However, the Authority was recently approved as a pilot state to utilize the U.S. Department of Treasury's Do Not Pay database system. Once this process starts, the Authority will be able to upload the volume of providers into SAM/EPLS and conduct the required checks on a monthly basis. Although the Authority is not currently conducting SAM/EPLS database checks at the frequency required, there were no improper payments identified.
		Completion Date:	Corrective action is expected to be complete by December 2018
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	038	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid expenditures were allowable to claim Children's Health Insurance Program funds.
		Corrective Action:	The Authority does not concur with the finding. The unallowable charges were the result of a system issue which was identified during the prior audit. The condition that led to the questioned costs identified in the 2017 fiscal year audit was corrected in July 2017. No correction action will be taken. The Authority will consult with the grantor regarding the resolution of the questioned costs. The conditions noted in this finding were previously reported in findings 2016-034, 2015-039, and 2014-037.
		Completion Date:	Not applicable
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	039	Finding:	The Health Care Authority made improper payments to Medicaid managed care recipients with Medicare insurance coverage.
		Corrective Action:	From March 2016 through June 2018, the Authority developed and ran an algorithm to identify and recoup duplicate Per Member Per Month (PMPM) premium payments for clients enrolled in Medicare. As of June 2018, the Authority implemented an enhancement to the ProviderOne payment system to automate recoupment of PMPM premiums for clients who are retro-enrolled in Medicare. The Authority will follow its normal finding resolution process with the U.S. Department of Health and Human Services regarding the resolution of questioned costs.
		Completion Date:	June 2018, subject to audit follow-up
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	040	Finding:	The Health Care Authority made improper Medicaid pharmacy fee-for-service payments for clients enrolled in managed care.
		Corrective Action:	The Authority does not concur with the finding. The pharmacy claims selected under this review were appropriately paid with the client being covered under the fee-for-service program at the time of claim submission and payment. The Authority does not recoup pharmacy payments for appropriately billed and paid services when the client's enrollment retroactively changes from fee-for-service to managed care. The Authority received informal guidance from Centers for Medicare and Medicaid Services (CMS) stating that this cost/benefit approach is appropriate. The Authority is requesting official guidance from CMS.
		Completion Date:	Not applicable
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	041	Finding:	The Health Care Authority made improper Medicaid payments to Federally Qualified Health Centers.
		Corrective Action:	The Authority will initiate the overpayment recoupment process and work with the grantor in the resolution of the questioned costs. The conditions noted in this finding were previously reported in findings 2016-030, 2015-033, 2014-036, and 2013-026.
		Completion Date:	Corrective action is expected to be complete by March 2019
		Agency Contact:	Lynda Karseboom Audit and Accountability Manager P.O. Box 45502 Olympia, WA 98504-5502 (360) 725-1228 Lynda.Karseboom@hca.wa.gov

Traffic Safety Commission — Agency 228

Audit Report	Finding Number	Finding and Corrective Action Status

1022086	2018-001	**Finding:** The Commission lacked adequate internal controls over contracts and grant monitoring.
		
		Corrective Action: The Commission concurs with the finding.
		
		To strengthen internal controls over contract monitoring and procurement, the Commission has implemented the following processes:
		• As of September 2018, began performing reconciliation between vendor contractor payments in the agency financial reporting system (AFRS) and the sub-ledgers maintained by the Finance Director. The process entails:
		  o Running quarterly reports from AFRS of payments made to vendor contractors during the quarter;
		  o Comparing the payments on the report to the sub-ledgers for the vender contractors and notifying the Finance Director if discrepancies are found;
		  o Identifying duplicate payments;
		  o Researching and correcting discrepancies.
		• Directed the policy committee to review and update procurement policies as needed to ensure they align with current state laws.
		• Required program managers to participate in the Department of Enterprise Services contract training as part of their training program.
		• Required program managers to address staff training needs in annual reviews.
		
		The Commission has also taken actions to strengthen controls over grant subrecipient monitoring. As of October 2017, the Commission began using the Washington Enterprise Management System (WEMS), an electronic grant monitoring system which automates the report completion and submission process. The system sends quarterly reminders and allows users to complete reports in the system. It also sends notification emails to the program managers when there are overdue reports. Since the adoption of the system, the number of lost or missing reports has decreased.
		
		In addition, by September 2019, the Commission is also planning on adopting the following changes to improve the subrecipient monitoring process:
		• Add language to the standard subrecipient agreements to state that quarterly reports must be submitted and approved before invoices will be processed.
		• Research the feasibility of implementing a feature in WEMS that would prevent grantees from submitting invoices until their quarterly reports have been submitted.
		• The Program Director, who has oversight of the grant management division, will develop a systematic file review protocol to ensure quarterly reports are properly completed and submitted in a timely manner.

Traffic Safety Commission **Agency 228**

Audit Report	Finding Number	Finding and Corrective Action Status
1022086	2018-001 (cont'd)	Completion Date: Corrective action is expected to be complete by September 2019 Agency Contact: Debbie Johnson Finance Director PO BOX 40944 Olympia, WA 98504-0944 (360) 725-9887 djohnson@wtsc.wa.gov

State of Washington
Status of Audit Resolution
December 2018

Traffic Safety Commission — Agency 228

Audit Report	Finding Number	Finding and Corrective Action Status	
1022086	2018-002	Finding:	The Commission lacked adequate internal controls over cash receipting.
		Corrective Action:	The Commission concurs with the finding. The Commission already purchased a combination lock/fire safe box to hold receipted checks overnight to be deposited the following day. By December 2018, the Commission will: • Develop written policies and procedures for cash receipting and deposits to ensure that cash and checks are deposited within 24 hours. • Provide training to administrative staff on the proper receipting of cash, including logging checks receipted in the check log. Prior to the 2020 Traffic Safety Conference, the Commission will work with the event planning vendor and the Office of Financial Management to determine the proper way to handle credit card payments received during registration to ensure cash receipt procedures are in compliance with the State Administrative and Accounting Manual.
		Completion Date:	Corrective action is expected to be complete by December 2018
		Agency Contact:	Debbie Johnson Finance Director PO BOX 40944 Olympia, WA 98504-0944 (360) 725-9887 djohnson@wtsc.wa.gov

Military Department **Agency 245**

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	052	Finding:	The Washington Military Department did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of Disaster Grants-Public Assistance received required audits.
		Corrective Action:	The Department partially concurs with the finding. Although the Department has a decentralized system for subrecipient monitoring, the finance division maintains the Department's Audit Tracker system to monitor subrecipient audits across the Department and alert program managers of audit exceptions and non-compliance with federal requirements. The Disaster Grants-Public Assistance (DGPA) Program performs program monitoring activities. Upon receipt of an audit finding notification, the DGPA Program performs an extensive review of the finding and all subrecipients who received federal funding during the audit period to determine if any management decision letters are needed. However, due to extensive staff turnover in the finance division beginning in July 2016, the Audit Tracker system has not been monitored and updated. Department management was not made aware of the situation. As identified by the auditors, there were 163 subrecipients that received funding during fiscal years 2015 and 2016. During this period, there was a significant amount of activity due to five new disasters spanning from October 2015 to April 2017. Program monitoring continued during this time period. Despite not being formally documented in the Audit Tracker system, many elements of the monitoring process have in fact been accomplished and documented. The Department has initiated the following actions to address the internal control weaknesses identified in the audit: • Reviewed and updated the existing subrecipient monitoring policy to clearly outline roles and responsibilities for departments and grant programs. • Implemented a quarterly internal control audit process performed by the finance division to review and document subrecipient monitoring activities. • Ensured all subrecipients submit completed and signed audit certification forms as required by the Department's contracts office. • Reviewed current regulations related to federal grant administration to ensure compliance with federal requirements. As of May 2018, the Department: • Completed a review of all open subrecipient agreements and determined that there were no audit findings related to the DGPA Program and therefore, no management decisions were needed.

Military Department **Agency 245**

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	052 (cont'd)	• Created a workgroup to review and address audit recommendations. The workgroup determined that the monitoring process may require possible modification. • Assigned funding source managers to perform independent monitoring to ensure subrecipients are receiving required audits and management decision letters are issued as needed. As of September 2018, the workgroup submited a proposal recommending proper alignment of subrecipient monitoring responsibilities between department administration and the Emergency Management division. By November 2018, the Department will finalize changes to policies and procedures, which are expected to be fully implemented by March 2019. Completion Date: Corrective action is expected to be complete by March 2019 Agency Contact: Rich Shimizu Deputy Finance Director Building #1: Headquarters Mailstop: TA-20 Tacoma, WA 98430-5032 (253) 512-7596 Rich.shimizu@mil.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	002	Finding:	The Department of Social and Health Services improperly charged about $4.1 million to multiple federal grants.
		Corrective Action:	The Department concurs with this finding. As of March 2017, the Department's Economic Services Administration (ESA) implemented a procedure to add the month of service (MOS) to transactions processed in the Agency Financial Reporting System (AFRS), the state's accounting system. Accounting staff are required to include MOS in the processing of all agency payments from AFRS. The Department utilizes the MOS to perform monthly review of AFRS transactions to identify unallowable charges and move them to the proper grant year via the journal voucher process. This process has helped ESA identify and ensure transactions not directly processed by the administration, such as payroll and benefits, are charged to the appropriate grant year. Prior to the start of the fiscal year 2017 audit, the Department identified approximately $22 million in expenditures charged to grants for activities that occurred before the start of the grant period. The Department had subsequently reversed $17.6 million of the improper charges. This information was disclosed to the auditors during their audit planning work. As of November 2017, the Department moved the timing of updating the Cost Allocation System to coincide with the commencement of the federal fiscal year. This change enables automatic charging of costs to the appropriate grant year through cost allocation for the applicable federal fiscal year. As of June 2018, the Department corrected the remaining $4.1 million of expenditures to the proper grant year using the journal voucher process. When the grantor contacts the Department regarding questioned costs, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in findings 2016-002, 2015-003, and 2014-022.
		Completion Date:	June 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	
2017 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 Department concurs with the finding. During the previous audit, 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 cost allocation plans. Subsequent to the prior year's finding, the Department received written directions from DCA to ensure cost allocation plans are submitted by June 30 of each year. The Department has since submitted the following three cost allocation plans to DCA: • Fiscal Year 2016 plan on February 28, 2017. • Fiscal Year 2017 plan on April 28, 2017. • Fiscal Year 2018 plan on June 30, 2017. The federal partners are actively working with the Department on approvals of the previously submitted plans. The conditions noted in this finding were previously reported in finding 2016-004.
		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 Status	
2017 F	012	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:	Due to the timing of the prior year audit finding, the Department did not have sufficient time to implement all corrective actions prior to the start of the fiscal year 2017 audit. Nonetheless, the Department already implemented the following corrective actions: As of May 2017, the Department: • Director of Vocational Rehabilitation issued a directive to staff to communicate the expectations for establishing timely individual plans of employment (IPEs) and meeting documentation requirements for IPE extensions. • Updated the customer service manual to reflect the requirements for extending IPE beyond the 90-day timeframe. • 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 IPEs development timeframe. This feature enabled more effective monitoring of the timeliness of IPEs completion. As of July 2017, the case management system was updated to require both the counselor and client's signatures upon completion of an IPE. As of March 2018, the Department: • Reviewed and enhanced reports from the case management system to monitor critical deadlines. • Established standard operating procedures for the IPE extension process and provided training to staff. As of June 2018, the Department enhanced the Supervisory Case Review Module in the case management system to strengthen internal controls in the review process of IPE establishment. As of September 2018, the Department developed training modules to include the review of management reports. The conditions noted in this finding were previously reported in finding 2016-011.
		Completion Date:	September 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	
2017 F	013	Finding:	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure client eligibility determinations were accurate and made within a reasonable period of time for the Vocational Rehabilitation program.
		Corrective Action:	Due to the timing of the prior year audit finding, the Department did not have sufficient time to implement all corrective actions prior to the start of the fiscal year 2017 audit. Nonetheless, the Department already implemented the following corrective actions: As of May 2017, the Department: • Director of Vocational Rehabilitation issued a directive to staff to communicate the expectations for timely client eligibility determinations with accurate supporting documentation. • Updated the customer service manual to reflect the documentation requirement for extending eligibility determination beyond the 60-day timeframe. • 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 individual plans of employment (IPEs) development timeframe. This feature enabled more effective monitoring of the timeliness of IPEs completion. As of March 2018, the Department: • Reviewed and enhanced reports from the case management system to monitor critical deadlines. • Established standard operating procedures for requesting extension of eligibility, including the supervisory review process. As of June 2018, the Department enhanced the Supervisory Case Review Module in the case management system to strengthen internal controls in the review process of eligibility determination. As of September 2018, the Department developed training modules to include the review of management reports. The conditions noted in this finding were previously reported in finding 2016-012.
		Completion Date:	September 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	
2017 F	014	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. Due to the timing of the prior year audit finding, the Department did not have sufficient time to implement all corrective actions prior to the start of the fiscal year 2017 audit. As of May 2017, the Department implemented the following corrective actions: • Issued an agency directive outlining the expectations for timely completion of individual plan for employment (IPEs) that are supported by proper required documentation. • Issued directive to field staff communicating the federal requirements that client employment services must be included on the IPE along with the counselor and client signatures. • Completed updates to the employee procedure manual to incorporate the new agency directives. • Conducted quarterly internal compliance reviews to ensure services were included in appropriately approved IPEs. • Generated reports from the Service Tracking and Reporting (STR) system that identify authorizations that were not on the client IPE prior to processing payments. Supervisors are required to review the identified authorizations, respond, and document any actions taken. • Monitored compliance reviews on the SharePoint site by forwarding a summary spreadsheet to each office queue that has authorizations to address. All Regional Administrator and fiscal compliance managers have access to the site and receive electronic notifications to each review request and response. As of January 2018, the Department: • Developed staff training to include system enhancements and required processes to assist staff in ensuring IPEs are complete and properly approved before services are paid for. • Contacted the U.S. Department of Education and received confirmation that the questioned costs were waived. As of October 2018, the Department: • Enhanced the existing ad hoc reports in the STR system to generate a report every other month to identify services purchased that are not included on the client plans for employment. • Reduced the response time for supervisors to document these detailed reviews from 30 days to 15 days.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	014 (cont'd)	The Department will submit required summaries of supervisor review and responses to Department management on a regular basis. Management will evaluate the need for possible system enhancements or policy revisions to fully correct the issues identified in the finding. The conditions noted in this finding were previously reported in finding 2016-013. Completion Date: October 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	
2017 F	015	Finding:	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.
		Corrective Action:	The Department concurs with the finding. As of September 2017, the Department developed standard operating procedures to provide guidance to staff on how to determine allowable use of earmarked funds. As of October 2017, the Department updated the programming in the case management system to ensure payments for pre-employment transition services from the earmarked funds are only made for eligible students. Two parameters were added before the system will allow the case worker to select payments under the earmarked category: • The client's date of birth must meet the criteria. • A specific field must be checked by the caseworker indicating client is a student. As of February 2018, the Department: • Developed standard operating procedures for identifying and correcting payment errors related to earmarked funds. • Contacted the U.S. Department of Education and received confirmation that the questioned costs were waived.
		Completion Date:	February 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	
2017 F	016	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:	The Department concurs with the finding. As of February 2018, the Department's Office of Indian Policy has established procedures to document the following information in the Agency Contracts database: • The yearly federal expenditures of each tribal entity. • Dates of completion for each tribal entity's single audits. As of March 2018, the Department's Behavioral Health Administration (BHA) maintains a master contract list for sending audit verification forms and ensures staff involved in the process of subrecipient monitoring work from the same master list. As of May 2018, BHA developed additional internal control procedures to supplement existing management bulletins and improve monitoring of subrecipients. This included: • Verifying subrecipients submit required audits. • Following up on all audit findings and issue management decisions promptly. • Requiring subrecipients to develop corrective action plans for audit findings, which will be tracked by the Department. The Department also accessed the Federal Audit Clearinghouse to review and determined that no other tribal audits contained findings that involved Department funds. The conditions noted in this finding were previously reported in findings 2016-014, 2015-016, and 2014-019.
		Completion Date:	May 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	
2017 F	017	Finding:	The Department of Social and Health Services did not have adequate internal controls over 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 Department acknowledges that adequate attendance records are necessary in the reconciliation process to determine allowable payments. Department of Early Learning (DEL) is responsible for authorizing child care payments and its 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. DEL is implementing an electronic attendance system and intends to require all providers to use it effective July 1, 2018. Due to timing of the prior audit, the Department did not have sufficient time to address all audit recommendations within the fiscal year 2017 audit period. Nonetheless, the Department continues to conduct post-payment reviews of cases where an improper payment appears likely to have occurred. For these cases, staff review the case specifics and perform verification to include requesting attendance records to determine if an overpayment has occurred. The review also determines if it is a provider or a client overpayment, the amount of the improper payment, and establishes an overpayment if appropriate. The Department has established a Process Review Panel (PRP) comprised of three experienced staff from the Department's Economic Services Administration. The PRP was tasked with reviewing and evaluating audit findings, exploring options and recommending appropriate corrective actions. As of February 2018, the Department: • Developed and implemented internal controls including third-party reviews based on recommendations from the PRP. • Explored pre-authorization reviews on high-risk and/or high-cost cases based on trend analysis conducted by the PRP. These controls will help improve accuracy in eligibility and authorization determinations, which will reduce the risk for improper billings from providers. To appropriately and effectively initiate and implement these substantial changes while minimizing impact to our clients, the Department will seek 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. 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.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	017 (cont'd)	The conditions noted in this finding were previously reported in finding 2016-019. Completion Date: February 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
2017 F	018	Finding: The Department of Social and Health Services did not establish adequate internal controls over and did not comply with federal requirements to sanction Temporary Assistance for Needy Families program participants who were not cooperative with the Department regarding child support issues. Corrective Action: The Department partially concurs with the audit finding. As of March 2017, the Department fully implemented new procedures to ensure Temporary Assistance for Needy Families (TANF) benefits are reduced or denied timely and accurately for participants who do not cooperate with child support requirements. The new procedures: • Increased the priority of noncooperation cases referred to the Community Services Division (CSD) to ensure documents are examined timely. • Implemented an automated process to identify currently closed cases that involve noncooperation, in the event the case is reopened. • Established a monitoring process to ensure all notifications of noncooperation received from prosecuting attorneys are entered into the case management system. By August 2018, the Division of Child Support Program Integrity Team will conduct an additional spot check audit to ensure all notifications are properly referred to CSD. The new procedures were implemented in March 2017 to address the prior year finding. The auditors did not identify any exceptions that occurred after March 2017 for the fiscal year 2017 audit period, validating the effectiveness of the new procedures. The Department will continue to follow the current process. The Department concurs that seven of the 11 clients identified in the finding received more benefits than they were eligible to receive. As of February 2018, the Department reviewed the exceptions identified and had established overpayments as appropriate. The Department does not concur with the questioned costs of $623 associated with one client identified in the finding, which would reduce the known question costs to $1,691. The Department found a procedural error occurred for this client, but the benefit amount received by the client during the audit period was found to be correct. For the remaining three clients in question, the Department: • Imposed sanctions on one client and the overpayment was already established appropriately for prior months. • Found procedural errors in the processing of two cases that did not result in any overpayments to the clients.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	018 (cont'd)	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 findings 2016-015 and 2015-018. Completion Date: February 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
2017 F	019	Finding: The Department of Social and Health Services did not have adequate internal controls in place 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 the prior year's finding, the Department spent significant time and effort updating policies and procedures to address the previously identified weaknesses in reporting of the Temporary Assistance for Needy Families (TANF) grant. The Department created a workgroup comprised of staff from the Department's Division of Finance and Financial Recovery, Community Services Division, and Research & Data Analysis (RDA) Division. As of February 2017, the Department developed manuals that outline collaborative procedures among the three divisions in report preparation. However, due to timing of the audit, the corrective actions implemented by the Department were not included in the fiscal year 2017 audit period. As of April 2018, the Department: • Developed Memorandums of Understanding (MOUs) including projection of expenditures with all partnering sources prior to the start of the federal fiscal year. These MOUs gave the Department an opportunity to discuss current program operations, as well as allowable activities and expenditures with the partnering sources. During presentation of the MOUs, the Department reviewed partners' methodologies and record management protocols, and offered training and assistance when needed. Based on MOUs received, the Department projects that it will exceed the level of effort requirement. • Implemented a quarterly monitoring and reporting schedule for all maintenance of effort (MOE) sources throughout the federal fiscal year to ensure MOE reported expenditures are allowable and adequately supported. The Department will continue to host weekly workgroup meetings to review and update existing policies and procedures as necessary. The workgroup will also focus on improving the Department's ability to forecast and monitor the level of TANF MOE expenditures throughout the year. The Department's RDA division is also taking actions to improve internal controls for ensuring the TANF quarterly reports are accurate and complete. Refer to finding 2017-020 for details. The conditions noted in this finding were previously reported in findings 2016-017 and 2015-020.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	019 (cont'd)	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	
2017 F	020	Finding:	The Department of Social and Health Services did not have adequate internal controls in place for ensuring the accuracy of submitted quarterly reports for the Temporary Assistance for Needy Families Grant.
		Corrective Action:	The Department partially concurs with this finding. The Department currently has the following processes in place to ensure the accuracy and completeness of quarterly reports for the Temporary Assistance for Needy Families Grant (TANF): • 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 custom software uses this data to comply with reporting requirements. • Runs a quality assurance (QA) process to review codes and results for each report to identify potential fatal and warning edits. Supervisors review results to determine if warning edits require correction and to monitor any changes in trend that may indicate an issue in the process. • Disseminates summary data to multiple partners for review prior to submission of quarterly reports to ensure they are accurate and complete. • As of January 2017, implemented a quarterly QA process, which selects a random sample from the case level 199 TANF Data Report and 209 SSP-MOE Data Report and checks the case data against the source data systems for accuracy. Supervisors review a summary of the QA results to confirm the validity of the sampling method and results, and determine any necessary follow-up actions. • Documentation on the new QA process was submitted to the auditor on September 5, 2017, for review as part of the 2017 Single Audit. The Department is monitoring, reviewing, and testing coding changes. While no version control software is used, staff maintain systematic copies of all code versions using filename conventions, duplicating most of the functionality of version control software. Archived versions are used to identify potential problems. The Department is not aware of any audit standard that requires version control software to be used by entities audited under the federal single audit. To improve internal controls to ensure accurate and complete reporting, the Department's Research and Data Analysis Division will: • Continue to perform quarterly QA testing using statistical sampling and document supervisor review of the sampling results. • Continue to update the written policies and procedures for this complex reporting process. The conditions noted in this finding were previously reported in finding 2016-016.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	020 (cont'd)	Completion Date: Corrective action is expected to be complete by March 2019 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
2017 F	021	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 partially concurs with the finding. In response to the prior year's finding, the Department spent significant time and effort on updating policies and procedures to address the previously identified weaknesses in reporting of the Temporary Assistance for Needy Families (TANF) grant. The Department created a workgroup comprised of staff from the Department's Division of Finance and Financial Recovery, Community Services Division, and Research & Data Analysis Division. As of February 2017, the Department: • Developed manuals that outline the collaborative procedures among the three divisions in report preparation. • 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 implemented by the Department were not included in the fiscal year 2017 audit period. As of April 2018, the Department: • Developed a quarterly reporting schedule to review source documentation submitted by other state agencies' activities and expenditures in addition to participating in weekly meetings. • Developed Memorandums of Understanding (MOUs) with other state agencies prior to the start of the federal fiscal year. These MOUs gave the Department an opportunity to discuss current program operations, as well as allowable activities and expenditures, with the partnering agencies. • Offered training and guidance to state agencies on expenditures and TANF maintenance of effort report preparation. • Retained all supporting documentation electronically and in field offices for review. The Department will continue to improve internal controls and ensure policies and procedures are sufficient. By January 2019, the Department will initiate discussions and seek appropriate guidance regarding establishing procedures and controls for verifying expenditures reported by other state agencies. The conditions noted in this finding were previously reported in findings 2016-018 and 2015-021.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	021 (cont'd)	Completion Date: Corrective action is expected to be complete by January 2019 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	
2017 F	022	Finding:	The Department of Social and Health Services did not report fraud affecting multiple federal programs to grantors.
		Corrective Action:	The Department concurs with the finding. As of August 2018, the Department reviewed guidance published by U.S. Department of Health and Human Services on the requirement for self-disclosing instances of fraud affecting federal awards. By January 2019, the Department will convene a workgroup to develop and implement sufficient procedures to ensure the Department reports, in writing, instances of fraud affecting grand awards. By March 2019, the Department will develop and provide training to staff regarding federal fraud reporting requirements.
		Completion Date:	Corrective action is expected to be complete by March 2019
		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	
2017 F	023	Finding:	The Department of Social and Health Services improperly charged payroll costs to the Child Support Enforcement Grant.
		Corrective Action:	The Department concurs with the finding. Department policy requires employees who do not spend 100 percent of their time on a specific grant to complete timesheets that are used for allocating payroll and benefits cost proportionately to the proper funding sources. In state fiscal year 2017, the Department changed the cost allocation methodology inadvertently charging payroll and benefits to the Child Support Enforcement Grant. Upon discovery, the Department immediately took action to make correction to the allocation methodology. As of December 2017, the Department updated procedures to reflect the correct allocation methodology and communicated the changes to staff. As of February 2018, journal vouchers were processed to correct the accounting transactions and resulting cost allocation for state fiscal year 2017. 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:	February 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
2017 F	026	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 has been working on implementing major changes to improve internal controls over determining client eligibility for the Child Care Development Fund (CCDF) grant. Due to the timing of the prior audit, the Department did not have sufficient time to implement all corrective actions during the 2017 fiscal year audit. The Department thoroughly reviewed each of the 2017 audit exceptions which were grouped into three categories, and has the following comments: (1) Improper eligibility determinations The Department did not fully comply with eligibility determination requirements in 17 cases selected for audit testing. However: • Eight cases resulted from minor procedural errors that had no effect on the eligibility of the cases and the associated payments. • Seven cases resulted from benefit calculation errors that had no effect on eligibility determination. In those cases, a partial payment error occurred due to incorrect copayment or amount of care authorized. The Department will establish overpayments. • Two cases were the result of clients fraudulently reporting household composition at the time of application. The Department appropriately requested fraud investigators verify household composition, closed the cases, and established overpayments. (2) Inadequate supervisory reviews The Department partially concurs with this condition as described in the finding. Child care program policy, as established and maintained by the Department of Early Learning (DEL), does not require secondary review or approval when determining eligibility and authorizing benefits and payment. Nonetheless, the Department continues to employ the following internal controls to ensure child care subsidy payment authorizations are made correctly: • Supervisory review is required for payment requests that exceed certain parameters to determine eligibility and necessity. If approved, the payment with the authorization will be submitted to the Social Service Payment System. • As of July 2017, the Department added a monthly report which identifies authorizations that appear to be missing the required approvals. Administrative staff review the exceptions on this report to ensure payments are proper. This report has not only

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	026 (cont'd)	helped in quality management efforts, it has also confirmed that the majority of the cases have been processed appropriately. • For authorizations for high cost special needs rates, the request and supporting documentation are reviewed by a panel of staff from the Department and DEL before payments are made. • One percent of the child care caseloads are reviewed monthly. In addition, new staff have 100 percent of their work audited by lead workers, either pre or post-authorization, until they achieve proficiency. (3) Verification of state median income level The Department does not concur with the condition as described in the finding. In September 2016, U.S. Department of Health and Human Services, Children and Families Administration adopted 81 FR 67438 regarding 45CFR 98.21which states in part: *"Some Lead Agencies currently use "look back" and recoupment policies as part of eligibility re-determinations. These review a family's eligibility for the prior eligibility period to see if the family was ineligible during any portion of that time and recoup benefits for any period where the family had been ineligible. However, there is no Federal requirement for Lead Agencies to recoup CCDF overpayments, except in instances of fraud. We strongly discourage such policies as they may impose a financial burden on low income families that is counter to CCDF's long-term goal of promoting family economic stability. The Act affirmatively states an eligible child will be considered to meet all eligibility requirements for a minimum of 12 months regardless of increases in income (as long as income remains at or below 85 percent of SMI) or temporary changes in parental employment or participation in education and training. Therefore, there are very limited circumstances in which a child would not be considered eligible after an initial eligibility determination. We encourage Lead Agencies instead to focus program integrity efforts on the largest areas of risk to the program, which tend to be intentional violations and fraud involving multiple parties."* To align with federal intent, DEL is planning to adopt rules regarding temporary income level increases. In response to the prior audit finding, the Department has implemented actions to ensure authorizations for child care are adequately supported with verified documentation based on DEL policy and procedures and the CCDF state plan. Specifically, the Department: • Finalized the verification desk aid and posted it to the Desk Aid SharePoint site.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	026 (cont'd)	• Reviewed, updated, and delivered systems navigation training for child care staff on the use of the Automated Client Eligibility System (ACES), Support Enforcement Management System (SEMS), and Electronics Jobs Automated System (eJAS) to confirm household composition and other eligibility criteria. • Automated the process for school-aged children in licensed care to have their authorization increased for July and August. The authorization will automatically revert to prior authorization at the start of a school year. • Adjusted the level of authorized care to 115 hours year-round for school-aged children in license-exempt family, friend, and neighbor care when the parent(s) are working 110 or more hours per month. To pay for additional hours of care needed by the school-aged child during school breaks or holidays, the provider can claim contingency hours on their invoice including summer months, with a maximum total of 230 hours during summer months. As of August 2016, DEL updated the state plan to clarify verification requirements concerning work schedules and new employment to support more family-friendly approaches. In addition, the Department has been collaborating with DEL to update policies and procedures, and make system enhancements: • As of December 2017, revised the applicable Washington Administrative Code (WAC) to allow more flexibility when calculating and verifying household income by removing the requirement that clients provide three months of wage information. • Revised applicable WAC to standardize authorization amounts for families across all provider types, including: o Parents participating in approved activities full-time and part-time, o Traditional, non-traditional, and variable working schedules, o School age and non-school age children. • Implemented system changes to minimize the risk of inaccurate reporting of household composition which can potentially lead to incorrect eligibility determinations and overpayments. Staff can now identify discrepancies in household composition reported by clients between the Child Care Subsidy Program and other programs within the Department. As of March 2018, the Department: • Confirmed the exceptions identified by the auditors and established necessary overpayments. • Requires clients to attest single parent status under penalty of perjury. • Requires clients to supply third party verification when household composition cannot be verified by reviewing Department records and systems.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	026 (cont'd)	• Implemented a child care process review panel by the Division of Program Integrity child care quality team. This system is based on the highly successful and established model currently in use by another federal program. The Department expects the review program will result in the same rigor and attention to eligibility determinations for child care subsidies. It will also identify cases with a high risk for errors, and enable the Department to make informed decisions regarding pre-authorization reviews. As of April 2018, the Department: • Ensured the language for the updated WAC is in place, and finalized the related handbook changes and staff training. • Communicated expectations to staff regarding the training requirements. • Added seven of the 25 requested full-time employees to assist with staffing the business-process redesign and support the information technology initiatives needed to improve internal controls. As of July 2018, the Department implemented a lead staff review of eligibility determinations that are not assigned through the automated workload assignment system. 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 2016-023, 2015-026, 2014-026, 2013-017, and 12-30. 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

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	027	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to identify and detect fraud in the Child Care and Development Fund program.
		Corrective Action:	The Department concurs with the audit finding. The Department has had a long-standing practice of managers assigning cases based off the priority level, starting with the highest priority cases. The Department maintains a goal of completing as many of the cases with the highest risk of fraud as staffing and workload allows. The Department's Office of Fraud and Accountability (OFA) agrees the fraud priority system does not include the cost of child care benefits, and a written policy did not exist for the priority scoring system. During state fiscal year 2017, a few of the highest risk fraud cases involving child care were not reviewed due to lack of sufficient staffing. As of December 2017, the Department had completed the processing of the majority of the highest risk fraud cases. As of February 2018, the OFA Director communicated a policy directive to staff to re-establish the required practice of giving top priority to reviewing cases with the highest level of risks. As of April 2018, the Department developed and implemented a process to include the child care benefit dollars at risk as a factor when determining the priority of fraud referral. The conditions noted in this finding were previously reported in findings 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	
2017 F	028	Finding:	The Department of Social and Health Services improperly charged $1,544 to the federal foster care grant.
		Corrective Action:	The Department concurs with the finding. To address the audit recommendations, the Department has: • Strengthened the review process to ensure services are authorized prior to making payments. A provider is not allowed to provide service until an approved status referral is in place. • Communicated with accounting field staff to emphasize the requirement of reviewing proper documentation when making invoice payments to vendors. Providers have also been informed of this internal procedure. The Department will work with the grantor to discuss any necessary repayment of the known questioned costs.
		Completion Date:	July 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	
2017 F	029	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with payment rate setting and application requirements for the Foster Care program.
		Corrective Action:	The Department concurs with the finding. During the 2017 fiscal year audit, the Department did not have a policy defining the frequency of a periodic review of foster care payment rates. As of February 2018, the Department updated its Operations Policy Manual specifying the methodology and review frequency of the basic maintenance payment rates. The reviews will occur every four years beginning in 2019. If an increase is necessary, the Department will submit a decision package for additional funding. The Department has also: • Amended the Title IV-E Plan and submitted to the U.S. Department of Health and Human Services (HHS) Administration of Children and Families. • Clarified policy that when a child is placed with a family residing and licensed in another state, the current rate of the applicable state will be paid. 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 2016-024, 2015-028, and 2014-027.
		Completion Date:	February 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	
2017 F	030	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:	Due to timing of the completion of the prior audit, the Department did not have sufficient time to make the required changes to the Agency Financial Reporting System, the state's accounting system, before the fiscal year 2017 audit period closed. As of October 2017, the Department: • Established new coding structure in the case management system, FAMLINK, to track state-funded spending. • Implemented written procedures on how to: o Reconcile the fiscal year maintenance of effort (MOE) amount to the amount reported by the Department. o Maintain adequate documentation to support the MOE calculations and that expenditures are used only for allowable purposes. As of January 2018, the Department developed written policies and procedures specifying how the adoption assistance savings amount will be determined. To ensure amounts reported to the federal grantor are accurate, financial information is extracted from FAMLINK to the Children's Administration Adoption Savings Calculation and Reporting Workbook. The amounts will be reviewed and certified before reporting to the grantor. As of February 2018, the Department sent the newly developed policies and procedures documenting implemented internal controls to the Administration of Children and Families for review. The conditions noted in this finding were previously reported in finding 2016-026.
		Completion Date:	February 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	
2017 F	042	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid intermediate care facilities.
		Corrective Action:	The Department concurs with the finding. The Department has an established log to track the receipt of Plans of Correction (POCs). However, the tracking log indicated a 10-working day review period instead of five working days as specified in the Department's policies and procedures. As of January 2018, the Department: • Communicated to staff about the requirement of reviewing POCs within five working days after receipt. • Corrected the tracking log to specify a five-working day review requirement. The Department agrees a facility was non-compliant with a condition of participation and did not submit a POC. Prior to the audit finding, the Department's Intermediate Care Facilities for Individual with Intellectual Disabilities unit was operating with the understanding a POC was not required for condition level citations. Therefore, the Department's initial correspondence to the facility requested a Letter of Credible Allegation of Compliance (LCAC) and made the POC optional. As of December 2017, the Department: • Developed standard operating procedures for the review and approval process of POCs, including the requirement of a POC for all condition level non-compliances. • Ensured facilities that are non-compliant with conditions of participation submit POCs in addition to the LCAC. This requirement will be included in the correspondence sent with the Statement of Deficiencies. • Sent official communication to facilities by the Policy Manager to inform them of the change in requirement. As of January 2018, the Department: • Conducted a revisit survey to the out-of-compliance facility and found it did not meet some of the standard level regulations but determined it complied with the conditions of participation. The Department has since requested a POC from the facility for the issues identified. The Department has kept the Center for Medicare and Medicaid Services informed and has not received any notification to revoke the certification of this facility. • Revised the correspondence to facilities to clearly state the requirement of a POC when deficiencies are identified in surveys. • Communicated the updated requirement to all staff.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	042 (cont'd)	The conditions noted in this finding were previously reported in findings 2016-037, 2015-045, and 2014-046. Completion Date: January 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	
2017 F	043	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid nursing home facilities.
		Corrective Action:	The Department concurs with the finding. As of April 2017, the Department implemented the federal electronic tracking application, called the Electronic Plan of Correction (ePOC), which enables the Department to monitor compliance more effectively. The system can electronically track and date-stamp the following: • Completion of Survey • Distribution of Statements of Deficiency (SOD) • Receipt of Plans of Corrections (POCs) from providers • Review of POCs by the Department • Approval of POCs by the Department By eliminating the mailing process through certified mail, the new system ensures nursing homes receive their SODs within 10 working days. The ePOC sends emails to provider staff regarding tracking updates. As of February 2018, the regional administrators and field managers conduct weekly meetings to identify SODs nearing the 10-day distribution requirement and POCs nearing their 5-day review requirement. The weekly communication also allows field managers to assess workload and inform regional administrators if any additional support is needed to meet requirements for distributions and reviews. The conditions noted in this finding were previous reported in findings 2016-036, 2015-044, and 2014-046.
		Completion Date:	February 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	
2017 F	044	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 does not concur 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. *Cost Reports* 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 support 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 do 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. 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 the cost reports. The Department will take the following actions: • By January 2019, provide training to providers to reinforce the requirement of maintaining adequate documentation to support ISS hours. • The Rate Unit will continue to: o Review a targeted sample of provider records to evaluate whether supporting documentation is adequate.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	044 (cont'd)	o Complete desk audits throughout the year and work with providers when discrepancies are identified on payment rates or amounts. • Continue to perform review of provider payments using sampling procedures to verify accuracy of information submitted by providers and request additional supporting documents as needed. • Continue to improve monitoring protocol by establishing consistent activities for monitoring providers to ensure they comply with cost report instructions. *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. It is the Department's priority to ensure individual client assessed support needs are met, and the Department will continue to use its authority to consider provider circumstances, as necessary, when calculating appropriate settlement amounts. Current policy and monitoring activities will remain in place to ensure individual client assessed support needs are met. *Cost of Care Adjustments* By December 2018, the Department will provide training to reviewers of Cost of Care Adjustment requests to ensure they follow Department policies and procedures. *Duplicate Payments* By December 2018, the Department will work with the Health Care Authority to review the duplicate payments identified in this audit. If duplicate payments are confirmed, overpayments will be processed. By June 2019, the Department will consult with the U.S. Department of Health and Human Services regarding whether the questioned costs identified by the audit should be repaid.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	044 (cont'd)	The conditions noted in this finding were previously reported in finding 2016-041, 2016-045, 2015-049, 2015-052, 2014-041, 2014-042, 2014-043, 2013-036, 2013-038, and 12-39. Inadequate internal controls over cost reports was not reported as a condition in any of the previously stated findings. Completion Date: Corrective action is expected to be complete by July 2019 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	
2017 F	045	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 support plans were properly approved.
		Corrective Action:	The Department does not concur with this finding. Person-centered service plans must be reviewed and revised upon reassessment of functional needs. This occurs at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. However, a signed person-centered service plan is not necessary nor required by the federal regulations, Washington's state Medicaid plan, or the Washington Administrative Code to properly determine or establish a client's eligibility to receive benefits. While the determination of eligibility and the development of the person-centered service plan may often take place during the same assessment visit with the client, completion of the two tasks are separate and distinct endeavors which are governed by different laws and requirements. The Department also notes that federal regulations provide latitude in obtaining consent in an alternate manner for those clients who are not able to provide a signature. The Department also disagrees with the auditors' conclusion that the lack of signed service plans resulted in improper payments. The Department made payments to qualified providers for covered services which were delivered to eligible beneficiaries. The Department has performed a thorough analysis of the audit results and found that, in 18 out of 26 exceptions, documentation was maintained in client files indicating staff received a signed service plan from the client and sent it to the Aging and Long-Term Support Administration's imaging hub. As of January 2018, the Department provided training to staff on the applicability of the federal regulations relating to signature requirements on person-centered service plans. In addition, as part of the established annual audit cycle, the Department has initiated a process to monitor staff compliance with federal and state requirements regarding tracking and documenting efforts to obtain signed service plans. As of June 2018, the Department issued a management bulletin to staff regarding signature requirements and outlining procedures for submitting signed service plans for imaging. If the 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 2018, subject to audit follow-up

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

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	045 (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	
2017 F	046	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 does not concur with this finding. Person-centered service plans must be reviewed and revised upon reassessment of functional needs. This occurs at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual. However, a signed person-centered service plan is not necessary nor required by federal regulations, Washington's state Medicaid plan, or the Washington Administrative Code to properly determine or establish a client's eligibility to receive benefits. While the determination of eligibility and the development of the person-centered service plan may often take place during the same assessment visit with the client, completion of the two tasks are separate and distinct endeavors that are governed by different laws and requirements. The Department also notes that federal regulations provide latitude in obtaining consent in an alternate manner for those clients who are not able to provide a signature. The Department also disagrees with the auditors' conclusion that the lack of signed service plans resulted in improper payments. The Department made payments to qualified providers for covered services which were delivered to eligible beneficiaries. As of January 2018, the Department provided training to staff on the applicability of the federal regulations relating to signature requirement on person-centered service plans. In addition, as part of the established annual audit cycle, the Department has initiated a process to monitor staff compliance with federal and state requirements regarding tracking and documenting efforts to obtain signed service plans. As of July 2018, the Department initiated a monthly monitoring process to track and monitor efforts to obtain signed service plans. Supervisors and the Department's Quality Compliance Coordinators will monitor to ensure compliance with federal and state requirements. The Department will continue to provide staff training on procedures to obtain client signatures on service plans, including the requirement of a witness' signature when a client is unable to sign. The Department will work with the federal grantor to determine if any questioned costs are required to be repaid. The conditions noted in this finding were previously reported in finding 2016-043.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	046 (cont'd)	Completion Date: Corrective action is expected to be complete by November 2018 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	
2017 F	047	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration made improper Medicaid nursing facility fee-for-service payments for clients enrolled in managed care.
		Corrective Action:	The Department partially concurs with this finding. The Department concurs that the two facilities reported in the finding either did not submit the required denial letter from the managed care organization (MCO) with their invoice or the submitted letters did not clearly convey a claim denial. However, the Department does not concur with the auditors' determination that these services would have been paid by the MCO or the Medicaid program has incurred duplicate payments. Therefore, the Department will not recover these payments identified by the auditor as unallowable. At times, patients need to be admitted to nursing facilities who do not meet skilled or rehabilitative level of care, or patients' stays exceed their eligibility period. These stays are not eligible for managed care coverage and the Department is responsible for payment of these claims. In support of the Department's mission and mandates, there are times when exceptions to the contract language must be made in order to maintain a patient's necessary care at a facility. When these exceptions are made, the Department communicates with both the MCO and the facility regarding the claims in question. The Department and the Health Care Authority have been engaging in a continuous process improvement, which includes: • Initiating multiple updates to contract language with MCOs to clarify the roles and responsibilities of the MCOs. • Continuing to update the nursing facility billing guide to provide further clarification of the Department's policy. • Issuing guidance via listserv messages to facilities, providing direct training, and coordinating with provider associations. As of September 2018, the Department developed a policy to document when payment exceptions need to be made for clients to maintain residency at a facility and who will have the authority to make this decision. 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:	September 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	
2017 F	048	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 Adult Family Home providers had proper background checks.
		Corrective Action:	The Department partially concurs with this finding. The Department agrees that one background check was not renewed timely. As of November 2017, the Department implemented an internal reporting tool which alerts staff to send a reminder notice to a provider when the current background check of an employee is expiring in 60 days. If the provider does not complete the background check by the required due date, a complaint investigation will be initiated. The Department does not concur with the two exceptions regarding the missing national fingerprint background check for the two providers. The providers in question had both applied in 2011, which was prior to WAC 388-76-10165 becoming effective and requiring a fingerprint check. The Department also does not agree the findings should be tied to questioned costs. The auditors did not identify any providers who had a disqualifying crime or negative action. While the one Adult Family Home in question was out of compliance with the licensing requirements of WAC 388-76 by not having current background check results on file, and is therefore subject to corrective action and sanctions by the Department, the provider was not unqualified to provide Medicaid paid services. Thus, the payments to the provider were proper. Additionally, the Department is unable to comment or validate the auditor's statement of noncompliance with background check issues related to the Adult Family Home employees. The auditor had failed to provide any data to substantiate this part of the finding. As of October 2018, the Department consulted with the U.S. Department of Health and Human Services regarding disagreement with the questioned costs and is currently awaiting a formal response. The conditions noted in this finding were previous reported in findings 2016-044, 2015-051, 2014-048, and 2013-037.
		Completion Date:	Corrective action is expected to be complete by January 2019
		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	
2017 F	049	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration did not ensure all Medicaid Community First Choice individual providers had proper fingerprint background checks.
		Corrective Action:	The Department concurs with this finding. For the one individual provider that did not complete a fingerprint background check as state law requires, the Department terminated the provider effective March 2018. The Department will continue to follow established internal controls to materially ensure Community First Choice individual providers have proper background checks. 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 previous reported in findings 2016-040 and 2015-040, 2014-049, 2013-040, 12-41, and 11-34.
		Completion Date:	March 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	
2017 F	050	Finding:	The Department of Social and Health Services, Aging and Long-Term Care Administration and Developmental Disabilities Administration, made improper overtime payments to Medicaid individual providers.
		Corrective Action:	The Department does not concur with the finding. The Department uses the Comprehensive Assessment Reporting Evaluation (CARE) tool, approved by the Centers for Medicare and Medicaid Services (CMS), to assess client needs and to allocate the number of hours of personal care and respite the client is eligible to receive. Payments were made to qualified providers for services the client was authorized to receive. All hours paid to the individual providers were allowable as no payments were made in excess of the CARE generated allowable hours. The Department's process complied with the CMS's directive outlined in the information bulletin published by the U.S. Department of Health and Human Services in July 2014. The directive required that any processes developed by States must comply with the Fair Labor Standards Act (FLSA). The Department protects clients' access to eligible services and supports from a provider of their choice through their person-centered service plan. In addition, overtime costs paid under FLSA can be reimbursed as a reasonable cost related to the delivery of Medicaid services. The Department cannot prevent the provider from being paid more than their work week limit because labor law requires payment for all hours worked. Providers must therefore be allowed to claim and be paid for hours worked. However, the Department does follow the post-payment procedure outlined in WAC 388-114-0120 to address claims that exceed a provider's work week limit. With the passage of Engrossed Second Substitute House Bill 1725 (ESSHB 1725), the Legislature imposed work week limits on individual providers. The statute also directed the Department not to impose work week limits on individual providers until the Department conducted a review of the plan of care for the clients served by the individual provider. These reviews were not completed until July 2016, and five of the payments found by the auditors to be unallowable were made prior to this time. The rules adopted as a result of ESSHB 1725 have a mechanism for terminating individual providers if they repeatedly exceed their work week limit. Regardless of whether the individual provider exceeds their work week limit, payment for all hours worked is required. The Department adheres to specific actions before stopping a payment to an individual provider who works more than the work week limit.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2017	050 (cont'd)	The restrictions imposed on the individual provider by these statutory limits and associated rules have no relation to the client's benefit, which is reflected as authorized hours. The Department also notes that the calculation of the questioned costs was incorrect. The provision of the hours themselves are not in question, only the payment of overtime for these hours. The cost of overtime is the difference between the individual provider's base rate of pay and one and a half times of the base rate. Therefore, questioned costs should be calculated only on the overtime cost. The Department will continue to: • Follow procedures to identify providers who have excess claims over the work week limit. • Issue necessary contract actions according to Department policy. If the grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. 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	
2017 F	051	Finding:	The Department of Social and Health Services charged payroll costs to the Disability Insurance/SSI Cluster that were not adequately supported.
		Corrective Action:	The Department concurs with the finding. The Department acknowledges that payroll certifications for the period from October 2016 to March 2017 were not submitted in a timely manner as required by Department administrative policy. As of October 2017, the Department: • Obtained the required certifications for the employees identified in the audit exceptions. • Reviewed the certifications and reconciled to the actual costs incurred to ensure that all the positions were charged accurately to the applicable federal programs. The Department also enhanced the monitoring process to ensure compliance. As of November 2017, the fiscal manager created recurring calendar reminders of the semi-annual certification due dates for the fiscal unit and supervisor. The review conducted by the Department showed that the $557,743 questioned costs were indeed allowable, and therefore no adjusting entries were required. The Department will work with the U.S. Social Security Admininstration if they contact the Department regarding the repayment of questioned costs.
		Completion Date:	November 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 Status	
1021987	2017-001	Finding:	The Department of Social and Health Services was unable to ensure payments made to a vendor were properly accounted for and adequately supported.
		Corrective Action:	The Department partially concurs with the finding. As acknowledged by the auditor, the Department has been monitoring the contract and communicating regularly with the vendor and its parent corporation. Prior to the start of the audit work, multiple attempts were made to resolve the issues. The Department does not agree with the auditor's conclusion that $987,088 of the overpayment to the vendor was for calendar year (CY) 2017. The vendor provided the Department with a reconciliation covering from April 2016 through the first quarter of 2018. However, the auditor only verified the information for CY2017. The amount of overpayment calculated by the auditor included only the CY2017 portion of the Federal Insurance Contributions Act (FICA) refunds. Based on the reconciliation period from April 2016 through the first quarter of 2018, the auditor did not consider the payments paid by the vendor in CY2016 and funding the Department provided in CY2018 when calculating the net FICA refund due for the period spanning three calendar years. By excluding the payments made by the vendor in CY2016 and funding the Department provided in January 2018, the net FICA refunds were overstated. As a result, the amount of overpayment reported in the finding was inflated. The Department agrees it has been unable to obtain adequate payment reconciliations from the vendor and has taken the following actions: • Initiated processes to obtain information directly from the taxing entities and trusts to verify payments. • Requested monthly bank statements and copies of quarterly reconciliations from the vendor to perform its own reconciliation. As of June 2018, the Department received $847,591 from the vendor for the overpaid employer portion of the FICA refunds for CY2016 to CY2018. In July 2018, the Department began meeting with the vendor on a regular basis to continue the reconciliation process and resolve the remaining FICA refund discrepancies; which they expect to complete by December 2018. The vendor is also taking actions to improve their accounting and reporting processes: • Drafting policies and procedures for FICA refunds and return of uncashed checks.

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status
1021987	2017-001 (cont'd)	• Developing an automated financial reconciliation report, which is expected to be completed by April 2019. By December 2018, the Department will: • Implement an IPOne system process to administer overpayment adjustments. • Work with the vendor to ensure all state unemployment tax returns are filed and payments are made for the CY2017 unemployment taxes. By April 2019, the Department will develop a process with the vendor to refund the uncashed checks to the Department and return to the federal grantor any portion of the uncashed checks that need to be repaid. The Department will continue to work with the vendor to complete reconciliation of all payments made to the vendor and monitor the contract to ensure all obligations are met. Completion Date: Corrective action is expected to be complete by April 2019 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
1021987	2017-002	Finding: The Department of Social and Health Services did not have adequate internal controls to ensure backgrounds checks were performed and documented in accordance with Department policy. Corrective Action: The Department does not concur with this finding. The Department has established adequate internal controls to ensure background checks are completed timely and that applicant's character, competence and suitability (CCS) assessments are properly documented. The Department is concerned that this finding inaccurately portrayed its current established process, specifically: • One employee whose subsequent background check was performed seven months late. o The Department conducted the initial background check of this employee timely with no record found. This one instance of late background check renewal should be viewed in the context in which eight background checks were performed on the employee within 15 years with no issues. • 23 instances when the CCS assessment was not documented to show why the staff or volunteers were approved to work with youths. o Department staff informed the auditors that prior to the administrative policy that was effective for calendar year 2011, it was the normal practice for the Superintendent or Community Facility Administrator (CFA) to conduct a verbal CCS assessment about any crimes committed. If a decision was made to hire an applicant after the verbal assessment, the record letter with the date and signature of the Superintendent or the CFA would be retained on file to show an assessment was performed. This verbal assessment process continued through December 2016. Since January 2017, CCS assessment forms are used for all employees with a criminal offense. It has been the Department's policy that as long as it is not a disqualifying crime, employees with records are allowed to be employed. The Department will continue to use the CCS assessment forms for all employees with a criminal offense. The Department will also continue to ensure background checks are performed and documented in accordance with its policy. 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	
1021987	2017-003	Finding:	The Department of Social and Health Services Developmental Disabilities Administration did not have adequate internal controls to ensure residential allowance requests were allowable and supported.
		Corrective Action:	The Department partially concurs with this finding. The Department did not agree that the eight reimbursement payments the auditors identified as missing documentation were not adequately supported. It is the Department's position that they were fully reviewed and appropriately approved, and that the payments were essential to meet client needs. For the other two reimbursement payments that were found unallowable, one was later confirmed to be for an allowable expense. The other payment was found to have a miscalculation which led to a higher reimbursement than the client needed. The $140 overpayment will be deducted from subsequent reimbursement requests. For the ten payments included in the finding, the Department determined that no further action is required. As stated in the fiscal year 2015 corrective action plan, the Department planned to develop training for providers. Since then, training has been provided at the quarterly regional providers meetings and was made available to all providers and department staff throughout 2016. Supported living providers also received agency-specific training when requested. To strengthen internal controls in the processing of residential allowance requests, the Department has taken the following corrective actions: • As of July 2017, the Department updated its policies on residential allowance requests. • As of July 2018, the Residential Allowance Request form, instructions and process were reviewed, updated and distributed to supported living providers. The Department will continue to evaluate the adequacy of the request forms and determine if revisions are needed. Furthermore, the Department will continue to offer relevant training to supported living agencies.
		Completion Date:	July 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	
1021987	2017-004	Finding:	The Department of Social and Health Services did not have adequate internal controls to ensure overtime at Green Hill School was properly authorized and supported.
		Corrective Action:	The Department does not concur with this finding. The Department has an established process to manage overtime at Green Hill School: • Overtime requests during business hours are approved by three Associate Superintendents at the school who are responsible for their own respective unit. • If overtime is needed after business hours, unit staff call the security office located at the school and speak to the Administrative Officer of the Day (AOD), who is the designee to approve overtime during non-business hours. All communication and correspondence related to these overtime requests, including approvals, are entered in the AOD log. The AOD performs the following procedures prior to approving any overtime: • Contacts other units to find out if they may have available staff who could fill in, therefore avoiding overtime charges. • Contacts on-call employees to find out if they can report to work, therefore avoiding overtime charges. • Approves overtime requests if the first two options are not available. • Records the approval in the AOD log book. Entries from the log are reviewed every Monday. After overtime approvals, additional requirements are in place to provide supporting documentation for overtime worked: • All approved overtime are required to be entered into the agency's timesheet system (Leave Tracker). • If an employee has reported over 40 hours worked for the week in Leave Tracker, the supervisor is required to reconcile the employee's timesheet with the unit's log book where the overtime occurred to confirm the employee was onsite. • Once the overtime work is verified, the employee's timesheet is approved. All overtime performed can be found in the AOD logs or on individual employee timesheets. The Department believes the current process in place is sufficient to ensure all overtime worked is properly approved and adequately documented.
		Completion Date:	Not applicable

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

Audit Report	Finding Number	Finding and Corrective Action Status	
1021987	2017-004 (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 Health **Agency 303**

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	003	Finding:	The Department of Health did not have adequate internal controls over and could not demonstrate it complied with requirements to perform risk assessments for all subrecipients of the Special Supplemental Nutrition Program for Woman, Infants and Children program.
		Corrective Action:	The Department partially concurs with the finding. The Department strives to ensure compliance with federal regulations and has the following procedures in place to evaluate the risk of subrecipients as part of the monitoring protocol: • An initial written risk assessment is required for new subrecipients of a federal award. • For each subsequent subaward, an informal risk assessment is performed to determine if the subrecipient's risk level has changed and thus requires a new written risk assessment. Otherwise, the Department relies on the initial risk assessment. Informal risk assessments are performed by staff, and Department procedure does not require documentation be maintained for those activities. The auditors determined that lack of documentation of the informal risk assessments did not meet federal requirements. The auditors also determined that the Department does not have adequate internal controls to ensure required assessments are performed. As of June 2018, the Department has: • Updated the internal procedures for the program to require all risk assessments be documented in accordance with guidance from the federal grantor. • Incorporated the review of risk assessments into the contracting processes. • Communicated changes of the risk assessment process to staff. • Provided staff training through regular work group meetings and advisements from the Fiscal Monitoring Unit. By March 2019, the Department will: • Update agency-wide policies and procedures for risk assessments. • Develop and provide formal staff training on the risk assessment process.
		Completion Date:	Corrective action is expected to be complete by March 2019
		Agency Contact:	Brandy Brush Internal Auditor PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 brandy.brush@doh.wa.gov

Department of Children, Youth, and Families — Agency 307

Audit Report	Finding Number	Finding and Corrective Action Status	
1022030	2017-001	Finding:	The Department of Children, Youth, and Families did not establish adequate internal controls to ensure licensed in-home providers complied with child care capacity requirements.
		Corrective Action:	The Department partially concurs with the finding. While the Department agrees with the audit finding that 20 providers had instances of operating over licensed capacity during the audit period, the Department does not agree the condition was caused by lack of additional monitoring to detect if providers exceed their licensed capacity. In addition to the annual reviews conducted by the licensors, other programs within the Department also monitor licensed capacity, including: • Random audits conducted by the subsidy team with referrals to the Licensing Unit for providers that appear to be over their capacity. • Investigations initiated by the Public Health and Safety Complaints Unit. • Investigations initiated by other divisions, including Child Protective Services. To address the audit recommendations, the Department will: • Investigate and provide technical assistance to providers who did not provide attendance records. • Establish overpayments for any subsidy payments made to providers who did not have supporting attendance records. • Establish overpayments for subsidy payments made to the provider who stated it did not provide care for the month under audit. The Department has also been working on improving internal controls to identify when providers are over their capacity. • As of July 2017, the Department finalized the procurement of an electronic time and attendance reporting system that will maintain electronic copies of attendance records and potentially reduce provider errors. • As of October 2018, the Department implemented the requirement for providers to use an electronic attendance system, allowing them the option to use the Department's electronic attendance system or an approved third-party system. By January 2019, the Department will: • Fully utilize the Department's electronic attendance system to monitor attendance data for all licensed childcare providers accepting subsidy payments. • Perform data analysis to detect noncompliant issues, including childcare capacity requirements. • Notify the Licensing Unit when providers are identified to have exceeded childcare capacity requirements.

Department of Children, Youth, and Families **Agency 307**

Audit Report	Finding Number	Finding and Corrective Action Status
1022030	2017-001 (cont'd)	• Provide follow-up technical assistance to noncompliant providers to ensure future compliance. Completion Date: Corrective action is expected to be complete by March 2019 Agency Contact: Stefanie Niemela Audit Liaison P.O. Box 40970 Olympia, WA 98504 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Children, Youth, and Families — Agency 307

Audit Report	Finding Number	Finding and Corrective Action Status
1022030	2017-002	**Finding:** The Department of Children, Youth, and Families did not establish adequate internal controls to ensure Quality Awards recipients were eligible and used grant funds only for allowable purposes. **Corrective Action:** The Department partially concurs with the finding. The Department maintains that neither the Early Achievers Participant Operating Guidelines, nor the Early Start Act referenced or required a Quality Improvement Plan (QIP) be submitted prior to the award or within a set timeframe. The Department will take the following actions to further strengthen internal controls: • Ensure documentation is collected and maintained in the Department's Early Learning System (WELS) to document how providers spend award funds. • Review and update written policies and procedures to: o Set clear expectations for staff when determining award eligibility, assessing the proper use of funds and maintaining required documentation. o Require staff to perform regular monitoring of providers' use of award funds in WELS to ensure they comply with reporting requirements and use funds for allowable purposes. o Include procedures to follow when an incomplete QIP is submitted. • Work with Child Care Aware of Washington, the program's contractor, to strengthen internal controls in delivering its contractual services to the Department. This includes ensuring the coaches employed by the contractor work with program participants to improve their understanding of QIPs and required documentation. • Update the Early Achievers Participant Operating Guidelines to include an expected timeline for documenting and updating QIP in WELS in order to maintain award eligibility. **Completion Date:** Corrective action is expected to be complete by January 2019 **Agency Contact:** Stefanie Niemela Audit Liaison P.O. Box 40970 Olympia, WA 98504 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	006	Finding:	The Department of Services for the Blind did not implement 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:	Previously, management had been relying on reviewing monthly reports from the case management system to identify delayed individual plans of employment (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 reviewed 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. The exceptions identified in the prior 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. In response to the audit recommendations, the Department has taken the following corrective actions: • As of August 2017, completed the testing of the 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, implemented a process to identify IPEs nearing the 90-day deadline for the upcoming week and to remind counselors of required client signatures and components for documenting a delay justification if an IPE is not expected to be developed within the 90-day timeframe. Regional Area Managers provided coaching to counselors on the effective use of the Dashboard feature and performed weekly monitoring of the use of the tool. • Communicated to Regional Area 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. • As of June 2018, finalized the revision of the Washington Administrative Code (WAC) to align with the new Workforce

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status
2017	006 (cont'd)	Innovation and Opportunity Act of 2014 that includes the requirements of delay justification documentation. • As of August 2018, formally adopted the revised agency 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. The conditions noted in this finding were previously reported in finding 2016-010. Completion Date: Corrective action is expected to be complete by December 2018 Agency Contact: Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	007	Finding:	The Department of Services for the Blind did not establish adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable time period.
		Corrective Action:	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 reviewed 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. The exceptions identified in the prior 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 of delayed eligibility determinations that were missing the required justification and documentation. In response to the audit recommendations, the Department has taken the following corrective actions: • As of August 2017, completed the testing of the 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, 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. Counselors are required to ensure exceptional and unforeseen circumstances are documented and that extensions with specific period are supported with a client agreement. Regional Area Managers provided coaching to counselors on the effective use of the Dashboard feature and performed weekly monitoring of the use of the tool. • Communicated to Regional Area Managers a target of less than ten percent overdue eligibility determinations 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. In addition, there were improvements in number of days taken to complete eligibility determinations.

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	007 (cont'd)	• As of June 2018, finalized the revision of the Washington Administrative Code (WAC) to align with the new Workforce Innovation and Opportunity Act of 2014 that includes the requirements of delay justification documentation. • As of August 2018, formally adopted the revised agency 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. The conditions noted in this finding were previously reported in finding 2016-009. Completion Date: Corrective action is expected to be complete by December 2018 Agency Contact: Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	008	Finding:	The Department of Services for the Blind did not have adequate internal controls to ensure cash draws were accurate and federal spending requirements were met for the Vocational Rehabilitation program.
		Corrective Action:	The Department concurs with the finding. The Department had experienced staff turnover in the fiscal unit that affected the level of oversight over the federal reimbursement request process. To address the audit recommendations, the Department implemented the following corrective actions: • As of September 2017, hired a Deputy Financial Officer to provide additional oversight to the federal draw process. • As of October 2017, developed an internal checklist for the federal draw process and incorporated in the existing procedures. • Implemented a secondary review by requiring the approval of the Deputy Financial Officer after the Accounting Manager prepares the federal draws.
		Completion Date:	October 2017, subject to audit follow-up
		Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	009	Finding:	The Department of Services for the Blind did not have adequate controls over, and was not compliant with, federal requirements for charging costs to the Vocational Rehabilitation program.
		Corrective Action:	In August 2017, the Department submitted a request to the U.S. Department of Education (DOE) cost allocation group to switch from an indirect cost rate to a Cost Allocation Plan (CAP) and requested the plan be approved retroactively to July 1, 2016. The Department charged reasonable and appropriate indirect costs to federal grants during fiscal year 2017 with the understanding that the federal granter would approve the CAP retroactively. As of May 2018, the Department received approval for the Cost Allocation Plans for fiscal year 2018 to 2020, with an effective date of July 1, 2017. However, the fiscal year 2017 CAP did not receive retroactive approval. As of September 2017, the Department implemented a secondary review process for indirect costs charged to federal grants. After accounting staff identifies the amount of indirect costs to charge against each grant, the Deputy Financial Officer conducts a review of the charges and approves the amounts. This secondary review process is in place and ongoing. The Department is currently working with DOE through the audit resolution process to determine whether the Department charged reasonable indirect costs during fiscal year 2017, and if any questioned costs need to be repaid.
		Completion Date:	Corrective action is expected to be complete by September 2019
		Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	010	Finding:	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, reporting requirements for the Vocational Rehabilitation Grant.
		Corrective Action:	The Department concurs with the finding. The Department processed adjustments in May 2017 to move expenditures to the appropriate grant year but inadvertently included the adjustments on the federal report ending March 2017. The Department had experienced staff turnover in the fiscal unit that affected the level of oversight over the federal reporting process. To address the audit recommendations, the Department has implemented the following corrective actions: • As of September 2017, hired a Deputy Financial Officer to provide additional oversight to the federal draw and reporting process. • As of October 2017, submitted a corrected federal fiscal year 2016 report to include only transactions through the reporting period ending March 2017. • As of November 2017, developed an internal checklist for the federal draw and reporting process and incorporated in the existing procedures. • Implemented a secondary review by requiring approval by the Deputy Financial Officer after the Accounting Manager prepares the federal reports.
		Completion Date:	November 2017, subject to audit follow-up
		Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	011	Finding:	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.
		Corrective Action:	The Department was required to set aside at least 15 percent of each Vocational Rehabilitation (VR) award for pre-employment transition services to students eligible for the earmarked funds. For the 2016 award year, the Department had accurately identified and tracked the earmarked expenditures throughout the year. The Department charged $869,402 of VR grant expenditures above the 85 percent of the 2016 grant allocated to basic support and employment services. This amount was reported on the 2017 federal report in March 2017 but the expenditures were not moved to the 2017 grant until May 2017. To address the audit recommendations, the Department has taken the following corrective actions: • As of May 2017, processed adjustments to move $869,402 of basic support service expenditures charged to the 2016 grant to the 2017 grant. • As of September 2017, hired a Deputy Financial Officer to provide additional oversight to the federal draw and reporting process. • As of November 2017, submitted a corrected federal fiscal year 2016 report to include only transactions through the reporting period of March 2017. • Updated procedures to include a secondary review process. Two managers are required to review payments charged to earmarked funds to ensure only allowable services for eligible students are included.
		Completion Date:	November 2017, subject to audit follow-up
		Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

State of Washington
Status of Audit Resolution
December 2018

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status
1021626	2017-001	**Finding:** The Department of Services for the Blind did not have adequate internal controls to ensure it followed state requirements and its own policies regarding small and attractive assets. **Corrective Action:** The Department concurs with the finding. To strengthen internal controls over monitoring small and attractive assets, the Department will: • Review and update policies related to equipment and inventory control. • Establish clear roles and responsibilities to ensure proper segregation of duties. • Maintain inventory records in accordance with requirements stipulated in the State Administrative & Accounting Manual. • Implement a statewide inventory audit every two years. • Provide training and technical assistance to staff on new procedures and roles/responsibilities. • Develop and implement a new case management system for clients who require equipment to complete employment plan. The new system will track the purchase, loan and assignment of equipment to clients. The Department expects the new system to be in place by March 2019. **Completion Date:** Corrective action is expected to be complete by June 2019 **Agency Contact:** Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Early Learning — Agency 357

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	024	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: • Began auditing providers based on month of service rather than month of payment in an effort to improve the timeliness of audit reviews. • Modified the Child Care and Development Fund (CCDF) Plan to align with federal and state regulations for fiscal year 2019 to 2021. • Improved internal controls and implemented preventative controls to assist in the detection of unallowable provider billings and reduce the risks of unallowable payments, including: o Recruited a Subsidy Policy Analyst tasked with monitoring program compliance with state and federal laws. The incumbent: ▪ 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 Implemented policies to include the Department's definition of intentional program violations and fraud, as well as the consequences for providers. • Developed a risk-based approach to audit providers' billings and payments that includes selecting providers' billings in excess of licensed capacity and providers billing the limit of their authorizations. The Department also continues to work with DSHS to: • Improve frequency of communication between the departments. • Clarify subsidy program rules and policies and modify current processes to align with the fiscal year 2019-2021 CCDF plan. • Develop record keeping templates and improve training using provider feedback. • 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.

Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	024 (cont'd)	• Address internal and external audit issues, and improve internal controls over client eligibility and directing payments to child care providers. • Collaborate through the Working Connection Childcare Reframe Workgroup and the Child Care Audit Committee on aligning and clarifying state rules and requirements with the reauthorization of the Child Care Development Fund 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: • Develop a standard consultation method to support providers in proper billing procedures when they bill incorrectly and incur an overpayment. • Use available data to identify high risk billing practices and follow the technical assistance and intentional program violation process outlined in the 2019-2021 CCDF Plan. • Finalize the implementation of an electronic attendance system for licensed providers by November 2018 and Family, Friend, and Neighbor providers by October 2019. This new system will electronically track daily attendance; enable accurate recording of child care attendance; and serve as data capture of subsidy child care usage. • Improve the reconciliation process by following Department policies, and ensure the policies meet all federal and state regulations when reviewing provider payments. The Department consults with the U.S. Department of Health and Human Services on audit findings. The audit resolution process includes conducting a case-by-case review and providing additional documentation as requested by the federal grantor when questioned costs are identified. The conditions noted in this finding were previously reported in findings 2016-021, 2015-023, 2014-023, 2013-016, 12-28, 11-23, 10-31, 9-12, and 8-13. Completion Date: Corrective action is expected to be complete by October 2019 Agency Contact: Stefanie Niemela Audit Liaison PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 Stefanie.niemela@dcyf.wa.gov

Department of Early Learning — Agency 357

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	025	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 the finding. In response to the prior audit finding, the Department: • Implemented new monitoring and compliance policies and procedures to clarify: o Use of a full checklist every three years. o Criteria when a site visit is needed. o Allowable methods of compliance. • Provided training to licensing staff on the new policies and procedures. • Implemented a new electronic caseload management system, WA COMPASS, in June 2017. The new system: o Provides electronic reminders to licensing staff and supervisors. o Allows licensing staff to make timely updates, improve data integrity and streamline work processes. o Provides electronic tools for tracking the 10-day health and safety rechecks requirement due to its capability of automatically converting from an abbreviated checklist to a full checklist when specified criteria is met. • Provided training to licensing staff on the WA COMPASS system. • Established operational milestones, which are aligned with the IT functionality milestones, to provide support to staff in the transition process. Department expectations are communicated to staff in the weekly WA COMPASS updates. • Implemented a system of statewide blended caseloads with the goals of maintaining equitable caseloads at the state, regional, and unit levels. The new process has enabled the Department to ensure full compliance with federal and state requirements for monitoring licensing activities of child care providers and facilities. All licensors have received the required training and are able to monitor and license all three child care settings: family homes, centers and school age programs. The Department is also creating an objective enforcement system by weighing all licensing standards that connect licensing infractions with the level of risk to children. The Department will provide more information and clarity about the risk level of each standard and the consequences for violations, and ensure that enforcement of these rules is both timely and consistent. As of October 1, 2018, the Department of Social and Health Services (DSHS) transferred the responsibility for completing provider background checks to the Department of Children, Youth, and Families (DCYF), formerly

Department of Early Learning **Agency 357**

Audit Report	Finding Number	Finding and Corrective Action Status
2017 F	025 (cont'd)	the Department of Early Learning. Previously, DSHS required this process to be completed before subsidy child care payment was authorized. DCYF has revised the applicable Washington Administrative Code to include Family, Friend, and Neighbor (FFN) providers in the requirement for comprehensive background checks prior to eligibility determination. DCYF License Exempt Specialists now verify background checks and approve all FFN providers prior to endorsing them to DSHS through an IT interface. Once the provider is approved by DCYF, DSHS will authorize payment. Additional corrective actions will be taken by DCYF. The new agency will: • Continue working on revising all licensing policies, procedures, and tasks to align with current state and federal rules and regulations. • Strive to respond to the demands of the Legislature and the needs of the provider community in aligning existing policies and procedures with the new Family Home and Child Care Center licensing rules in the Washington Administrative Code. • Re-prioritize additional time resources achieved with the new WA COMPASS system to managing higher caseloads and meeting additional state and federal licensing requirements. • Continue to provide training to staff on both the WA COMPASS system and new weighted licensing rules. The Department consults with the U.S. Department of Health and Human Services on audit findings. The audit resolution process includes conducting a case-by-case review and providing additional documentation as requested by the federal grantor when questioned costs are identified. The conditions noted in this finding were previously reported in findings 2016-022 and 2015-024. Completion Date: Corrective action is expected to be complete by October 2020 Agency Contact: Stefanie Niemela Audit Liaison PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 Stefanie.niemela@dcyf.wa.gov

Washington State University **Agency 365**

Audit Report	Finding Number	Finding and Corrective Action Status	
1020905	2017-001	Finding:	The Washington State University (University) did not have adequate internal controls in place for the fiscal year to ensure the accurate presentation of its permanent endowment fund additions, and investment and component unit footnotes.
		Corrective Action:	The specific errors identified in the footnotes were adjusted prior to publishing the financial statements. As of July 2018, the University has: • Conducted an effective financial statement review and analysis with management to ensure the statements and footnotes are accurate and complete. • Developed an internal process to ensure sufficient research is performed to implement new Governmental Accounting Standards Board standards using the checklist for Accounting Standards Changes published by the State Auditor's Office. • Invested in training and technical resources to ensure that: o All future changes to accounting guidance are researched and applied to financial statements and footnotes in a timely manner. o Assessment of changes to financial operations are appropriately assigned to responsible staff so that relevant accounting and auditing changes are promptly identified. o Staff involved in financial statement preparation attend relevant trainings and online webcasts related to governmental accounting standards and generally accepted accounting principles. The University has an established practice of performing secondary review of prepared financial statements and notes prior to submission for audit. However, this management control was not in place during the current audit due to staff turnover and shortages within the Business Services Team. As of January 2018, the University hired a new controller with the experience and credentials to provide appropriate oversight and review of all financial statement reporting activities.
		Completion Date:	October 2018, subject to audit follow-up
		Agency Contact:	Heather Lopez Chief Audit Executive PO Box 641221 Pullman, WA 99164-1221 (509) 339-3551 hlopez@wsu.edu

The Evergreen State College — Agency 376

Audit Report	Finding Number	Finding and Corrective Action Status	
1021189	2017-001	Finding:	The College did not have adequate internal controls in place to ensure it accurately reported its financial statements and notes.
		Corrective Action:	All material misstatements identified by the auditors were corrected in the College's final financial statements. To address the audit recommendations, the College is in the process of hiring an Assistant Accounting Manager. This position is newly established and will be responsible for: • Developing a process to implement new Governmental Accounting Standard Board (GASB) statements timely and correctly. • Assisting in the preparation and independent review of year-end financial statements.
		Completion Date:	Corrective action is expected to be complete in January 2019
		Agency Contact:	Dave Kohler Associate Vice President for Business Services 2700 Evergreen Parkway NW Olympia, WA 98505 (360) 867-6451 kohlerd@evergreen.edu

Eastern Washington State Historical Society — Agency 395

Audit Report	Finding Number	Finding and Corrective Action Status	
1021710	2017-001	Finding:	The Eastern Washington State Historical Society did not comply with procurement laws or required state policies and did not perform adequate contract monitoring.
		Corrective Action:	The Eastern Washington State Historical Society (Museum) concurs with the finding. As of July 2018, the Museum appointed the Chief Financial Officer as the Contract Manager to oversee procurement and to develop an effective process for monitoring and tracking all active agency contracts. To address the audit recommendations, the Museum has established internal policies and procedures related to contracts, procurement, management, and monitoring. This includes: • Following the requirements of Department of Enterprise Services (DES) Direct Buy Purchases/Procurements Policy for purchases of goods and services up to $10,000. • Requiring all contracts that exceed the direct buy limit to be reviewed by the Attorney General Office to ensure they comply with procurement regulations. • Monitoring vendor expenditures to ensure a competitive procurement process is initiated when expenditures are expected to exceed the threshold during the fiscal year. • Following the DES Delegation of Authority policy in the procurement of goods and services to ensure purchases adhere to the criteria stipulated in the policy. • Incorporating DES best practices of monitoring repetitive purchases to ensure that the Museum does not exceed either the direct buy limit without a competitive procurement process or the delegated authority limit. As of July 2018, a monthly monitoring report has been developed for this purpose. • Implementing procedures for procuring sole source contracts, including the related requirements of state public inspection. The Museum will continue to work with DES to obtain approval to exempt exhibition contracts. • Requiring the Contract Manager to review all departments' contracts, and maintain a final copy in the contract file. As of September 2018, the Museum's confidential secretary has developed a checklist for monitoring required contract training for all employees and sending reminders before the expected completion dates. By December 2018, required training will be set up in the state Learning Management System for each employee.

Eastern Washington State Historical Society **Agency 395**

Audit Report	Finding Number	Finding and Corrective Action Status
1021710	2017-001 (cont'd)	Completion Date: Corrective action is expected to be complete by December 2018 Agency Contact: Francis Langston Chief Financial Officer 2316 W. 1st Avenue Spokane, WA 99201 (509) 363-5326 francis.langston@northwestmuseum.org

Eastern Washington State Historical Society — Agency 395

Audit Report	Finding Number	Finding and Corrective Action Status	
1021710	2017-002	Finding:	The Eastern Washington State Historical Society did not have adequate internal controls in place to ensure donations were properly deposited and accounted for.
		Corrective Action:	The Eastern Washington State Historical Society (Museum) concurs with the finding. The Museum has had a past practice of receipting and depositing all donations into the Northwest Museum of Arts and Culture Foundation's (Foundation) account. To strengthen internal controls to better safeguard donations, the Museum has implemented the following procedural changes to ensure donations are properly deposited and accounted for: • The Museum will only accept non-endowed donations. • The Foundation has the endowment and will: o Accept all endowed donations. o Track restricted and unrestricted endowed funds separately. o Distribute interest earnings from the endowed donations quarterly to the Museum. o Ensure interest distributions from restricted donations are clearly identified with the intent of the donations. Additionally, the Museum has: • Instructed donors to designate donations appropriately for the intended recipient. • Begun performing monthly reconciliations of receipted donations against the bank statements for the Museum's bank account. • Begun auditing receipted donations by management on a monthly basis to ensure money designated for the Museum is deposited into its bank account appropriately. As of June 2018, the Foundation has returned to the Museum all non-endowed funds that were previously accepted on behalf of the Museum. As of October 2018, the Museum has developed written policies and procedures over the donation receipting process to formalize the newly implemented process.
		Completion Date:	October 2018, subject to audit follow-up
		Agency Contact:	Francis Langston Chief Financial Officer 2316 W. 1st Avenue Spokane, WA 99201 (509) 363-5326 francis.langston@northwestmuseum.org

Department of Ecology — Agency 461

Audit Report	Finding Number	Finding and Corrective Action Status	
1020673	2017-001	Finding:	The Department of Ecology's internal controls over financial statement preparation are inadequate to ensure accurate reporting.
		Corrective Action:	Some of the errors identified by the auditors on the cash flow statement were corrected in the Department's final financial statements. In response to the audit finding, the Department has taken steps to address issues identified by the auditors: • As of January 2018, obtained reassurance from the contractor that the Clean Water Revolving Fund financial audit was conducted in accordance with General Accepted Government Auditing Standards, as stipulated on the master contract with the state. • As of February 2018, consulted with the Office of Financial Management (OFM) Statewide Accounting unit regarding the preparation of the statewide Cash Flow Statements and the appropriate reports to use for verifying numbers. Based on OFM recommendation: o Consulted with the Department of Labor and Industries who contracted with an external auditor to assist them with the development of a Cash Flow Statement template. o Discussed with the Department's contractor for their assistance in developing a template for internal use. • As of March 2018, developed procedures to perform reconciliation of fund activities for revenues and expenditures with the reports from the Treasurer Office's cash management system. • As of April 2018, worked with OFM to design data queries for running financial reports from the statewide financial database to prepare financial statements. • As of September 2018, developed procedures to require additional review prior to publishing of the financial statements.
		Completion Date:	September 2018, subject to audit follow-up
		Agency Contact:	Janis Henry Senior Financial Advisor PO Box 47615 Olympia, WA 98504-7615 (360) 407-6386 Janis.Henry@ecy.wa.gov

State of Washington
Status of Audit Resolution
December 2018

Department of Ecology **Agency 461**

Audit Report	Finding Number	Finding and Corrective Action Status	
1021796	2017-001	Finding:	The Department of Ecology did not have adequate internal controls over fee collections for the vehicle emission testing program.
		Corrective Action:	To address the audit recommendations, the Department has taken the following actions: • As of September 2018, designated the Air Quality (AQ) Program's Financial Unit to perform review and reconciliation of vehicle emission fees and implemented updated procedures for reconciliation and revenue review. The process includes: o Receiving weekly supporting documents via email from the Vehicle Emission Program's contractor for the week's payments. o Running a monthly revenue report from the state's accounting system, Agency Financial Reporting System (AFRS), and from the contractor's online system for the same period. o Reconciling revenue received in AFRS to supporting documentation received and the contractor's report. o Providing training to staff responsible for the reconciliation process. • Established a quarterly monitoring process for AQ Program management to review and sign off on the monthly reconciliations performed in the prior quarter. AQ Budget Manager is responsible for investigating and correcting any variances or issues discovered in the review. • Clarified with the contractor what type of deductions are allowed under the contract. The Department has requested and received a credit of $1,376 from the contractor. By December 2018, the Department will complete quarterly review for the quarter ending December 2018.
		Completion Date:	Corrective action is expected to be complete by December 2018
		Agency Contact:	Janis Henry Senior Financial Advisor PO Box 47615 Olympia, WA 98504-7615 (360) 407-6386 Janis.Henry@ecy.wa.gov

Employment Security Department — Agency 540

Audit Report	Finding Number	Finding and Corrective Action Status	
2017 F	005	Finding:	The Employment Security Department did not have adequate internal controls over and did not comply with requirements to ensure only eligible claimants of the Unemployment Insurance program received weekly benefits.
		Corrective Action:	The Department concurs with the finding. The audit identified some design flaws in the Unemployment Tax and Benefit (UTAB) system causing cases selected for the job search verification process not being forwarded for verification. As of February 2018, the Department has: • Corrected the design flaws in the system that were identified in the audit. • Established new monitoring procedures to help ensure all work search verifications are completed and staff reviews are adequately documented. As of May 2018, the Department's Office of Internal Audit began conducting an assurance engagement to provide assurance to management that the Department has implemented corrective action to address the audit recommendations. The audit has been completed and did not identify any material gap in assurance. As of July 2018, the results of the assurance engagement were finalized and reported to Department management.
		Completion Date:	July 2018, subject to audit follow-up
		Agency Contact:	Ben Hainline Director of Internal Audit PO Box 46000 Olympia, WA 98504-6000 (360) 902-9276 bhainline@esd.wa.gov

South Puget Sound Community College — Agency 675

Audit Report	Finding Number	Finding and Corrective Action Status	
1020970	2017-001	Finding:	The College did not have adequate internal controls in place to ensure it accurately reported its financial statements and notes.
		Corrective Action:	The errors identified by the auditors were corrected in the College's final financial statements. College staff had to prepare two sets of financial statements with an extremely short turn-around in time for the fiscal year 2016 and 2017 audits. The back-to-back audits were necessary to bring the College into compliance with the Northwest Commission on Colleges and Universities Accreditation requirements to have annual financial statement audits in accordance with generally accepted auditing standards. This short preparation timeframe also adversely impacted the ability of management to perform timely review of the financial statements prior to submitting for audit. The College has since established the correct reporting timeline. To prepare for the fiscal year 2018 financial statements cycle, the College will continue to work with the State Board for Community and Technical College for guidance and participate in training opportunities. In addition, the Chief Enterprise Services Officer will continue to: • Perform thorough review of year-end financial information on statement templates to verify the accuracy of extracted data from the financial system. • Identify and perform normal annual adjustments. • Review prior year report adjustments to assess the impact on the current year's accounting, and perform necessary adjustments. • Document all adjustments to the financial statements on an adjustment form. • Submit a copy of the adjustment form with backup documentation to the Vice President for Administrative Services (VP) for review. To ensure statements and footnotes are prepared accurately and in accordance with all reporting standards and principles, all financial statements and the complete financial report will be reviewed by the VP. Additionally, backup documentation will be maintained and submitted for the review process. As of September 2018, the College has taken the following actions to strengthen controls over the process of implementing new Governmental Accounting Standards Board (GASB) standards: • Incorporated resources and templates available on the website of the State Auditor's Office (SAO). • Subscribed to publications for new GASB standard announcements. • Maintained a checklist for accounting standards changes, available on the SAO website, for each new GASB pronouncement. • Assigned staff for the review and interpretation of new GASB statements, and ensure staff attend available training.

South Puget Sound Community College **Agency 675**

Audit Report	Finding Number	Finding and Corrective Action Status
1020970	2017-001 (cont'd)	• Developed implementation plans for new GASB statements that have significant impact on the College's accounting or financial reporting process. • Maintained an annual summary log of all current and upcoming GASB accounting standard changes. Completion Date: September 2018, subject to audit follow-up Agency Contact: Mary An. Schmidt Chief Enterprise Services Officer 2011 Mottman Rd SW Olympia, WA 98512 (360) 596-5372 mschmidt@spscc.edu

Wenatchee Valley College — Agency 686

Audit Report	Finding Number	Finding and Corrective Action Status	
1021995	2016-001	Finding:	The Wenatchee Valley College's (College) internal controls over accounting and financial statement preparation were not adequate to ensure accurate reporting.
		Corrective Action:	The College researched and corrected all known errors identified by the auditors. The College began to take corrective actions prior to the conclusion of the audit. Additional resources were allocated to the College's accounting and financial reporting activities, including: • Hiring a fiscal analyst in May 2016. • Hiring a budget analyst/internal control specialist in September 2017. • Engaging the services of an accounting firm in January 2017 to produce the financial statements for fiscal years 2015, 2016, and 2017. • Implementing a secondary review process for accounting transactions and aged accounts beginning mid-2017. As of September 2018, the College began scheduling internal control audits to evaluate adequacy of controls and ensure accurate reporting.
		Completion Date:	September 2018, subject to audit follow-up
		Agency Contact:	Janice Fredson Director of Fiscal Services 1300 Fifth Street Wenatchee, WA 98801 (509) 682-6505 jfredson@wvc.edu

Wenatchee Valley College **Agency 686**

Audit Report	Finding Number	Finding and Corrective Action Status	
1021995	2016-002	Finding:	Internal control processes over financial reporting of the Wenatchee Valley College Foundation did not ensure that all transactions were properly recorded, reconciled or reported.
		Corrective Action:	The Board of Trustees at Wenatchee Valley College (College) and the Wenatchee Valley College Foundation Board concur with the finding. To address the audit recommendations, the College has initiated actions to correct deficiencies at the Foundation through two newly created sub-committees: • Budget and Finance • Audit These committees, along with the Executive Director and accountant, have created policy and procedure manuals, which include: • An outline of staff assignments as related to the Foundation's accounting processes. • Directives on the organization and retention of accounting records. In addition, procedures have been updated to include the following requirements: • Perform analytical review of all journal entries. • Maintain adequate documentation to support the appropriateness of the entries. • Review and approve all journal entries by the Executive Director prior to posting. • Utilize reconciliation forms to ensure crucial details of adjusting entries are completed. • Maintain and organize complete records of all adjusting entries in binders. • Require bank statements to be reconciled within three weeks of receipt of the statements. • Reconcile cash receipt logs to monthly bank statements. • Require all reconciliations to be signed and dated by the preparer and reviewer when completed. • Continue to cross-train personnel to ensure timely posting and reconciling of account activities. The College will continue to work with Foundation accounting staff to ensure compliance with internal procedures, as well as audit standards.
		Completion Date:	July 2018, subject to audit follow-up
		Agency Contact:	Janice Fredson Director of Fiscal Services 1300 Fifth Street Wenatchee, WA 98801 (509) 682-6505 jfredson@wvc.edu

Wenatchee Valley College — Agency 686

Audit Report	Finding Number	Finding and Corrective Action Status	
1020770	2015-001	Finding:	The Wenatchee Valley College's (College) internal controls over accounting and financial statement preparation were not adequate to ensure accurate reporting.
		Corrective Action:	The College researched and corrected all known errors identified by the auditors. The College began to take corrective actions prior to the conclusion of the audit. Additional resources were allocated to the College's accounting and financial reporting activities. These include: • Hiring a Fiscal Analyst in May 2016. • Hiring a Budget Analyst/Internal Control Specialist in September 2017. • Engaging the services of an accounting firm in January 2017 to produce the financial statements for fiscal year 2015, 2016 and 2017. • Implementing a secondary review process for accounting transactions and aged accounts beginning mid-2017. As of September 2018, the College started conducting internal control audits to evaluate if controls are adequate to ensure accurate financial reporting.
		Completion Date:	September 2018, subject to audit follow-up
		Agency Contact:	Janice Fredson Director of Fiscal Services 1300 Fifth Street Wenatchee, WA 98801 (509) 682-6505 jfredson@wvc.edu

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Schedule 2 – Fraud Findings by Agency

AGENCY NUMBER	AGENCY	AUDIT NUMBER	FINDING NUMBER	PAGE
300	Department of Social and Health Services	1020632	001	111
300	Department of Social and Health Services	1020734	001	112
300	Department of Social and Health Services	1022310	001	113
300	Department of Social and Health Services	1022311	001	114
465	Washington State Parks and Recreation Commission	1022112	001	116

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State of Washington
Status of Audit Resolution
December 2018

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Resolution	
1020632	001	Finding:	The Department of Social and Health Services did not adequately monitor its contracted supported living providers resulting in misappropriation of client funds between March 9, 2013, and March 2, 2015.
		Fraud Amount:	$15,333
		Amount to be Recovered:	$0
		Recovery to date:	$15,333 reimbursed to affected clients by providers
		Resolution /Status:	This fraud finding involved three service providers who misappropriated client funds. As of February 2018, the Department: • Issued the three providers Statement of Deficiency letters and performed additional reviews of client funds to ensure there is no risk of additional loss to other clients. • Conducted follow-up reviews with the three providers. The reviews verified and ensured the providers have the following controls in place: o Implement policies and procedures to adequately safeguard client funds and track all client income and benefits. o Perform monthly reconciliations of client funds and a second individual reviews the reconciliations to ensure accuracy. o Require purchases made with, or withdrawals of, client funds to be fully supported by documentation and made only for allowable purposes. o Complete and maintain updated individual financial plans for all clients in accordance with Department rules. The Department will continue to monitor contracted providers' internal controls to ensure they are adequate to prevent client fund misappropriation. In addition, the Department will continue to conduct regular client fund reviews for supported living providers across the state.
		Personnel Action Taken:	Not applicable
		Criminal Action Taken:	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 Resolution	
1020734	001	Finding:	The Department of Social and Health Services did not adequately monitor its contracted supported living provider resulting in misappropriation of client funds between May 28, 2015, and November 29, 2016.
		Fraud Amount:	$18,858
		Amount to be Recovered:	$0
		Recovery to date:	Misappropriated funds and questionable transactions totaling $18,858 were reimbursed to affected clients by provider.
		Resolution /Status:	This fraud finding involved a former finance manager of the provider who misappropriated client funds. As of December 2017, the Social Security Administration and the Department terminated the status of the provider as the representative payee for the clients. As of January 2018, the Department appointed new representative payees to the affected clients. The Department will continue to monitor contracted providers' internal controls to ensure they are adequate to prevent client fund misappropriation. In addition, the Department will continue to conduct regular client fund reviews for supported living providers across the state to ensure: • Policies and procedures adequately safeguard client funds. • Providers are tracking all client income and benefits. • Monthly reconciliations of client funds are performed and independently reviewed to ensure accuracy. • Purchases or withdrawals of client funds are only for allowable purposes and are fully supported by documentation.
		Personnel Action Taken:	Not applicable
		Criminal Action Taken:	In October 2017, the former Manager pled guilty in federal court to one count of Social Security Fraud – Representative Payee Fraud and was ordered to pay $15,984 in restitution to the Social Security Administration.
		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 Resolution	
1022310	001	Finding:	The Department of Social and Health Services did not adequately monitor its contracted supported living provider resulting in misappropriation of client funds between December 31, 2014, and June 30, 2016.
		Fraud Amount:	$31,963
		Amount to be Recovered:	$0
		Recovery to date:	Misappropriated funds totaling $31,963 were reimbursed to the Department.
		Resolution /Status:	This fraud finding involved a former Department employee receiving food, childcare and medical benefits that she was not qualified to receive. The auditors determined that internal controls at the Department were not adequate to safeguard public resources. As part of a continuous quality improvement effort, the Department: • Enacted changes to improve internal controls over eligibility determinations, in collaboration with the Department of Children, Youth and Families, for Child Care Subsidy Programs. Many of these changes were implemented after the timeframe for this investigation, and focused on reducing errors related to household composition and ensuring appropriate secondary review for high-risk cases. • Convened a workgroup to develop sufficient procedures to ensure fraud is reported appropriately in accordance with Department policies and include referring to other Agencies as necessary. By January 2019, an administration-wide policy will be implemented to provide guidance to staff about fraud reporting requirements to federal grantors and other state agencies that are involved in the fraud.
		Personnel Action Taken:	The employee was terminated in October 2017.
		Criminal Action Taken:	In March 2017, the case was referred to the Kitsap County Prosecutor's Office. In October 2017, the employee entered into an agreement with the county's Felony Diversion Program and paid restitution to the Department. The employee also signed a Disqualification Consent Agreement with the Department agreeing she would be disqualified from basic food assistance for one year.
		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 Resolution
1022311	001	**Finding:** The Department of Social and Health Services did not adequately monitor its contracted supported living providers resulting in misappropriation of client funds between April 2, 2015, and February 6, 2018. **Fraud Amount:** $19,369 **Amount to be Recovered:** $0 **Recovery to date:** $19,369 reimbursed to affected clients by the providers included in the investigations. **Resolution /Status:** This fraud finding involved four service providers who misappropriated client funds. As of September 2018, the Department has: • Confirmed all affected clients from Provider A, B, C and D have been fully reimbursed. • Issued a Statement of Deficiency letter, citing Provider A for failure to adequately monitor client funds. • Issued a Statement of Deficiency letter, citing Provider C for failure to reconcile and verify client accounts on a monthly basis and for failure to develop a plan to protect clients from financial exploitation. • Referred Provider B for criminal investigation. • Submitted a report to the Police Department regarding Provider D for criminal investigation. The Department is currently: • Working with service providers to ensure they have adequate policies and procedures in place to safeguard client funds and to track all client income and benefits. • Ensuring client withdrawals and/or purchases have supporting documentation and are for allowable purposes. • Monitoring service providers to ensure reconciliations of client funds are performed monthly and verified by a second individual for accuracy and completeness. • Conducting clients fund reviews, within available staffing resources, for supported living providers across the state. By June 2019, the Department will: • Provide service providers optional templates that may be used for creating individual financial plans for clients. • Develop a provider bulletin for all service providers related to money management for clients. • Conduct additional reviews of client funds at Provider B and ensure no other clients are at risk of financial loss. By December 2019, the Department will offer training to service providers that focuses on safeguards and prevention of client financial exploitation and theft.

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

Audit Report	Finding Number	Finding and Corrective Action
1022311	001 (cont'd)	Personnel Action Taken: Provider B has terminated the employee. The former employee paid $200 in restitution to Provider B in April 2018. Criminal Action Taken: Provider B: • Referred the investigation to the Seattle police and an investigation is pending. • Three clients are pressing charges against the former employee. Provider C: • Submitted reports to the Bellevue Police Department, as well as the Department's Complaint Resolution Unit and Adult Protective Services. • Has an ongoing investigation by the Bellevue Police Department, An individual not connected to the Provider has been identified in connection with the theft; however, charges have not been filed at the time of this report. Provider D: • Submitted a report to the Kennewick Police Department, and an investigation is pending. Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Washington State Parks and Recreation Commission — Agency 465

Audit Report	Finding Number	Finding and Resolution	
1022112	001	Finding:	The Commission conducted an investigation and determined that a misappropriation occurred between May 2016 and August 2017, involving a purchase card loss totaling $15,315 and fuel card loss of $764.
		Fraud Amount:	$16,079
		Amount to be Recovered:	$19,856
		Recovery to date:	$8,660
		Resolution /Status:	The Commission has taken the following actions to strengthen internal controls over purchase cards to improve oversight and monitoring: • Provide fraud awareness training to key staff. • Conduct enhanced reviews of purchase card documentation to ensure purchases are allowable. Implement Payment Analytics, a web-based solution provided by U.S. Bank, to enhance purchase card transaction monitoring to be more targeted, efficient and effective. The Commission will be able to receive email notifications of possible non-compliance and spend violations so preventive actions can be taken.
		Personnel Action Taken:	Employee resigned before any personnel action could be taken.
		Criminal Action Taken:	The report was forwarded to the Klickitat County Prosecuting Attorney's Office. The recovery of the remaining misappropriated amount and/or restitutions will be determined by the outcome of the criminal investigation.
		Agency Contact:	Mark Bibeau Chief Financial Officer PO Box 42650 Olympia, WA 98504-2650 Phone: (360) 902-8610 Mark.Bibeau@parks.wa.gov