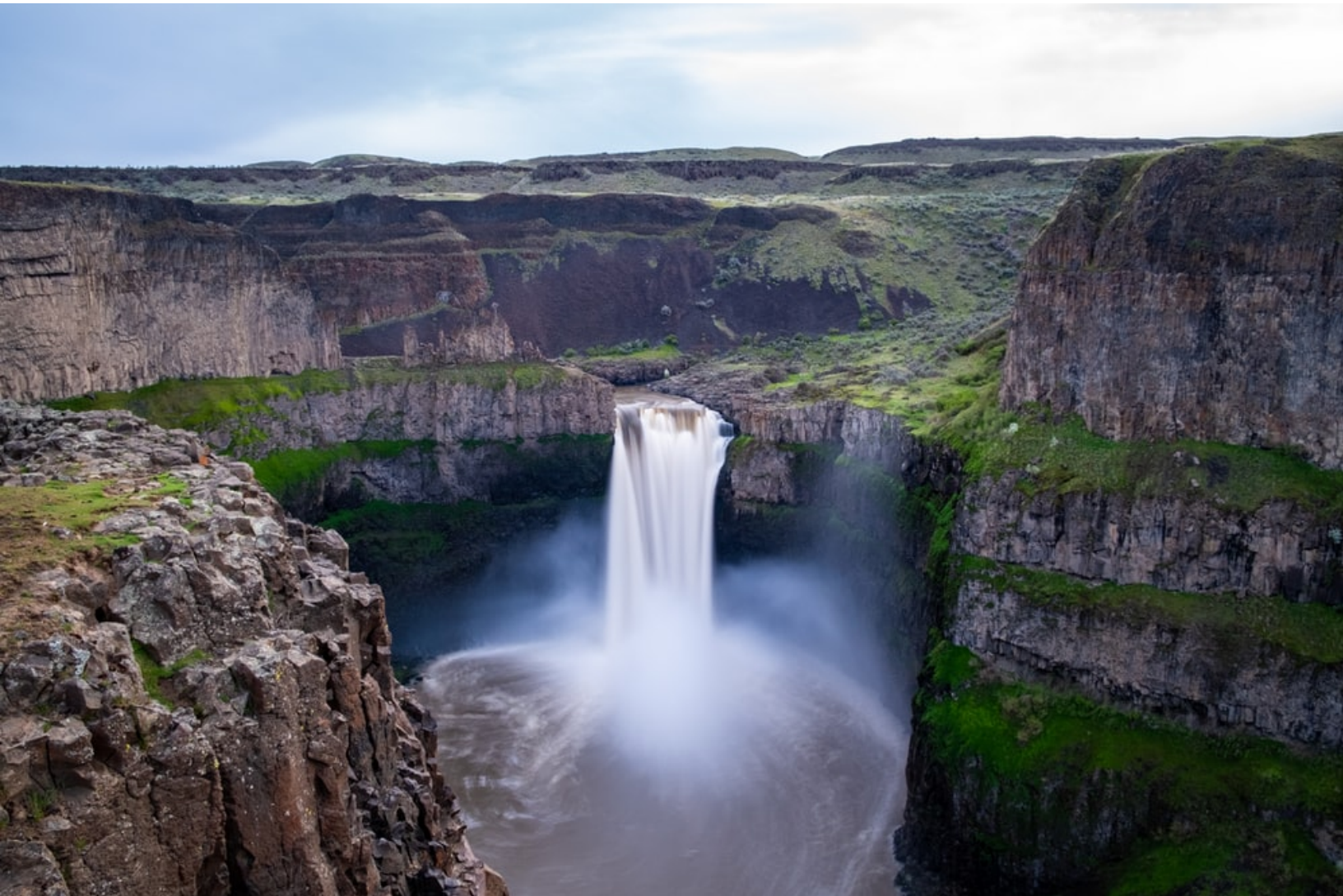
2019
Audit Resolution Report

State of Washington
Office of Financial Management
November 2019



STATE OF WASHINGTON
OFFICE OF FINANCIAL MANAGEMENT

2019
Audit Resolution Report

ACCOUNTING DIVISION
DECEMBER 2019

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State of Washington
Status of Audit Resolution
December 2019

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State of Washington
Status of Audit Resolution
December 2019

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 section 43.88.160 (6)(d) 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, 2018, and October 31, 2019.

The audit reports issued during that period include:

- 61 federal compliance findings
- 17 non-federal findings
- 3 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 2019

Schedule 1 – Audit Findings by Agency

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2018 F = Statewide Single Audit Report

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	001	Finding:	The State should improve internal controls over specific areas of recording and reporting financial activity 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. Responses from each agency are listed below: ***State Board for Community and Technical Colleges*** It is the Board's priority to ensure accurate financial data from the new financial system (ctcLink) is interfaced into the Agency Financial Reporting System (AFRS). Since the fiscal year 2017 audit, the Board has had a support team dedicated to assist the two colleges who implemented the ctcLink system to close their prior fiscal years. As of July 2018, the Board required all colleges' fiscal months be closed on the same schedule. As of November 2018: • The Community Colleges of Spokane closed fiscal years 2016, 2017, and 2018. • The Tacoma Community College closed fiscal year 2018. The Board is currently reviewing and reconciling the colleges' financial data to AFRS; making necessary adjustments to ensure the data was recorded accurately in the system. The Board will continue to work with college staff to resolve outstanding issues. As of April 2019, the Board implemented an automated process for uploading data from the ctcLink system to AFRS. The new process reduces the Board's workload and enables more timely and accurate reconciliations and adjustments of college financial data reported in AFRS at year-end. On July 2019, a newly re-designed global chart of accounts system was implemented, which has significantly improved the college system's ability to consistently track and report revenue and expenses. However, this implementation also necessitated the customization of the AFRS upload process to be re-configured to work with the new chart of accounts. As of October 2019, testing of the customization of the AFRS upload process was complete and was successfully deployed. In the coming months, the State Board anticipates the first ctcLink college data to be uploaded to AFRS using the updated customization.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	001 (cont'd)	***Department of Licensing*** The Department has completed a reconciliation of revenues to identify the sources of receipts in the clearing account and to correctly classify revenue in the accounting records. Additionally, the Department implemented new processes to ensure sources of revenue receipts are promptly identified and accurately recorded in the state's accounting system. ***University of Washington*** Since the University has a different accounting basis for reporting, OFM processes year-end adjustments to consolidate and properly report the University's financial information in the state's financial statements. In fiscal year 2018, certain misclassification of funds on the University's financial statements were not identified timely, resulting in misstatements on the state's financial statements. OFM and the University have been working on strengthening internal controls to ensure the year-end process for consolidating, adjusting and reporting year-end financial data in the state's accounting system are completed timely and accurately. As of June 2019, OFM implemented a monitoring plan for higher education institutions to identify issues that require immediate attention during the fiscal year. In addition, OFM will request the financial statements from each university and will compare material amounts on the statements to AFRS. Any variances identified will be evaluated with each university. For the fiscal year 2019 CAFR, OFM conducted an analytical review of the University of Washington's financial statements before the CAFR opinion was issued. ***Office of Financial Management*** OFM prepares the state's financial statements in accordance with generally accepted accounting principles. OFM concurs that several year-end adjustments were inaccurately recorded in fiscal year 2018 when implementing the new accounting standards related to pensions and other post-employment benefits. These errors were corrected in the state's final financial statements. OFM is responsible for ensuring all agencies report their fiscal activities accurately, and recognizes the importance of internal controls over recording and reporting financial transactions. OFM has the following procedures in place to monitor and identify significant agency activities that may impact the state's financial reporting:

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	001 (cont'd)	• Perform quarterly, mid-year, and year-end analytical reviews to 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. • Conduct 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 State's accounting system. When interpretation of standards are not definitive, OFM will seek guidance from the Governmental Accounting Standards Board. • Monitor agencies' financial data by running monthly reports from AFRS to identify incorrect transactions and questionable balances. In fiscal year 2018, OFM utilized a new financial reporting software tool to prepare the State's Comprehensive Annual Financial Report (CAFR). The reporting software tool improved the efficiency and accuracy for developing the report. For fiscal year 2019, OFM has extended the agreed-upon opinion date for the CAFR, allowing additional time for preparation and review. OFM expects that increased proficiency in using the reporting software tool and additional preparation time will allow sufficient dedicated resources for year-end review. OFM maintains ongoing communication with agencies and continually emphasizes the need to seek OFM guidance when reporting unique accounting activities. As of January 2019, OFM: • Increased communication with agencies regarding the importance of preforming regular and timely general ledger reconciliations. • Identified agencies with significant impact to the state's financial statements. Quarterly engagement meetings have been initiated with those agencies to discuss current issues and concerns, and to communicate any updated implementation guidance for new accounting standards. OFM will continue to: • Conduct meetings with all agencies prior to fiscal year-end close to provide important reminders and review outstanding issues. • Provide ongoing training classes to all state agencies on various topics related to the processing and reporting of financial activities. • Work with the State Board for Community and Technical Colleges, Department of Licensing, and the University of Washington to strengthen their internal controls over processing and reporting of financial activities.

State of Washington

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	001 (cont'd)	Completion Date: Corrective action is expected to be complete by June 2020 Contact: Brian Tinney Statewide Accounting Assistant Director PO Box 43127 Olympia, WA 98504-3127 (360)725-0171 brian.tinney@ofm.wa.gov

Office of Civil Legal Aid — Agency 057

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	009	Finding:	The Office of Civil Legal Aid did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Crime Victims Assistance program received required audits.
		Corrective Action:	The Office concurs with the finding. As of January 2019, the Office: • Established and implemented policies and procedures to monitor subrecipient audits in accordance with federal regulations. • Developed an audit certification form to determine if subrecipients are subject to audit requirement based on established criteria. The new process requires: • Subrecipients subject to the audit to: o Submit audit reports by specified due dates. o Complete corrective action plans and management responses if audit reports include findings. • Subrecipients not subject to audit must submit signed certifications of exemption within nine months of the end of the subrecipient's fiscal year. Additionally, the Office has established a system to track subrecipients fiscal year-end and send annual notification of certification due date. Since implementation of the new policies and procedures, the Office has received three Single Audit reports and one certification of exemption.
		Completion Date:	January 2019, subject to audit follow-up
		Agency Contact:	James A. Bamberger Director PO Box 41183 Olympia, WA 98504-1183 (360) 704-4135 jim.bamberger@ocla.wa.gov

Office of Civil Legal Aid — Agency 057

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	010	Finding:	The Office of Civil Legal Aid did not have adequate internal controls over and did not comply with requirements to ensure subgrants of the Crime Victim Assistance Program received required risk assessments.
		Corrective Action:	The Office concurs with the finding. To address the audit recommendations, the Office: • Established and implemented policies and procedures to ensure risk assessments of subrecipients are performed and properly documented. • Developed a risk assessment tool to evaluate the ability of each subrecipient to perform the work and manage the administrative and financial responsibilities in accordance with the subgrant's terms and conditions. Results of the risk assessment will be used as the basis for determining the level and type of monitoring activities. • Developed a risk assessment and monitoring checklist to track required monitoring activities. In addition, the Office has upgraded internal controls and formalized procedures for monitoring subrecipients by: • Conducting initial risk assessment prior to entering into a new subgrant agreement. • Performing annual reassessments of all subrecipients within 30 days of the start of the state fiscal year. • Implementing necessary corrective actions and scheduling appropriate follow-up activities if a risk assessment indicates an elevated risk associated with the subrecipient. As of April 2019, the Office had completed initial assessments of all current subrecipients.
		Completion Date:	April 2019, subject to audit follow-up
		Agency Contact:	James A. Bamberger Director PO Box 41183 Olympia, WA 98504-1183 (360) 704-4135 jim.bamberger@ocla.wa.gov

Office of the State Treasurer — Agency 090

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	007	Finding:	The Office of the State Treasurer did not have adequate internal controls to properly identify and notify participating counties of the amount and source of funds they received for the Schools and Roads program.
		Corrective Action:	The Office does not concur with the finding. It is the Office's priority to establish and maintain an effective system of internal controls to ensure financial integrity of public funds. The error reported in this finding was an isolated incident that was identified prior to the audit. As of July 2018, the Office had promptly corrected the mistake and subsequently followed up with each county to confirm the funding source was correctly recorded in their systems. The Office continually makes improvement to internal processes and appreciates the auditor's recommendations to strengthen controls over the proper identification of funding types and amounts to participating counties of the program. As of September 2018, the Office has: • Provided training to responsible staff to properly identify the different funding types. • Formalized procedures to perform adequate review of the disbursements to ensure the amounts and funding types are reported accurately to the counties. The Office continues to strive for the highest standards in fiscal management. The internal audit position recently added to the Office's staff will provide on-going evaluation and monitoring of the Office's internal procedures and control activities.
		Completion Date:	September 2018, subject to audit follow-up
		Agency Contact:	Abby Chavez Internal Auditor PO Box 40207 Olympia, WA 98501-2201 (360) 902-8965 abby.chavez@tre.wa.gov

Department of Commerce **Agency 103**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	032	Finding:	The Department of Commerce did not have adequate internal controls over and did not comply with requirements to monitor subrecipients of the Low-Income Home Energy Assistance program.
		Corrective Action:	The Department concurs with the finding. The Low-Income Home Energy Assistance program (LIHEAP) contracted with 26 subrecipients. These agencies are required to enter payment data for each client that receives a LIHEAP benefit into a centralized database. The Department uses this information to select transactions for onsite and desk monitoring. In response to the audit recommendations, the Department has strengthened internal controls over monitoring activities of subrecipients to ensure subawards from LIHEAP are used for authorized purposes. The following changes were incorporated in the current contract monitoring process: • Increased the threshold for onsite and desk monitoring review from one to three months of fiscal transactions. • Requested general ledger and back up documentation for each selected transaction to verify allowability of costs. As of January 2019, the program reviewed and formally updated the program monitoring plan to reflect the new process of subrecipient monitoring. As of June 2019, the program: • Worked with the Department's Energy Division, which also makes subawards of LIHEAP funds, to coordinate and increase efforts around fiscal and administrative monitoring. When opportunities exist, program staff will attend trainings hosted by the Energy Division on subrecipient monitoring. • Performed analytical reviews of each subrecipient's spending trends over a five-year period to help identify the highest three months of spending. With the collaboration of the Information Services Division, program staff created a report that identifies the months that should be included for fiscal transaction reviews. Subrecipients are then required to submit backup documentation for each expense incurred for those months. The Department also required subrecipients to submit back up documentation for invoices during the program year. This new requirement had been included in the special terms and conditions of the new contracts, which was effective October 1, 2019. Technical assistance and training on this requirement was provided to subrecipients during the Department's conference in September 2019. By providing staff training, leveraging Department resources to increase monitoring and utilizing a data-driven approach to identify high-risk

Department of Commerce **Agency 103**

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	032 (cont'd)	transactions, the Department will enhance the detection of unallowable or unsupported costs at the subrecipient level. Completion Date: October 2019, subject to audit follow-up Agency Contact: Shanna-Mae Cullen-Oden Internal Audit Manager PO Box 42525 Olympia, WA 98504-2525 (360) 725-4030 Shanna-mae.cullen-oden@commerce.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	041	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with a state law requirement to perform semi-annual data sharing with health insurers.
		Corrective Action:	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. While it is not within the Authority's scope of responsibilities to regulate insurance companies, several other methods of data sharing are regularly employed to achieve the goal of identifying third party liability. The Authority has requested legislation that modifies the specific method and timing of data exchange with insurance carriers. 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. The Authority anticipates the finding will be resolved through the legislation request and/or the decision of the legislative committees regarding resolution. The conditions noted in this finding were previously reported in findings 2017-031, 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 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	042	Finding:	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure certain Medicaid providers were revalidated every five years or that screening and fingerprint-based criminal background check requirements were met.
		Corrective Action:	The Authority is aware of the current situation with provider revalidation and is closely monitoring with routine reports. The Authority has prioritized revalidation work, and is making progress towards revalidation compliance. 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 also noted that federal regulations require providers to be re-categorized as high risk under very specific, limited circumstances. The Authority determined that there were approximately two dozen providers, out of 98,000, that met the specific criteria and required to be re-categorized as high risk. The Authority has implemented internal processes for divisions to notify the provider enrollment unit of any events related to provider overpayments, payment suspensions or new sanctions, which would trigger the need to adjust a provider's risk level to high. As of December 2018, the Authority: • Completed the process of re-categorizing current high-risk providers. • Updated procedures to include the new process of adjusting risk level when a qualifying event occurs. By November 2019, the Department will send notification of the revalidation requirement to all providers who enrolled with the Authority prior to March 31, 2014. By March 2020, the Authority will implement the new fingerprint requirement and will conduct fingerprint-based criminal background checks on the high risk providers identified under the re-categorization process. The conditions noted in this finding were previously reported in finding 2017-033.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	043	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 eligible nursing home claims.
		Corrective Action:	To address the audit recommendation, 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 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 findings 2017-034, 2016-029, 2015-032, 2014-039, 13-031, 12-54, and 11-39.
		Completion Date:	March 2018, subject to audit follow-up
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	044	Finding:	The Health Care Authority did not have adequate internal controls to ensure its federal draws for the Medicaid Transformation Demonstration project were adequately supported.
		Corrective Action:	The Authority is aware of the staffing turnover in the Medicaid Transformation Demonstration (MTD) Project. As of June 2019, the Authority: • Completed the process of filling vacant positions. • Developed policies and procedures describing the roles and responsibilities of staff within the project. The Authority is working on improving internal controls to ensure its federal draws for the MTD project are allowable and adequately supported. As of August 2019, the Authority contracted with an independent external auditor to review the Designated State Health Programs (DSHP) expenditure reporting for calendar years 2017 and 2018, and to validate the accuracy of federal claims. The Authority also: • Completed documenting defined administrative costs for DSHP. • Provided guidance to DSHP entities to ensure defined administrative costs are excluded from certified public expenditure reports. DSHP entities include state agencies, cities and county governments that use different financial payment systems to generate expenditure reports. Therefore, the Authority finds it challenging to require DSHP entities to provide supporting documentation in a consistent manner. The Authority will work with DSHP entities to ensure adequate and consistent supporting documentation is provided on certified public expenditure reports. The Authority will consult with the U.S. Department of Health and Human Services regarding establishing a process for program integrity as appropriate.
		Completion Date:	August 2019, subject to audit follow-up
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	045	Finding:	The Health Care Authority claimed Medicaid federal funds for Medicaid expenditures that exceeded the two-year time limit.
		Corrective Action:	For the expenditures identified in this audit as outside the two-year claim period, the Authority will research to determine if they were in fact unallowable. When the Center for Medicaid and Medicare (CMS) sends award closeout data and initiates the closeout process, the Authority will make any needed adjustments and return the federal funds to CMS. The Authority will continue to explore options to ensure refunds will be processed more timely to return claimed federal funds that are outside the allowable period.
		Completion Date:	Corrective action is expected to be complete by February 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	046	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:	The Authority currently has the follow processes in place to verify that providers have not been suspended or debarred: • Conducts reviews of the List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System/System for Award Management (EPLS/SAM) database checks during new provider enrollment and provider re-validation. • Conducts monthly LEIE database checks on Medicaid providers. • Managed Care Organizations conduct LEIE and EPLS/SAM database checks on network providers under the Authority's Apple Health contract. The Authority is not currently conducting monthly checks with EPLS/SAM. The system only has the ability to search a single individual and there is 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/SAM checks on providers. Last year, the Authority was approved as a pilot state to utilize the U.S. Department of Treasury's Do Not Pay database system, which will allow the Authority to upload the volume of providers into EPLS/SAM and conduct the required checks on a monthly basis. However, this process has since stalled on the federal side. The Authority is exploring other opportunities to meet compliance. Although the Authority is not currently conducting EPLS/SAM database checks at the frequency required, there were no improper payments identified. The conditions noted in this finding were previously reported in findings 2017-037.
		Completion Date:	Corrective action is expected to be complete by December 2019
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	047	Finding:	The Health Care Authority, Section of Program Integrity, Data Analytics and Review Unit, did not establish adequate internal controls over and did not comply with requirements to identify and refer suspected fraud cases for investigation.
		Corrective Action:	To address the auditor's recommendations, the Authority will take actions to improve internal controls over monitoring provider case reviews to ensure suspected fraud cases are appropriately referred for investigation. The Authority will review current policies and procedures and update as necessary to include: • Conducting secondary reviews of audits and findings to ensure they are accurate and supported. • Maintaining sufficient documentation to support case decisions. • Providing necessary and adequate training to staff to ensure all requirements to identify and investigate suspected fraud cases are met. As of September 2019, the Authority has requested additional funding in the 2020 supplemental budget to support the implementation of these activities and other program integrity improvement efforts, including recommendations from the Centers for Medicare & Medicaid Services.
		Completion Date:	Corrective action is expected to be complete by June 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	048	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 cause of condition of the finding. The auditors determined that the Authority does not conduct a post-eligibility review for coverage under the Children's Health Insurance Program (CHIP) when a household's income is below 133 percent of the federal poverty level. There is no such requirement in the Authority's federally approved verification plan, and the Authority does not agree that a material weakness in internal control exists. The condition that led to the $3,293 in unallowable claims for additional CHIP funds was corrected in July 2017. The remaining $852 in questioned costs represent claims that were not only eligible for additional CHIP funds, but also allowable at a higher rate than the Authority claimed. 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 2017-038, 2016-034, 2015-039, and 2014-037.
		Completion Date:	Not applicable
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

State Health Care Authority — Agency 107

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	049	Finding:	The Health Care Authority made improper payments for Medicaid managed care recipients with Medicare insurance coverage.
		Corrective Action:	The Authority has implemented the following corrective actions: • As of March 2016, developed an algorithm to identify Per Member Per Month (PMPM) premium payments for clients enrolled in Medicare. • As of June 2018, went live with the enhancements to the ProviderOne system to automate recoupment of PMPM premiums for clients who are retro-enrolled in Medicare. • Ran the new algorithm for the period from the last algorithm run in November 2017 to the system enhancement in June 2018, and identified all PMPM premium duplicate payments. As of August 2019, the Authority completed the recoveries of the duplicate PMPM premium payments. The conditions noted in this finding were previously reported in findings 2017-039.
		Completion Date:	August 2019, subject to audit follow-up
		Agency Contact:	Keri Kelley External Audit Compliance Manager PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

Department of Labor and Industries — Agency 235

Audit Report	Finding Number	Finding and Corrective Action Status	
1024490	2018-001	Finding:	The Department of Labor & Industries did not have controls in place to ensure annual inspections of elevators and related conveyances were performed, as required by state law.
		Corrective Action:	The Department concurs with the finding. The Department strives to ensure compliance with state law, and has been making continual efforts in improving the elevator inspection process. However, the Department faced significant challenges in filling inspector positions due to salary lags compared to similar positions within the industry. In 2016, the Department contracted for an independent study to evaluate current processes and identify areas for improvements. The study resulted in a number of recommendations for program improvements and enhancements to be implemented in phases. As of June 2018, Phase I of program improvements and enhancements was complete with the following results: • Pursued and obtained salary increases for elevator inspectors to address recruitment and retention. • Hired six additional inspectors. • Developed standardized work for annual inspections to streamline work process. • Updated online forms. • Revised technical briefs for stakeholders. As of November 2018, the Department launched Phase II of program improvements and enhancements, which will be fully implemented by December 2021. Specifically, the Department: • Began the development of virtual inspection capability via live streaming through Skype, which will allow inspectors in one location to remotely inspect residential chairlifts. The Department hopes to expand this capability to include elevators, escalators, and other conveyances in other locations, thus saving travel time and expediting services to contractors and service companies. • Secured $1.5 million of funding from the legislature to develop the New Conveyance Management System, a new computer software used for scheduling and managing inspection billing and all types of records. • Implemented procedural changes for elevator inspections which include: o Developing program-wide standard work procedures for inspectors. o Developing a guideline for overdue inspections and protocol for inspectors.

Department of Labor and Industries **Agency 235**

Audit Report	Finding Number	Finding and Corrective Action Status
1024490	2018-001 (cont'd)	o Focusing inspections in areas of higher concentrations of conveyances to increase efficiency and to focus efforts on areas with greatest ridership. • Requested funding to hire ten additional staff, including eight inspectors and two central office staff members, to increase timeliness of inspections. Completion Date: Corrective action is expected to be complete by December 2021 Agency Contact: Jennifer Myers, CPA Director Internal Audit PO Box 40005 Olympia WA 98507-4005 (360) 902-9117 Myej235@lni.wa.gov

Military Department — Agency 245

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	008	Finding:	The Military Department charged payroll costs to the Military Operations and Maintenance program that were not properly supported.
		Corrective Action:	The Department concurs with the finding. Department policy requires: • Employees who are permanently assigned to activities directly benefiting a single federal program to submit a Certification of Time and Effort (certification) on a quarterly basis. • Supervisors to review certifications for accuracy before submitting to the Payroll Office. In some cases, despite efforts made by the Payroll Office to send reminders to employees and their supervisors, the certifications were never submitted to the Payroll Office. The Department initiated the following actions to ensure payroll costs charged to a federal grant are supported by required documentation: • Updated time and effort reporting policy to provide timekeeping guidance and clarify requirements. • Provided copies of the policy to overtime-exempt employees and supervisors who are subject to the certification requirement. • Provided training to employees and supervisors on the Department's procedures regarding time and effort certification. • Required Payroll Office to follow up with the designated supervisor for any employee's past due certifications. Continued non-compliance with Department policy will lead to escalated actions as necessary until required documentation is received. The Department consulted with the grantor and confirmed that the questioned costs identified in the audit did not have to be repaid.
		Completion Date:	August 2019, subject to audit follow-up
		Agency Contact:	TJ Rajcevich Deputy Finance Director Building #1: Headquarters Mailstop: TA-20 Tacoma, WA 98430-5032 (253) 512-7596 timothy.rajcevich@mil.wa.gov

Military Department **Agency 245**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	061	Finding:	The 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:	In response to prior year's finding, the Department implemented process changes as outlined in the corrective action plan. As of November 2018, the Department updated the existing subrecipient monitoring policy to clearly outline roles and responsibilities for divisions and grant programs. The Finance Division maintains the Department's Audit Tracker system and is responsible for collecting audit data from subrecipients across the Department. As of October 2019, the division completed documenting all relevant audits for subrecipients that received grant funds in 2017 and 2018. In collaboration with the Public Assistance and other grant programs, the Finance Division also completed the following activities: • Verified all required audits occurred. • Ensured all subrecipient audit findings related to the program were followed up on. • Ensured management decision letters were issued promptly where necessary. • Continued to add new subrecipients to the Audit Tracker system as new grants are awarded in 2019 and beyond. • Monitored audit status in the system and followed up as required. The program will continue to perform program monitoring activities. Upon receipt of an audit finding notification, the program performs an extensive review of the finding and issues management decision letters as needed. The conditions noted in this finding were previously reported in finding 2017-052.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	TJ Rajcevich Deputy Finance Director Building #1: Headquarters Mailstop: TA-20 Tacoma, WA 98430-5032 (253) 512-7596 timothy.rajcevich@mil.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	002	Finding:	The Department of Social and Health Services improperly charged $454,838 to the SNAP Cluster.
		Corrective Action:	The Department concurs with the finding. In response to prior audit findings, the Department had taken steps to correct the deficiencies identified by the auditors. As of March 2017, the Department's Economic Services Administration implemented a mandatory process for staff to include the month of service (MOS) to transactions processed in the Agency Financial Reporting System (AFRS). The Department utilizes the MOS to perform a monthly review of AFRS transactions to identify unallowable charges and move them to the proper grant year via the journal voucher process. However, at the time of this audit, the Department has not established a process to ensure staff were following procedures to meet period of performance requirements. As of December 2018, the Department had moved the improperly charged expenditures identified in the audit to the proper grant year via the journal voucher process. As of February 2019, the Department updated processes and procedures for management oversight to prevent future expenditures from being improperly charged to the wrong grant year. The Department: • Assigned backup coverage during staff absences. • Began reviewing and monitoring monthly expenditure reports, and taking action where appropriate. • Increased staff accountability through the use of a monthly task list. • Began meeting monthly with the Accounting and Internal Control Administrator to provide updates on corrective action status related to period of performance issues. If the grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in findings 2017-002, 2016-002, 2015-003, and 2014-022.
		Completion Date:	February 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	021	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable period of time.
		Corrective Action:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with eligibility timelines and required procedures. As of April 2019, the Department implemented the following procedures: • The Fiscal Compliance Manager conducts six-month review of eligibility extensions to identify cases that do not conform to policy and documentation requirements. These cases are sent to the respective supervisors for follow-up. • Supervisors' monthly case reviews now include mandatory follow-up activities to ensure reviews are effective and properly documented. • Rehabilitation Technicians review cases coming due within 30 days for eligibility determination and alert counselors of upcoming due dates. • Supervisors complete an on-line coaching tool monthly with Rehabilitation Technicians, as needed. As of June 2019, the Department: • Revised the eligibility extension letter to include a mandatory field for the extension end date. • Amended eligibility extension procedures to require follow-up with clients when extension letters are not returned. As of October 2019, the Department: • Enhanced the case management report to identify eligibility extension dates and determination completion dates. • Provided training to staff on updated procedural guidance that clearly define "exceptional and unforeseen circumstances." By December 2019, the Department will update the eligibility extension process in the case management system to auto-generate: • Case narratives • Client letters • Completion dates The conditions noted in this finding were previously reported in findings 2017-013 and 2016-012.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	021 (cont'd)	Completion Date: Corrective action is expected to be complete by January 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	022	Finding:	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.
		Corrective Action:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with timelines and required procedures. As of April 2019, the Department implemented the following procedures: • The Fiscal Compliance Manager conducts a six-month review of individual plans of employment (IPE) to identify cases that do not conform to policy and documentation requirements. These cases are sent to the respective supervisors for follow-up. • Supervisors correct any IPE that does not conform to policy and documentation requirements. • Rehabilitation Technicians review IPEs coming due within 30 days and alert counselors of upcoming due dates. • Supervisors complete an on-line coaching tool monthly with Rehabilitation Technicians as needed. As of May 2019, the Department revised the eligibility determination letter to include an appointment date with the client to begin the IPE process. As of June 2019, the Department amended procedures to require counselors to follow-up with clients when IPE extension letters are not returned, and to ensure both counselor and client properly approve the completed IPE. As of August 2019, the Department provided training to field staff on the new procedures. The conditions noted in this finding were previously reported in findings 2017-012 and 2016-011.
		Completion Date:	August 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	023	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with federal requirements to ensure payments paid on behalf of clients for Vocational Rehabilitation were allowable.
		Corrective Action:	The Department concurs with the finding. The Department will establish additional procedural guidance aimed at ensuring full compliance with federal requirements. In addition, the Department will enhance management reports and coaching tools to support supervisory oversight and monitoring of compliance with allowable uses of program funds. As of March 2019, the Department issued a directive requiring case records to be reviewed prior to authorization of services. Staff perform reviews to ensure: • Services are properly documented in the individual plan for employment (IPE). • The IPE has been approved by the counselor and client. • Case actions are appropriately referred to the supervisor if necessary. As of May 2019, the Department: • Updated procedures to clarify that payments for any authorized services on an IPE cannot be made until the IPE is properly signed by client. • Created detailed procedures for supervisors to conduct monthly review of payments. • Enhanced the case management system's preventative controls to only allow authorizations of services that are included on the IPEs. If an emergency, non-authorized service is needed, supervisory approval is required to proceed. • Consulted with the grantor to determine whether any questioned costs need to be repaid. As of July 2019, the Department reviewed all service category requirements from the Department of Education and identified process improvements. The conditions noted in this finding were previously reported in findings 2017-014 and 2016-013.
		Completion Date:	July 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	024	Finding:	The Department of Social and Health Services did not have adequate internal controls to ensure its federal financial reports for the Vocational Rehabilitation grant were accurately prepared.
		Corrective Action:	The Department concurs with the finding. As of September 2018, the Department established written procedures to require secondary reviews of the Federal Financial Report (SF-425). As of April 2019, the Department established written procedures to require secondary reviews of the Program Cost Report (RSA-2). The Finance and Budget Manager reviews completed reports for accuracy. The Department continues to strengthen internal controls over reporting to ensure program reports are complete and accurate.
		Completion Date:	April 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	025	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional and National Significance and Block Grants for Prevention and Treatment of Substance Abuse programs received required audits.
		Corrective Action:	As of July 1, 2018, the Behavioral Health Administration's Division of Behavioral Health and Recovery was transferred from the Department to the Health Care Authority (Authority). The Authority assumed the responsibilities over the Block Grants for Prevention and Treatment of Substance Abuse and Substance Abuse and Mental Health Services Projects of Regional and National Significance. As of October 2019, the Authority established a work group to coordinate the efforts of multiple divisions across the agency and work on establishing an overall subrecipient monitoring process. By March 2020, the Authority will: • Evaluate the existing process in monitoring subrecipient audits and identify potential improvements. • Assess and update policies and procedures related to subrecipient monitoring. • Strengthen internal controls to ensure: o Subrecipients submit required audits. o Subrecipients take timely actions on all deficiencies identified from audits or onsite reviews. o All audit findings and corrective action plans are tracked and management decisions are issued promptly. The conditions noted in this finding were previously reported in findings 2017-016, 2016-014, 2015-016, and 2014-019.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Keri Kelley External Audit Compliance Manager State Health Care Authority PO Box 45502 Olympia, WA 98504-5502 (360) 725-9586 keri.kelley@hca.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	026	Finding:	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to ensure payments to child care providers paid with Temporary Assistance for Needy Families funds were allowable.
		Corrective Action:	The Department partially concurs with the finding. The Department works with the Department of Children, Youth, and Families (DCYF) to ensure payments to child care providers paid with Temporary Assistance for Needy Families funds were allowable. DCYF policy requires providers receiving subsidy payments to maintain attendance records and provide them upon request. However, because attendance records are paper-based, it is not feasible for staff to request, review and reconcile all records before subsidy payments are made. In response to prior findings, the Department has implemented internal controls including: • Third-party reviews through the establishment of the Process Review Panel (PRP) to review and evaluate audit findings, explore options and recommend appropriate corrective actions. • Pre-authorization reviews on high-risk and/or high cost cases based on trend analysis discovered during the PRP. As of December 2018, DCYF requires all licensed providers who accept subsidy payments to use DCYF's electronic attendance system or an approved third party system to track attendance. DCYF's system enables accurate, real-time recording of child care attendance, tracks daily attendance, and captures data on child care usage. DCYF has since expanded the requirement to all families, friends and neighbor providers. Beginning July 1, 2019, the Department will transfer responsibility for administering all aspects of client eligibility determination and child care provider payment to DCYF. The Department will continue to conduct post-payment reviews where improper payments appear likely to have occurred, or refer to DCYF for review. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and take appropriate action. The conditions noted in this finding were previously reported in findings 2017-017 and 2016-019.
		Completion Date:	February 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	027	Finding: The Department of Social and Health Services did not have adequate internal controls over maintenance of effort requirements for the Temporary Assistance for Needy Families grant. Corrective Action: The Department partially concurs with the finding. In response to prior years' findings, the Department has taken actions to improve internal controls over the maintenance of effort (MOE) process for the Temporary Assistance for Needy Families (TANF) grant. As of February 2017, the Department developed manuals that outline the collaborative report preparation procedures among the Community Services Division, the Research and Data Analysis Division (RDA) and the Division of Finance and Financial Recovery. As of March 2018, the Department: • Hosted weekly workgroup meetings to review and update existing policies, procedures and manuals as necessary. The workgroup also focuses on improving the Department's ability to forecast and monitor the level of TANF program's MOE expenditures throughout the year. • Implemented a quarterly monitoring and reporting schedule for all MOE sources throughout the federal fiscal year to ensure MOE reported expenditures are allowable and accurate. • Established a process for reviewing future budgets on programs subject to MOE requirements by: o Performing trend analysis by comparing budget data to previous years to ensure there is no significant fluctuations. o Obtaining written confirmation from partnering sources at the beginning of the federal fiscal year that program operations and expenditure levels will be similar to the previous year. o Reviewing TANF MOE reports and monitor departmental expenditures on a quarterly basis to ensure MOE requirements will be met. The Department's RDA Division is also taking actions to improve internal controls for ensuring the TANF quarterly reports are accurate and complete. By January 2020, the Division will: • Track which employees make coding changes. • Require that supervisors review coding changes and document these reviews. • Add a section in the TANF MOE manual outlining the roles and responsibilities of employees who make coding changes and for management who review those changes. The conditions noted in this finding were previously reported in findings 2017-019, 2016-017 and 2015-020.

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	027 (cont'd)	Completion Date: Corrective action is expected to be complete by January 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

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

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	028 (cont'd)	The conditions noted in this finding were previously reported in findings 2017-020 and 2016-016. Completion Date: Corrective action is expected to be complete by January 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	029	Finding:	The Department of Social and Health Services did not have adequate internal controls in place for submitting quarterly and annual reports for the Temporary Assistance for Needy Families grant.
		Corrective Action:	The Department does not concur with the finding. In response to prior years' findings, the Department has taken actions to improve internal controls over the reporting process for the Temporary Assistance for Needy Families (TANF) grant. As of March 2018, prior to the end of the audit period, the Department fully implemented the following process changes: • Hosted weekly workgroup meetings to review and update existing policies and procedures as necessary to strengthen internal control. • Implemented a quarterly monitoring and reporting schedule for all maintenance of effort (MOE) sources to ensure reported expenditures are allowable, accurate and submitted in a timely manner. • Established a process for reviewing future budgets on programs subject to MOE requirements: o Perform trend analysis by comparing budget data to previous years to ensure there is no significant fluctuations. o Obtain written confirmation from partnering sources at the beginning of the federal fiscal year that program operations and expenditure levels will be similar to the previous year. o Review TANF MOE reports and monitor departmental expenditures on a quarterly basis to ensure MOE requirements will be met. Additionally, the Department: • Reviews all reported expenditures to ensure they are accurate, verifiable, and not used for other federal matching purposes, • Maintains all supporting documentation locally and electronically for the reports submitted to the federal grantor. The Department maintains that current processes and procedures are adequate to ensure expenditures are verifiable and meet federal regulations. The conditions noted in this finding were previously reported in findings 2017-021, 2016-018, and 2015-021.
		Completion Date:	Not applicable
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	030	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with client eligibility requirements for the Working Connections Child Care program.
		Corrective Action:	The Department partially concurs with the finding. The exceptions identified by the auditor results from minor procedural errors or incorrect calculations that did not have an effect on the eligibility determinations. While some of these errors caused payment errors, the clients were eligible. In response to the fiscal years 2016 and 2017 findings, the Department has enacted major changes to improve internal controls over eligibility determination. Many of these changes were implemented during fiscal year 2018, while some were implemented at the beginning of fiscal year 2019. The Department of Children, Youth, and Families (DCYF), formerly the Department of Early Learning, established child care program policies. DCYF policy does not require secondary review or approval when determining eligibility, or authorizing benefits and payments. Beginning July 1, 2019, the Department will transfer responsibility for administering all aspects of client eligibility determination and child care provider payment to DCYF under the Child Care Development Fund. The Department has continued to employ the following controls to ensure child care subsidy payment authorizations are made correctly: • Require a supervisory review of payment requests that exceed certain parameters. The supervisor reviews the justifications for the need of additional payment and will deny the payment if the client is not eligible. A monthly report is generated and supervisor checks for any authorization that appears to have been approved without the required secondary review. • For authorizations with high cost special needs rates, a panel consisting of DSHS and DCYF staff review the request and supporting documentation prior to approval. The authorization is subsequently reviewed by a supervisor prior to payment. • Require one hundred percent of new employees' work be audited by a lead worker until they achieve proficiency. These reviews may be conducted before or after authorization. • Requires at least one percent of child care cases be audited monthly. • Participate in the Improper Payments Information Act audit required by the Federal Office of Child Care and conducted by the DCYF once every three years. As of August 2017, the Department: • Implemented enhancements in the Barcode system to automatically generate a sixty-day reminder letter requesting income verification of new employment.

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

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Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	030 (cont'd)	If the grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs with the grantor and take appropriate action. The conditions noted in this finding were previously reported in findings 2017-026, 2016-023, 2015-026, 2014-026, 2013-017 and 12-30. Completion Date: May 2019, subject to audit follow-up Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

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

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Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	031 (cont'd)	Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	036	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to detect fraud in the Child Care and Development Fund program.
		Corrective Action:	The Department concurs with the audit finding. In response to prior audit recommendations, the Department took steps to include child care dollars as a risk factor in determining the priority of fraud referral investigations. In December 2017, the Department convened a workgroup to modify the Fraud Early Detection program (FRED) algorithm to address child care cases while not adversely affecting other medical programs that also use the FRED algorithm. In February 2018, the Office of Fraud and Accountability's (OFA) Senior Director issued a directive to managers that all cases rated as 1 or 2 should be assigned for investigations within 90 days after referral. As of April 2018, an algorithm was implemented in the Barcode system to include child care benefit payments and household composition. This enhancement increases the assigned point values in child care cases, resulting in a higher priority level for investigation. The Department will continue to: • Maintain a goal of completing as many of the fraud cases with highest risk as staffing and workload allows. • Monitor the monthly status of all FRED cases by OFA managers to ensure high priority cases are assigned timely. • Review monthly performance measurement reports. The conditions noted in this finding were previously reported in findings 2017-027, 2016-020 and 2015-025.
		Completion Date:	April 2018, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	037	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure it separately identified and reported demonstration project costs.
		Corrective Action:	The Department concurs with the finding. As of July 1, 2018, the Legislature created a new state agency that combined the Department's Children's Administration and the Department of Early Learning. The new agency is called the Department of Children, Youth and Families (DCYF) and is now responsible for managing the Foster Care program. DCYF assigned specific system coding in FamLink, the system used to track costs for service payments and contracts. The new codes track payments made for the demonstration project. The Department revised its reporting process to separately identify and report project costs for both the Title IV-E Foster Care program and the demonstration project. The Department will work with the grantor if revisions to prior reports are determined to be necessary.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison Department of Children, Youth and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Social and Health Services — Agency 300

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

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	039	Finding:	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal level of effort requirements for the Adoption Assistance program.
		Corrective Action:	The Department concurs with the finding. In response to prior audit findings, the Children's Administration of the Department had improved internal controls and developed written policies and procedures to ensure the federal level of effort requirements are met for the Adoption Assistance program. As of July 1, 2018, the Legislature created the Department of Children, Youth, and Families (DCYF) by combining the Children's Administration and the Department of Early Learning. The new agency assumed the responsibilities of managing the Adoption Assistance program. To address the audit recommendations, DCYF has implemented appropriate corrective actions, which include: • Established written procedures for staff to identify and accurately report adoption savings expenditures. • Reviewed annual reports to ensure reported expenditures are accurate and supported by adequate documentation. • Provided training to staff on the policies and procedures. The conditions noted in this finding were previously reported in findings 2017-030 and 2016-026.
		Completion Date:	September 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison Department of Children, Youth, and Families PO Box 40970 Olympia, WA 98504-0970 (360) 725-4402 stefanie.niemela@dcyf.wa.gov

Department of Social and Health Services — Agency 300

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

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	050 (cont'd)	Completion Date: Corrective action is expected to be complete by June 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	051	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration made improper Medicaid payments to individual providers when clients were hospitalized or admitted to long-term care facilities.
		Corrective Action:	The Department concurs with the finding. The Department is in the process of enhancing monitoring procedures for identifying unallowable payments. By January 2020: • The overpayment functionality in the Department's Individual ProviderOne system is expected to be fully implemented. • The Department will begin the process of issuing overpayments to the providers for any unallowable payments. The Department will work with the federal grantor to determine if any questioned costs identified in the audit and associated costs need to be repaid.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	052	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls and did not comply with survey requirements for Medicaid intermediate care facilities.
		Corrective Action:	The Department partially concurs with the finding. The Department utilizes a survey-tracking tool to monitor survey due dates and completion, and has established internal controls to ensure survey requirements for Medicaid intermediate care facilities are met. The one recertification that was performed past its due date in April 2018 was not an indication of internal control deficiency, but rather a result of resource prioritization. The facility was non-compliant with a condition of participation from a prior recertification survey, and was imposed with a "Denial of Payment" penalty for new admissions. After receiving the facility's credible allegation of compliance letter in January 2018, the Department conducted two re-survey visits and subsequently placed the facility back in compliance in March 2018. The facility's recertification was performed in May 2018 due to the Department's executive decision to prioritize a recertification survey of another facility that had been out of substantial compliance and placed clients' safety and welfare at risk. As of April 2019, the Department requested assistance from: • Certified surveyors of other units within Residential Care Services as needed. • The federal grantor's contracted certified surveyors, if available, to meet compliance with survey intervals. The Department will continue to ensure survey requirements are met. The conditions noted in this finding were previously reported in finding 2017-042, 2016-037, 2015-045, and 2014-046.
		Completion Date:	April 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	053	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure it complied with survey requirements for Medicaid nursing home facilities.
		Corrective Action:	The Department does not concur with the finding. In response to prior audit findings, the Department had implemented the Electronic Plan of Correction (ePOC), an electronic application that enables the Department to monitor compliance more effectively. The Department asserts that internal controls have been strengthened to ensure Statements of Deficiencies (SOD) are mailed by the tenth working day after survey exits, as evidenced by the steady decrease in audit exceptions since fiscal year 2016. The auditors reported two cases where the Department did not deliver SOD within ten working days as required. One case was due to the failure of the ePOC system on the provider end, resulting in the Department manually delivering the SOD to the provider on the eleventh day. The Department subsequently confirmed that the technical problem had been resolved for the provider in question. In the second case, an administrative review of the SOD caused a slight delay and resulted in the Department delivering the SOD to the provider on the eleventh day. In both cases, the SOD were delivered less than 24 hours beyond the federal requirement. The providers submitted their plans of correction timely with no impact from the one-day delay. System failures are beyond the control of the Department, and administrative reviews are essential to ensure SOD are complete and accurate. These should be considered acceptable reasons for providers not receiving their SOD within the required ten days. The Department will continue to use existing internal controls and quality assurance reviews to monitor the timeliness of SOD distribution to providers. The conditions noted in this finding were previously reported in finding 2017-043, 2016-036, 2015-044 and 2014-046.
		Completion Date:	February 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	054	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid payments to home care agencies were allowable.
		Corrective Action:	The Department partially concurs with the finding. The Department concurs that there were 25 instances when a daily payment was not supported by an electronic timekeeping record. These payments were made to a home care agency that subsequently closed and did not respond to the request for documentation. However, the Department does not concur that payments with no attached task sheets or missing signatures on task sheets should be included in questioned costs. Task sheets are used to document what tasks were completed during the provider's shift, as required by the home care agency contract. They are not a federal or state requirement. As of May 2019, the Department: • Issued an overpayment to the home care agency that did not respond to the request for electronic time keeping records to support the payment. • Reimbursed the federal questioned costs. As of June 2019, the Department: • Modified the tool provided to the Area Agencies on Aging (AAA) for monitoring home care agency's compliance with electronic timekeeping contractual requirements. • Worked with AAA's contract management staff to request corrective action plans from home care agencies that are noncompliant with contractual requirements. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action.
		Completion Date:	June 2019, subject to audit follow-up
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	055	Finding:	The Department of Social and Health Services did not ensure the federal portion of uncashed Medicaid checks was returned to its grantor.
		Corrective Action:	The Department concurs with the finding. The Department is implementing a process for the vendor to return uncashed checks to the Department. By January 2020, the Department and the vendor will: • Complete the development of an interface to identify uncashed checks older than 180 days. • Develop a report listing the uncashed checks that need to be returned to the Department. • Request the vendor to return uncashed checks that were issued from April 2016 through December 31, 2017. Thereafter, the vendor is required to submit a monthly report with any uncashed checks. By March 2020, the Department will return the federal share of all uncashed checks to the Center for Medicaid and Medicare Services.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.Meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	056	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure all Medicaid Community First Choice individual providers had proper background checks.
		Corrective Action:	The Department partially concurs with the finding. The Department asserts that adequate internal controls are in place to ensure all Medicaid individual providers had proper background checks. Centers for Medicare & Medicaid Services require a minimum of 86 percent proficiency statewide related to compliance with individual provider background checks. The Department has monitored this requirement for many years and has consistently achieved over 90 percent proficiency statewide. The audit identified: • Five instances when fingerprint background check were not performed on Community First Choice (CFC) individual providers within the required timeframe. In all cases, the Department subsequently completed fingerprint background checks and found no disqualifying crimes. • One instance where a background check was not renewed after two years. Although this requirement is included in the Department policy, the State Plan does not require individual providers to complete background checks every two years to remain qualified. The State Plan only requires a state background check prior to contracting, and a federal background check, when required, within 120 days of being hired. The Department agrees that two of the three Area Agency on Aging (AAA) proficiency improvement plans did not address how the AAA would correct a background check deficiency. To address the audit recommendations, the Department will continue to follow established internal controls to materially ensure CFC individual providers have timely background checks. As of June 2019, the Department revised its internal process for approving proficiency improvement plans to ensure accuracy and completeness. The Department will identify associated costs related to unallowable payments for personal care services. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in finding 2017-049, 2016-040, 2015-040, 2014-049, 2013-40, 12-41, and 11-34.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	056 (cont'd)	Completion Date: June 2019, subject to audit follow-up Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	057	Finding:	The Department of Social and Health Services, Aging and Long-Term Support and Developmental Disabilities Administrations, did not have adequate internal controls over and did not comply with requirements to ensure some Medicaid providers were properly revalidated or screened, and fingerprint-based criminal background check requirements were met.
		Corrective Action:	The Department concurs with the finding. As of November 2017, the Department developed a process to screen and track each nursing facility contract to ensure validation and revalidation occurred within the five-year requirement. As of September 2018, the Department completed screening of all nursing facilities. As of October 2018, the Department implemented an automated process to screen providers in the Agency Contracts Database (ACD). The new process includes a built-in system edit in the ACD that prevents a new or renewal of Medicaid contract to be approved or signed unless the screening process has been successfully completed in ACD. The Department will continue to: • Verify and document proof of identity and authorization to work in the U.S. from individual providers before revalidating providers' contracts. • Perform quality assurance monitoring and remediation activities to ensure compliance with contracting requirements. By January 2020, the Department will complete a workload impact assessment and cost analysis for: • Monitoring provider risk levels for risk level reassignment due to overpayments or Medicaid fraud referral. • Implementing a process to conduct fingerprint-based criminal background checks for high-risk providers to meet additional fingerprint requirements. Once workload impact and cost analysis is complete, the Department will determine the best course of action to comply with screening and fingerprint requirements.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	058	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and was not compliant with requirements to ensure Medicaid payments to supported living providers were allowable.
		Corrective Action:	The Department partially concurs with the finding. State law provides the Department the authority to authorize payments for individuals in community residential programs. The system is designed to allow supported living (SL) providers the resource flexibility needed throughout the year to meet the changing needs of the individual clients. The Department requires that clients receive all authorized Instruction and Support Services (ISS) hours over the course of the year. Providers are expected to provide hours in a flexible way within the year in order to address clients' individualized needs. SL providers are required to complete and certify annual cost reports, which reconcile hours and ISS dollars authorized to hours and ISS dollars provided. After reviewing cost reports, the Department establishes settlements when providers were paid for more direct service hours than they provided in a calendar year or when providers received more reimbursement (in dollars) for direct support costs compared with what was actually incurred during the year. <u>Cost Reports and Timesheets</u> The cost reports are not used to provide information to establish rates or allocate appropriate funds. Rather, rates are established through a rate setting process which includes a method to adjust for the sharing of service hours within households or clusters, and for needed supports that occur on an infrequent basis. All of these items are factored into calculating a daily rate for the individual client. The direct hours reported in the cost reports does not take into consideration the annual needs for support services, such as medical appointments and periodic essential shopping, The daily rates established through the rate setting process encompass these support hours. As such, looking at a snapshot of hours does not accurately reflect the cost of care provided and does not take into consideration that the rate assessment is based on a client's daily, weekly and annual needs for support services. Support services are evaluated and spread out over the entire year. The algorithm encompasses and factors in these support hours to determine the daily rate. The staffing plan is not intended to be a reflection of the daily hours provided, but rather a snapshot of the client's average assessed needs. During the cost settlement process, the Department's rate analysts verify accuracy of the reports and request additional documentation for support when necessary. The Department works with the providers to address any issues prior to the filing of cost reports.

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

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	058 (cont'd)	• Complete desk audits of selected providers and work with the providers to resolve any payment discrepancies identified. The conditions noted in this finding were previously reported in findings 2017-044, 2016-041, 2016-045, 2015-049, 2015-052, 2014-041, 2014-042, 2013-036, 2013-038, and 12-39. Completion Date: Corrective action is expected to be complete by July 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	059	Finding:	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client service plans were properly approved.
		Corrective Action:	The Department partially concurs with the finding. While the Department agrees that person-centered service plans must be signed by the Department, client, and provider, the Department does not agree that improper payments can be assigned when a person-centered service plan is not signed by an individual responsible for its implementation. The Centers for Medicare and Medicaid Services (CMS) had previously provided guidance to the Department stating that the federal rules covering eligibility for services are separate from the rules on person-centered service planning. In all the cases reviewed by the auditors in the audit, the Department made payments to qualified providers for covered services delivered to eligible beneficiaries. The lack of a signed service plan does not render a client ineligible for services and therefore should not result in an improper payment. In January 2018, the Department updated the quality assurance procedures in monitoring compliance for obtaining client signatures on service plans. The Division's Quality Assurance team reviews client and Department signatures from a statewide sample, including documented attempts to obtain signatures. The review is part of an established annual audit cycle and measures statewide proficiency. If the annual review determines that the proficiency has fallen below the CMS standard of 86 percent, a quality improvement plan will be implemented to improve statewide performance. The Department also disagrees that any signatures received after 60 days should result in exceptions. Federal regulations require signatures, but not within a specified amount of time. CMS did provide guidance that in some cases it may be difficult to obtain signatures and gave direction on steps the Department can take to comply with the rules while still continuing services without the required signatures. Based on CMS guidance, effective December 2018, the Department changed its regulations to no longer require the termination of services should a client not return a signed service plan within 60 days of the completion of assessment. Since the previous rule was in conflict with federal guidance and has subsequently been revised, the Department disagrees with the auditor's determination that: • Improper payments resulted from seven service plans that were not signed by the clients within 60 days. • Seven Department signatures and two provider signatures received after 60 days were audit exceptions. The 60-day time frame for the Department and providers was not required by either federal or state regulations.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	059 (cont'd)	As of July 2019, the Department: • Revised its policies and procedures to add the requirement of provider signatures on person-centered service plans. This requirement was also added to the quality assurance monitoring process. • Provided training and outreach efforts to field staff on the new requirement and the alternatives for obtaining client's signature on person-centered service plans. As of November 2019, the Department: • Completed targeted reviews to measure compliance and determined that additional actions were needed to increase the proficiency rate with this requirement. • Began piloting technical upgrades in the Comprehensive Assessment and Reporting Evaluation assessment tool to allow clients to sign their service plans via an electronic method. The Department will consult with CMS to clarify if person-centered service plans that are missing signatures should result in unallowable payments, and if applicable, the associated costs related to any unallowable payments. If the federal grantor contacts the Department regarding questioned costs that should be repaid, the Department will confirm these costs and will take appropriate action. The conditions noted in this finding were previously reported in finding 2017-045. Completion Date: November 2019, subject to audit follow up Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	060	Finding:	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client service plans were properly approved.
		Corrective Action:	The Department partially concurs with the finding. The auditors expanded the audit scope in fiscal year 2018 to include a review of provider signatures on person-centered service plans, in addition to Department and client signatures, for compliance with federal requirements. While the Department agrees that it must comply with federal regulations regarding obtaining signatures on clients' person-centered service plans, the Department does not agree that improper payments can be assigned when a service plan is not signed by an individual responsible for its implementation. The Centers for Medicare and Medicaid Services (CMS) had provided guidance to the Department stating that the federal rules covering eligibility for services are separate from the rules on person-centered service planning. In all the cases reviewed by the auditors in the audit, the Department made payments to qualified providers for covered services delivered to eligible beneficiaries. The lack of a signed person-centered service plan does not render a client ineligible for services or a provider unqualified to provide services, and therefore should not result in an improper payment. The Department also disagrees that any signatures received after 60 days should result in exceptions. Federal regulations require signatures, but not within a specified amount of time. CMS did provide guidance that in some cases it may be difficult to obtain signatures and gave direction on steps the Department can take to comply with the rules while still continuing services without the required signatures. Based on CMS guidance, effective December 2018, the Department changed its regulations for the Community First Choice Program to no longer require the termination of services should a client not return a signed person-centered service plan within 60 days of the completion of assessment. The Department has quality assurance processes in place to monitor compliance in obtaining client and Department signatures on person-centered service plans: • The Administration's Quality Compliance Coordination team reviews client and Department signatures from a statewide sample, including documented attempts to obtain signatures. The review is part of an established annual audit cycle and measures statewide proficiency. If the annual review determines that the proficiency has

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	060 (cont'd)	fallen below the CMS standard of 86 percent, a quality improvement plan will be implemented to improve statewide performance. • Case Manager Supervisors perform monthly monitoring of all staff for compliance with signature requirements. As of August 2019, the Department: • Updated policies and procedures to add the requirement of provider signatures on person-centered service plans. This requirement was also added to the quality assurance monitoring process. • Developed and implemented a training specifically designed to provide support and guidance to staff in obtaining required signatures on service plans in alignment with CMS guidance. By June 2020, the Department will: • Consult with CMS to determine if person-centered service plans that are missing signatures should result in an unallowable payment. If necessary, the Department will identify associated costs related to any unallowable payments. • Work with the U.S. Department of Health and Human Services to determine if any costs identified by the audit should be repaid. By September 2020, the Department will enhance the quality assurance process to monitor compliance with the signatures requirement. The conditions noted in this finding were previously reported in finding 2017-046 and 2016-043. Completion Date: Corrective action is expected to be complete by September 2020 Agency Contact: Rick Meyer External Audit Compliance Manager PO Box 45804 Olympia, WA 98504-5804 (360) 664-6027 Richard.meyer@dshs.wa.gov

Department of Social and Health Services — Agency 300

Audit Report	Finding Number	Finding and Corrective Action Status
1024523	2018-001	Finding: The Department of Social and Health Services, Rehabilitation Administration, did not have adequate internal controls to ensure overtime at Naselle Youth Camp was properly authorized. Corrective Action: Effective July 1, 2019, the Juvenile Rehabilitation Division's programs, including the Naselle Youth Camp, were transferred to the Department of Children, Youth, and Families. The Department partially concurs with the finding. While a selection of employees' overtime authorization forms were not properly authorized before payday, the Department has the following established controls to ensure overtime hours for these employees were allowable and authorized: • The Administrative Officer of the Day (AOD) maintains an overtime log that records employee names and dates of overtime worked. The AOD performs the following procedures prior to approving any overtime: o Contacts other units to find out if they may have available staff who could fill in, therefore avoiding overtime charges. o Contacts on-call employees to find out if they can report to work, therefore avoiding overtime charges. o Approves overtime requests if the first two options are not available. o Records the approval in the AOD log. Entries from the log are reviewed every Monday. • After overtime approval is obtained from the AOD, additional requirements are in place to provide supporting documentation for overtime worked: o All approved overtime are required to be entered into the agency's timesheet system, Leave Tracker. o If an employee has over 40 hours for the week in Leave Tracker, the supervisor is required to reconcile the employee's timesheet with the unit's log where the overtime occurred to confirm the employee was on site. o Once the overtime hours are verified, the employee's timesheet is approved. The overtime hours for the employees included in the finding were recorded in the AOD logs, and were approved by supervisors in Leave Tracker prior to payment. In response to the finding, the Department will take the following actions: • Review and update policies and procedures for overtime approval. • Provide training to managers and staff on the overtime approval process. • Research options for simplifying overtime authorizations for juvenile rehabilitation facilities.

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

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

Department of Health — Agency 303

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	003	Finding:	The Department of Health improperly charged $151 to the Special Supplemental Nutrition Program for Women, Infants and Children grant.
		Corrective Action:	The Department concurs with the finding. The Department has been working on a new system, Cascades MIS, which issues benefits on electronic benefit cards. The new system has built-in safeguards, which will prevent loading funds onto a client's benefit card if proof of identity/residence and/or income verification is not provided within 30 days after the initial intake appointment. By December 2019, the Department will fully implement the Cascades MIS system. Additionally, the Department will: • Review current program policies to ensure they comply with federal requirements. • Clarify policies and rules related to program eligibility with local agencies, and provide training and technical assistance as needed. • Consult with the federal grantor to discuss whether the known questioned costs identified in the audit should be repaid.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 kristina.white@doh.wa.gov

State of Washington
Status of Audit Resolution
December 2019

Department of Health — Agency 303

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	004	Finding:	The Department of Health improperly charged $31,051 to the Special Supplemental Nutrition Program for Women, Infants and Children grant.
		Corrective Action:	The Department strengthened internal controls to ensure quarterly time certifications are submitted in a timely manner. This included: • Reviewing Department policies and procedures to ensure they meet federal requirements. • Evaluating current processes to identify areas that need improvement. • Providing training to staff on Department policies and federal regulations related to time certifications. The Department consulted with the grantor to discuss whether the questioned costs identified in the audit should be repaid.
		Completion Date:	July 2019, subject to audit follow-up
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 kristina.white@doh.wa.gov

Department of Health — Agency 303

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	005	Finding:	The Department of Health did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Special Supplemental Nutrition Program for Women, Infants, and Children program received required audits.
		Corrective Action:	The Department concurs with the finding. To strengthen internal controls over subrecipient monitoring, the Department will: • Review and update the agency process of monitoring subrecipient audits to ensure the Department complies with federal requirements. • Improve the agency spreadsheet used to track audit activities to include audit periods and due dates. • Implement a process to follow up on subrecipient audit findings and issue timely management decisions.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 kristina.white@doh.wa.gov

Department of Health **Agency 303**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	006	Finding:	The Department of Health did not have adequate internal controls over and was not compliant with cash management requirements for the Special Supplemental Nutrition Program for Women, Infants and Children grant.
		Corrective Action:	The Department concurs with the finding. To strengthen internal controls over program cash management, the Department will: • Update the Cash Management Improvement Act agreement to accurately reflect planned cash draw actions. • Review and update agency procedures to ensure cash draws are performed in accordance with the Cash Management Improvement Act agreement. • Ensure staff understand the federal requirements related to cash management and provide cross-training on processes to ensure compliance with federal regulations.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 kristina.white@doh.wa.gov

Department of Health — Agency 303

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	040	Finding:	The Department of Health did not have adequate internal controls to ensure it complied with survey requirements for Medicaid hospitals and home health agencies.
		Corrective Action:	To ensure the Department complies with survey requirements, the Department strengthened internal controls to ensure Statements of Deficiencies are sent to facilities within the 10-day required timeframe. This included: • Adding a field to the Integrated Licensing Reporting System to track the due dates of Statements of Deficiencies. • Generating a report for management to monitor and notify staff on Statements of Deficiencies that are coming due. • Sending written notification to the Centers for Medicare and Medicaid Services when a Statement of Deficiency is expected to be submitted late.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 Kristina.White@doh.wa.gov

Department of Health — Agency 303

Audit Report	Finding Number	Finding and Corrective Action Status	
1024307	2018-001	Finding:	The Department of Health did not have adequate internal controls to ensure it followed state requirements and its own policies related to small and attractive assets.
		Corrective Action:	The Department concurs with the finding. In response to the audit recommendations, the Department has taken steps to correct the deficiencies identified by the auditors. As of June 2019, the Department began scaling up a business project that focused on managing IT, capital, and small and attractive assets. The intended outcomes and deliverables of the project include: • Updating agency policies and procedures on small and attractive assets. • Defining clear roles and responsibilities. • Designating agency inventory control officer(s). • Assigning sequential tags to new assets. • Conducting inventory of all agency assets to comply with the State Administrative and Accounting Manual requirements. As of July 2019, the Department began assigning sequential tags to new IT assets.
		Completion Date:	Corrective action is expected to be complete by January 2020
		Agency Contact:	Kristina White External Audit Manager PO Box 47890 Olympia, WA 98504-7890 (360) 236-4547 Kristina.White@doh.wa.gov

Department of Children, Youth, and Families — Agency 307

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	033	Finding:	The Department of Children, Youth, and Families did not have adequate internal controls to ensure payroll charges to the Child Care and Development Fund program were allowable and properly supported.
		Corrective Action:	The Department partially concurs with the finding. During the six-month period in which the auditor found semi-annual certifications were not completed, the Department's immediate priority was to transition from the former Department of Early Learning (DEL) by the June 2018 deadline. Due to insufficient available resources, responsible staff were not able to complete the semi-annual certifications timely as required by Department policy. The Department concurs with the exceptions identified by the auditor that semi-annual certifications or timesheets were not completed for five employees to allocate their time as required. As of March 2018, the Department made retroactive adjustments to the payroll coding of affected employees to appropriately charge multiple cost activities. The employees were also reminded of the need to complete monthly timesheets as required by federal regulations. As of September 2018, the Department completed the semi-annual certifications for the second half of fiscal year 2018 for DEL and provided the information to the auditor as part of the program audit. While the Department concurs that semi-annual certifications, documentation, or timesheets were not completed as described in the finding, the cause of the issue was an isolated, exceptional circumstance that no longer presents an internal control issue going forward. The Department has: • Implemented preventative internal controls over allowable retroactive adjustments to ensure payroll charges are properly documented. • Continued to review position action requests and monthly payroll reports to ensure employees who charge to multiple cost activities complete timesheets as required. 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 2019, subject to audit follow-up
		Agency Contact:	Stefanie Niemela Audit Liaison PO Box 40970 Olympia, WA 98504-0970 (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
2018 F	034	Finding: The Department of Children, Youth, and Families 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 partially concurs with the finding. The auditor found eight providers had not paid the correct rates based on their region. After further review, the Department confirmed the rates were correctly determined. As specified in state regulations, centers in four counties are assigned rates for a region not based on their geographic location in order to account for market differences in these counties. However, due to timing of the audit, the auditor was unable to reverse these exceptions. In response to prior audit findings, the Department: • Modified the Child Care and Development Fund Plan to align with federal and state regulations for fiscal years 2019 to 2021. • Improved internal controls and implemented preventative controls to assist in the detection of improper provider billings and reduce the risks of unallowable payments. • Implemented policies to include the Department's definition of fraud, as well as the consequences for providers. • Initiated a risk-based approach to audit providers' billings and payments that includes selecting providers' billings in excess of licensed capacity and billings to the limit of the provider's authorizations. The Department will continue to refine this approach. • Collaborated across agencies and divisions, through the Working Connection Child Care Reframe Workgroup and the Child Care Audit Committee, to align and clarify state rules and requirements with those of the Child Care and Development Block Grant Act. The Department has also taken the following actions: • As of October 2018, implemented new rules requiring new family, friends and neighbors (FFN) providers to receive a full portable background check (PBC) when applying to be providers. Upon approval, the Department assigns a vendor number which, together with the provider's eligibility information, is communicated to the Department of Social and Health Services to create an authorization. This separation of duties strengthens internal controls and helps to reduce payment errors. By December 2019, the Department expects all existing FFN providers to complete the transition to the PBC process. • As of November 2018, implemented a process that allows subsidy auditors to provide technical assistance to providers who had been using incorrect billing practices. With the implementation of the new program violation rules in July 2019, providers with repeat violations are now excluded from receiving child care subsidy payment.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	034 (cont'd)	• As of December 2018, required all licensed providers who accept subsidy to use the Department's electronic attendance system or an approved third party system to track attendance. In addition, new FFN providers are required to use the Department's new electronic system within 90 days after being authorized to receive subsidy payment. The Department's system: o Enables accurate, real-time recording of child care attendance, tracking of daily attendance, and capturing data on child care usage. o Has the ability to support third party electronic attendance systems. The Department continues to add links to more third party systems and improve reporting capabilities. o Is capable of generating reports that allow the Department to conduct automated audits beginning in April 2019. • As of November 2019: o FFN providers are required to use the Department's system or an approved third party system for tracking attendance. o The billing guides were updated to help providers understand billing rules, authorization and the billing process. In addition, the Department will: • Update training curriculum, and require all licensed homes and FFN providers to complete training prior to the expiration of the 2019-2021 tentative agreement with the Service Employees International Union. • Continue to research options for simplifying authorization and billing rules. • Develop rules defining provider program violations and establishing additional consequences for intentional violations. 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 finding 2017-024, 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 June 2021 Agency Contact: Stefanie Niemela Audit Liaison PO Box 40970 Olympia, WA 98504-0970 (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

2018 F	035	Finding: The Department of Children, Youth, and Families 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 prior audit findings, the Department:
		• Implemented new monitoring and compliance agreement policies and procedures to clarify:
		  o Mandatory use of a full checklist every three years.
		  o When a site visit is needed.
		  o Acceptable methods of verifying compliance and the timelines for documentation.
		• Implemented a new electronic caseload management system, WA COMPASS, and provided training to licensing staff in using the system to manage licensing inspections and monitor visits. The system provides electronic reminders to licensing staff and supervisors, and has improved data integrity and streamlined staff work processes.
		• Provided training to all child care licensing staff regarding the new policies and procedures, including the 10-day health and safety recheck requirements and timely documentation of follow-up visits. Currently, supervisors are able to run a report to identify over-due cases and address concerns with licensing staff.
		• Enhanced reports generated from WA COMPASS for tracking and monitoring the due dates of health and safety rechecks.
		
		As of October 2018, the Department implemented new rules requiring new family, friends and neighbors (FFN) providers to receive a full portable background check (PBC) when applying to be a provider. Upon approval, the Department assigns a vendor number which, together with the provider's eligibility information, is communicated to Department of Social and Health Services (DSHS) to create an authorization. By December 2019, the Department expects all existing FFN providers to complete the transition to the PBC process.
		
		As of January 2019, the Department also clarified and implemented a policy revision to allow for "termination without notice" of a provider when an unsafe environment exists or when the provider becomes ineligible. DSHS has already provided updated training to its staff on the revised Department policies. The Department is working on updating the Washington Administrative Code (WAC) language to be consistent with the policy revision.
		
		The Department has been preparing for the implementation of a revised WAC on Family Home and Child Care Center in response to the demands of the legislature and the needs of the provider community.

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

Audit Report	Finding Number	Finding and Corrective Action Status
2018 F	035 (cont'd)	As of August 2019, the revised WAC became effective. As part of the preparation process, the Department: • Ensured all child care licensing staff completed mandatory training on the revised WAC components and resulting policies, procedures, and task changes. • Developed new checklists to enable more focused monitoring. • Developed an inspection report that can clearly delineate the high-risk areas that would require follow-up visits. The Department continues to revise licensing policies, procedures and tasks as needed to align with current state and federal rules and regulations. 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 finding 2017-025, 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

Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	018	Finding:	The Department of Services for the Blind did not have adequate internal controls over federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable time period.
		Corrective Action:	The Department has addressed prior audit findings and has implemented corrective actions to ensure client eligibility determination is completed timely and adequate supporting documentation is maintained when a delay is necessary. Specifically, the Department: • Implemented the Dashboard in the case management system for Case Managers to manage their caseloads on a real-time basis. • 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. • Required Counselors to document exceptional and unforeseen circumstances, and support extensions of specific period of time with a client agreement. • Provided training to counselors on the effective use of the Dashboard feature. Area Managers perform weekly monitoring of the use of the tool. The Department continues to improve internal controls by ongoing coaching and monitoring. As a result, the number of delayed eligibility determinations has been declining. For fiscal year 2018, three percent of eligibility determinations were delayed, compared to the respective 8.3 percent and 12.5 percent in the previous two years. Additionally, a significant number of the past due cases were delayed by only one to three days, which was often found to be caused by errors in calculating due dates. As of February 2019, the Department: • Provided additional training to staff about eligibility requirements and how to accurately calculate the due dates of eligibility determinations. • Defined the criteria for exceptional and unforeseen circumstances and how to document the circumstances. This guidance was added to the Department's procedure manual and was included in the staff training. • Implemented a new case management system that will help to strengthen the process for review and documentation by supervisors. The conditions noted in this finding were previously reported in findings 2017-007 and 2016-009.
		Completion Date:	June 2019, subject to audit follow-up

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

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	018 (cont'd)	Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

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Department of Services for the Blind — Agency 315

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	019	Finding:	The Department of Services for the Blind did not have adequate internal controls over reporting requirements for the Vocational Rehabilitation Grant.
		Corrective Action:	In response to prior year's audit finding, the Department had implemented corrective actions to improve internal controls over the federal reporting process. However, the Department continues to experience staff turnover in the positions that create and review the program cost reports. As of December 2018, the Department hired a consultant to: • Assist with an organizational plan for the fiscal unit. • Strengthen internal controls over the federal reporting process, including a secondary review. The Department anticipates that the organizational plan and hiring of required staff will be completed by March 2020. The conditions noted in this finding were previously reported in findings 2017-010.
		Completion Date:	Corrective action is expected to be complete by March 2020
		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	
2018 F	020	Finding:	The Department of Services for the Blind did not have adequate internal controls over and was not compliant with requirements to ensure cash draws were accurate and timely for the Vocational Rehabilitation program.
		Corrective Action:	In response to prior year's audit finding, the Department implemented corrective actions to improve internal controls over cash management. However, the Department continues to experience staff turnover in the positions that perform federal draws. As of December 2018, the Department hired a consultant to: • Assist with an organizational plan for the fiscal unit. • Strengthen internal controls over the federal draw process to include a secondary review. The Department anticipates that the organizational plan and hiring of required staff will be completed by March 2020. The conditions noted in this finding were previously reported in findings 2017-008.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Lorie Christoferson Deputy Financial Officer PO Box 40933 Olympia, WA 98504-0933 (360) 725-3840 Lorie.christoferson@dsb.wa.gov

Department of Transportation — Agency 405

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	011	Finding:	The Washington State Department of Transportation did not have adequate internal controls over and did not comply with suspension and debarment requirements.
		Corrective Action:	The Department is committed to ensuring grant programs comply with federal regulations. The Department's program staff performed a review of the subrecipients and confirmed that none of the local agencies that received payments for fiscal year 2018 were suspended or debarred. In April 2019, the Department received a management decision letter for the finding from the Federal Highway Administration. The federal grantor concurred with the Department's proposed corrective actions as outlined in the initial response to the finding recommendations. As of May 2019, the Department: • Updated the Local Agency Guidelines Manual to require explicit language regarding suspension and debarment be included in subrecipient contracts. • Updated the boilerplate agreement to include a suspension and debarment clause for subrecipients to certify.
		Completion Date:	June 2019, subject to audit follow-up
		Agency Contact:	Steve McKerney Internal Audit Director PO Box 47320 Olympia, WA 98504-7320 (360) 705-7004 McKernS@wsdot.wa.gov

Department of Transportation — Agency 405

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	012	Finding:	The Department of Transportation did not have adequate internal controls over and did not comply with requirements to perform risk assessments for subrecipients of the Highway Planning and Construction Cluster.
		Corrective Action:	The Department is committed to ensuring grant programs comply with federal regulations. To strengthen internal controls over subrecipient monitoring, the Department: • Evaluated the current processes at both the regional and headquarters level to identify areas for improvement regarding risk assessments for subrecipients. • Updated polices and establish procedures for performing risk assessments to determine the appropriate level of monitoring. • Worked with project stakeholders to develop a system for documenting risk assessments of subrecipients. As of June 2019, the Department's Local Program Office developed a form to complete and document subrecipient's risk assessments.
		Completion Date:	June 2019, subject to audit follow-up
		Agency Contact:	Steve McKerney Internal Audit Director PO Box 47320 Olympia, WA 98504-7320 (360) 705-7004 McKernS@wsdot.wa.gov

Department of Transportation — Agency 405

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	013	Finding:	The Washington State Department of Transportation did not have adequate internal controls over and did not comply with requirements to collect certified payrolls from contractors on projects funded by the Highway Planning and Construction Cluster.
		Corrective Action:	The Department does not concur with the finding. After consulting with the Federal Highway Administration (FHWA) and conducting additional research, the Department believes its process complies with the Davis-Bacon Act and federal regulations for contractor payment of prevailing wages. Please consider the email dated February 6, 2019, from FHWA in support of the Department's compliance with the regulations at issue, and as referenced in the Department's technical response to the State Auditor's Office. In April 2019, the Department received a management decision letter for the finding from FHWA. The federal grantor approves the Department's Construction Manual and Standard Specifications and concluded that the procedures contain the necessary controls to ensure reasonable compliance with 29 CFR 5.5 and the Davis-Bacon and Related Acts. As of June 2019, the Department has also taken the following actions: • Issued a Construction Bulletin to the regional offices regarding monitoring timely collection of certified payrolls from contractors. • Conducted discussions at various statewide meetings. • Posted additional resources for regional offices on the Construction SharePoint site. • Discussed with the Department of Labor and Industry to utilize its reporting tool beginning in January 2020, including how the system could be utilized/modified for the Davis-Bacon requirements.
		Completion Date:	June 2019, subject to audit follow-up
		Agency Contact:	Steve McKerney Internal Audit Director PO Box 47320 Olympia, WA 98504-7320 (360) 705-7004 McKernS@wsdot.wa.gov

Department of Transportation — Agency 405

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	014	Finding:	The Department of Transportation did not have adequate internal controls over and did not comply with requirements to collect certified payrolls from contractors on projects funded by the Federal Transit Cluster.
		Corrective Action:	The Department does not concur with the finding. After consulting with the Federal Transit Administration (FTA) and the Federal Highway Administration and conducting additional research, the Department believes its process complies with the Davis-Bacon Act and federal regulations for contractor payment of prevailing wages. As of June 2019, the Department has taken the following actions in the continued effort of improvement: • Issued a Construction Bulletin to the regional offices regarding monitoring timely collection of certified payrolls from contractors. • Conducted discussions at various statewide meetings. • Posted additional resources for regional offices on the Construction SharePoint site. • Discussed with the Department of Labor and Industry to utilize its reporting tool beginning in January 2020, including how the system could be utilized/modified for the Davis-Bacon requirements. The Department will continue to use Construction Bulletins to communicate best practices and other pertinent guidance to its regional construction offices on an ongoing basis, and will share this information with the Terminal and Vessel Engineering groups in the Ferries Division. The Department will consult with FTA for any further actions needed to resolve this finding. Federal management decisions for Single Audit findings are due within six months of issuing the Single Audit report. The Department will await the FTA management decision by September 2019 for any further action in response to the finding.
		Completion Date:	June 2019, subject to audit follow-up
		Agency Contact:	Steve McKerney Internal Audit Director PO Box 47320 Olympia, WA 98504-7320 (360) 705-7004 McKernS@wsdot.wa.gov

Department of Transportation **Agency 405**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	015	Finding:	The Department of Transportation, State Ferries Division, did not have adequate internal controls over and did not comply with equipment management requirements.
		Corrective Action:	It is the Department's position that the parts in question identified in the audit are not capital assets and, therefore, the requirements cited in the audit finding do not apply to these parts. The parts in question have no utility to the State until they are installed on a larger assembly or depreciable asset, in this case one of the Department's ferry vessels. Once installed, the parts cease to be discrete items and are part of the vessel. When an installed part meets the definition of a betterment as defined in Chapter 30 of the State Administrative and Accounting Manual, it is capitalized and depreciated as part of the vessel. If the part does not meet the definition of a betterment, it is expensed when purchased. The Department recognizes the importance of safeguarding and accounting for these parts properly through their installation on one of the vessels. In the ordinary course of business, purchased parts are delivered to the warehouse and are almost immediately transferred to the vessel. Occasionally, a vessel's scheduled maintenance will be delayed due to operational needs which necessitates the parts be stored in the warehouse. As of May 2019, the Department convened a work group consisting of subject matter experts over all aspects of capital assets. In September 2019, the work group met with the State Auditor's Office (SAO) and the Office of Financial Management (OFM) to discuss the audit recommendations and the Department's process of tracking the vessel parts. Within established policies and procedures, the Department will use its internal inventory management system, Minor Cap, to track the parts from time of receipt, installation on the larger assembly, and until ultimately disposed of through the Ferry Division's warehouse. The Department is working with OFM to obtain a letter of approval/waiver to use the alternative inventory management system, which the Department previously used. In November 2019, the Department sent a written request to SAO to consider the finding resolved based on the actions taken. The Department looks forward to working with SAO during the next audit to resolve any remaining items reported in this finding.
		Completion Date:	Corrective action is expected to be complete by March 2020

Department of Transportation **Agency 405**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	015 (cont'd)	Agency Contact:	Steve McKerney Internal Audit Director PO Box 47320 Olympia, WA 98504-7320 (360) 705-7004 McKernS@wsdot.wa.gov

Department of Ecology — Agency 461

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	016	Finding:	The Department of Ecology did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Capitalization Grants for Clean Water State Revolving Funds program received required audits and management decisions on audit findings were issued in a timely manner.
		Corrective Action:	In response to the audit recommendations, the Department updated agency policy on subrecipient monitoring. A new policy has also been developed to formalize program responsibilities for corrective actions and audit resolution. Additionally, the Department developed procedures on managing subawards to ensure federal compliance, which include: • Requiring subrecipients to return postcards to indicate if they are subject to audit requirement. • Assigning dedicated staff to maintain the tracking spreadsheet used to monitor subrecipient audit activities. • Establishing a communication protocol to notify programs when subrecipients receive audit findings, and the required follow-up actions. Increasing oversight of subrecipients who are not meeting Department requirements. The Department may apply sanction for continued non-compliance. The Department is also developing policies, procedures and a checklist for programs to clarify their roles and responsibilities related to follow-up of audit items.
		Completion Date:	Corrective action is expected to complete by January 2020
		Agency Contact:	Janis Henry Senior Financial Advisor PO Box 47615 Olympia, WA 98504-7615 (360) 407-6386 Janis.Henry@ecy.wa.gov

Department of Ecology **Agency 461**

Audit Report	Finding Number	Finding and Corrective Action Status	
2018 F	017	Finding:	The Department of Ecology did not have adequate internal controls over and did not comply with reporting requirements for the Capitalization Grants for Clean Water State Revolving Funds program.
		Corrective Action:	The Department partially concurs with the finding. The finding resulted from conflicting guidance provided by the regional office of the Environmental Protection Agency (EPA) and the guidance the auditor received from EPA's Office of Inspector General. The Department requested clarification and guidance from the EPA on how to properly report federal equivalency expenditures on the quarterly financial reports and the schedule of expenditures of federal awards (SEFA). In June 2019, EPA provided the following official guidance for reporting equivalency projects: • The SEFA should report funds disbursed to the Equivalency projects regardless of funding. • The quarterly reports should report actual draws from the Capitalization grants. • The quarterly reports should not be used for the SEFA. The Department has since updated tracking spreadsheets to capture all funds disbursed for equivalency projects. In June 2019, the Department received guidance from EPA to implement appropriate procedures related to the financial reporting of equivalency projects in accordance with the guidance received.
		Completion Date:	June 2019, 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

Department of Ecology **Agency 461**

Audit Report	Finding Number	Finding and Corrective Action Status	
1023397	2018-001	Finding:	The Department's internal controls over financial statement preparation are inadequate to ensure accurate reporting. OPEB and Pension statements were not included in the Financial Statements.
		Corrective Action:	The errors identified by the auditors were corrected in the Department's final financial statements. The finding was due to timing difference between the receipt of pension and other postemployment benefits information and the date the annual report to the federal grantor was due. In response to the finding, the Department: • Discussed with the Office of Financial Management (OFM) to obtain the Department's pension and other postemployment benefits data for the Clean Water State Revolving and the Water Pollution Control Revolving Accounts by the end of September each year. • Initiated discussions with the State Auditor's Office to perform agreed upon procedures instead of financial statement audits. The former is less time-consuming while also acceptable by the federal grantor. • Established a process to identify new GASB standards each year and confirm with OFM if they have potential impact on the financial statements. As of October 2019, the Department updated procedures to include all new GASB standards and detailed instructions on preparing the financial statements to meet standards.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	Lisa Darnell Fiscal Manager PO Box 47615 Olympia, WA 98504-7615 (360) 407-7052 lisa.darnell@ecy.wa.gov

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Department of Ecology **Agency 461**

Audit Report	Finding Number	Finding and Corrective Action Status	
1024311	2018-001	Finding:	The Department of Ecology did not have adequate internal controls over and did not comply with requirements to conduct underground storage tank compliance inspections every three years.
		Corrective Action:	The Department has not met the federal requirement of inspecting every underground storage tank (UST) every three years mainly due to the high turnover of inspection staff in some regional offices. The Department is aware of the situation and has taken the following actions: • Expedited the training of new UST inspectors to conduct independent inspections. • Provided cross training to staff to conduct UST inspections. • Assigned inspectors from other regional offices to assist with the workload of the short-staffed regions. As of October 2019, all past due inspections identified in the audit had been completed. The Department is actively monitoring upcoming inspections and managing inspection backlog. Additionally, the Department will: • Create a new report from the UST database to identify UST sites in each region that are within six months of the end of the three-year period, and take appropriate actions. By December 2019, the Department expects the reporting capability to be fully functional. • Allocate sufficient resources to each region to ensure that every UST site is inspected every three years to meet federal and state requirements. • Continue to submit quarterly reports to inform the federal grantor on UST sites that have not yet met the three-year inspection cycle requirement. The third quarter report was recently submitted to the federal grantor and no concern was raised in the Department's performance in this area.
		Completion Date:	Corrective action is expected to be complete by December 2019
		Agency Contact:	Lisa Darnell Fiscal Manager PO Box 47615 Olympia, WA 98504-7615 (360) 407-7052 lisa.darnell@ecy.wa.gov

Department of Fish and Wildlife — Agency 477

Audit Report	Finding Number	Finding and Corrective Action Status	
1024439	2018-001	Finding:	The Department of Fish and Wildlife did not adequately monitor wildlife damage prevention cooperative agreements.
		Corrective Action:	The Department concurs with the finding. To address the audit recommendations, the Department implemented the following processes to establish effective fiscal monitoring of the wildlife damage prevention cooperative agreements: • Updated cooperative agreements with private landowners with additional language to: o Provide clear expectations regarding documentation of activities and costs. o Clearly state the scope of services. o Adopt a standard reimbursement rate for range riding. • Began using a new invoice form for new cooperative agreements. The new form has accompanying instructions and identifies the private landowners' costs and the Department's cost share amounts. • Developed a standardized daily log for landowners to document range rider activities. The completed log is required to be attached to invoices submitted to the Department. • Ensured invoiced amounts are reconciled to supporting documentation before payments are made.
		Completion Date:	September 2019, subject to audit follow-up
		Agency Contact:	Mario Cruz Director of Internal Audit PO Box 43200 Olympia, WA 98504-3200 (360) 902-2420 Mario.Cruz@dfw.wa.gov

Department of Natural Resources — Agency 490

Audit Report	Finding Number	Finding and Corrective Action Status
1024321	2018-001	**Finding:** The Department did not adequately monitor its contract with Clark County related to operations at the Livingston Quarry. **Corrective Action:** The Department concurs with the finding. In July 2017, the Department became aware of an inadequate system of internal controls in the operations of the Livingston Quarry. In January 2019, the Department issued a stop work order to Clark County (County), and has since been working with the County and the operator to address the internal control deficiencies and other contract violations. As of August 2019, the Department: • Increased funding to establish a full-time Mining Program Manager position. • Assigned the Mining Program Manager as the Contract Administrator, with assistance from the region engineer to provide on-site contract administration. • Negotiated a revised Plan of Operations with the County to ensure it operates in compliance with contract terms and provisions. • Lifted the stop work order and resumed quarry operations. Additionally, the Department has strengthened contract monitoring procedures related to the quarry operations, which include: • Routinely comparing load tickets to invoices from the County during the processing and hauling of state rock. • Reconciling scale tickets against the County's monthly production reports. • Performing regular site visits to prevent unauthorized mining activities on state land. **Completion Date:** August 2019, subject to audit follow-up **Agency Contact:** Charles Malone Risk and Legal Affairs Manager PO Box 47041 Olympia WA 98504-7041 (360) 902-1264 Charles.Malone@dnr.wa.gov

Whatcom Community College — Agency 621

Audit Report	Finding Number	Finding and Corrective Action Status	
1023657	2018-001	Finding:	The College did not have adequate internal controls over financial statement preparation to ensure accurate reporting.
		Corrective Action:	The College acknowledges that there were deficiencies in the financial reporting process. As of April 2019, the College debriefed the fiscal year 2018 audit experience and identified opportunities for improvement, including: • Use of source data for verification. • Establishing a more comprehensive review process for financial statements. • Retaining thorough documentation of the prior audit results, including feedback from the audit team, as references for subsequent financial statement preparation. • Allowing sufficient time for the preparation and review of the financial statements. College staff will continue to participate actively in the financial statements work group for latest updates to financial reporting and to share best practices. The work group is comprised of staff members from the other 33 Washington State community and technical colleges.
		Completion Date:	May 2019, subject to audit follow-up
		Agency Contact:	William Martens Director for Business and Finance 237 West Kellogg Rd. Bellingham, WA 98226 (360) 383-3046 wmartens@whatcom.edu

Bellevue College **Agency 627**

Audit Report	Finding Number	Finding and Corrective Action Status	
1023493	2018-001	Finding:	The College did not have adequate internal controls in place to ensure the proper classification of restricted and unrestricted net position.
		Corrective Action:	The College concurs with the finding and the errors identified by the auditors were corrected in the College's final financial statements. The College recognizes the importance of a strong internal control environment, and have implemented the following procedures to strengthen controls over the preparation of financial statements: • Adopted a formula prescribed by the Governmental Accounting Standard Board for calculating restricted and unrestricted net position. • Formalized a review process to include additional levels of review and scrutiny of the financial statements.
		Completion Date:	April 2019, subject to audit follow-up
		Agency Contact:	James A Craswell Interim Executive Director of Finance 3000 Landerholm Circle SE Bellevue, WA 98007 (425) 564-4250 James.craswell@bellevuecollege.edu

Seattle Colleges **Agency 670**

Audit Report	Finding Number	Finding and Corrective Action Status	
1023488	2018-001	Finding:	The College did not include all foundation information, which resulted in an incomplete set of financial statements in accordance with governmental accounting standards.
		Corrective Action:	The Seattle College (College) concurs with the finding. During the audit year, the College has launched a new nonprofit foundation and has been focusing on consolidating resources and streamlining processes with some of the existing foundations. To address the audit recommendations, the College will: • Work with the foundations to ensure annual audits are conducted. • Incorporate the audited financial statements of the foundations into the colleges' financial statements, beginning with fiscal year 2019.
		Completion Date:	Corrective action is expected to be complete by March 2020
		Agency Contact:	Susan Dresser Sr. Director of Financial Reporting 1500 Harvard Avenue Seattle, WA 98122 (206) 419-6934 Susan.Dresser@seattlecolleges.edu

Tacoma Community College **Agency 678**

Audit Report	Finding Number	Finding and Corrective Action Status	
1023607	2018-001	Finding:	The College did not have adequate internal controls over cash receipting and local funds to ensure adequate safeguarding of public funds.
		Corrective Action:	The College concurs with the finding. To address the auditor's recommendations, the College has implemented the following corrective actions: • Since the conversion to the ctcLink system in fiscal year 2016, the College has been working on resolving the issue of correctly recording cash deposits in the system on a timely basis. This issue often caused delays in recording and processing deposits within the 24-hour required timeframe. As of June 2017, the College had resolved the system issue and is now in compliance with the cash receipt requirement as outlined in the state accounting and administrative manual. • With only one fiscal technician responsible for preparing bank deposits for the College Bookstore, some deposits were not done timely during the employee's absences. There were also isolated instances when cash deposits were delayed due to reconciliation problem with the deposit and the sales report. As of May 2019, the bookstore manager has provided additional training and cross-trained other bookstore staff as back-up to ensure compliance with the cash-receipting requirement. The conversion to ctcLink has also caused other systemic technical and functional issues. The College has been working on correctly reconciling the general ledger with the bank statements. In November 2017, the College identified a $4 million unreconciled account balance for fiscal year 2017 and notified the State Board for Community and Technical Colleges (SBCTC). SBCTC subsequently took the lead in reconciling the College's accounting records and other reporting anomalies of the cTcLink system. As of September 2019, after additional analysis and reconciliation of some balance sheet accounts, the $4 million account imbalance for fiscal year 2017 was accounted for. The College also identified the proper process of correctly reconciling the general ledger with bank statements, and will continue to work with SBCTC to resolve any outstanding reconciliation issues.
		Completion Date:	November 2019, subject to audit follow-up
		Agency Contact:	Nermalyn Edwards Assistant Director of Financial Services 6501 South 19th Street Tacoma, WA 98466 (253) 566-5013 NEdwards@tacomacc.edu

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Wenatchee Valley College — Agency 686

Audit Report	Finding Number	Finding and Corrective Action Status	
1023336	2017-001	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:	In response to the fiscal year 2016 audit finding, the College created two sub-committees to address audit recommendations and develop written processes to correct the deficiencies identified by the auditors. These committees, along with the Executive Director and the accountant, created policy and procedure manuals to strengthen internal controls over financial reporting of the College's Foundation. Procedures were 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

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-001	Finding:	The design of the ctcLink system did not include an appropriate level of design review, resulting in the system missing critical data validation elements.
		Corrective Action:	The State Board for Community and Technical Colleges (State Board) concurs with this finding. The lessons learned from the two colleges in the 2015 pilot resulted in the redesign of the ctcLink system and the data validation process. The following corrective actions have already been implemented: As of December 2017: • The State Board assumed the authority to make waiver code changes from the colleges. The new business process requires the use of a Waiver Request Form to be submitted for review by State Board's technical support and accounting staff prior to implementation by the board's functional analysts. College staff provide a third level of review. The new form also includes a field for colleges to designate the effective date of implementation. • Class and course fee data entry continues to be a joint responsibility of the State Board and local colleges. The State Board adopts tuition and fee schedules and local colleges may establish additional fees. The State Board now has tools and training available, and requires the college class schedule builders to complete the training prior to having the ability to make changes in the system. The State Board has also provided guidance on how to verify the accuracy of tuition fee schedules entered into the system. Additional review of fees and schedules entered in the system is conducted by State Board's functional analysts. • Waiver approvals remain a locally managed business process. To ensure accuracy and completeness for all waivers processed by batch, the State Board has provided additional training and continues to work with the colleges to improve processes and protocols. As of October 2019, the State Board created a segregation of duties matrix to help colleges identify potential security conflicts. To improve controls over payroll, the colleges identified system roles that separate responsibility for setting up new employees in the payroll system and processing payroll, thus mitigating the risk of improper payments. Additional safeguards include: • Setting an upper cap on a single paycheck that limits the amount paid to any employee. • Issuing a warning when classified employees are paid outside of the assigned pay range. • Having a designated authority reviewing and verifying payroll.
		Completion Date:	October 2019, subject to audit follow-up

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-001 (cont'd)	Agency Contact:	John Boesenberg Deputy Executive Director, Business Operations PO Box 42495 Olympia, WA 98504-2495 (360) 704-4303 jboesenberg@sbctc.edu

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-002	Finding:	The State Board for Community and Technical Colleges did not perform adequate testing of the ctcLink system, resulting in several types of processing errors.
		Corrective Action:	The State Board for Community and Technical Colleges (State Board) concurs with this finding. In response to lessons learned from the pilot colleges, the State Board completely revamped the system testing protocol. As of February 2018, a robust testing and data validation plan was implemented for system upgrades and deployments. System changes now require testing in multiple environments: • The developer performs unit testing followed by a technical review prior to code migration to system integration testing by State Board staff. • The State Board's technical support group performs full regression testing for the software updates. System changes must meet specific exit criteria and pass secondary code review before the support group can recommend the change for user acceptance testing. • College users test the ctcLink application and validate the migrated data during six two-week sprints. Specific exit criteria must be met before the testing team can recommend the change for implementation. • The State Board Application Services Director performs final review and grants approval to move system changes into production. Additionally, the State Board purchased a test automation software that performs a complete automated regression test to identify any software updates or code revisions. The Human Capital Management pillar was completed and work has commenced on the Campus Solutions and Finance pillars. The State Board continues to work with the product vendor to improve the product's reporting capabilities.
		Completion Date:	February 2018, subject to audit follow-up
		Agency Contact:	John Boesenberg Deputy Executive Director, Business Operations PO Box 42495 Olympia, WA 98504-2495 (360) 704-4303 jboesenberg@sbctc.edu

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-003	Finding:	The State Board for Community and Technical Colleges Board did not have adequate documentation to provide reasonable assurance that the data converted from the legacy system to ctcLink is complete and accurate.
		Corrective Action:	The State Board for Community and Technical Colleges (State Board) concurs with this finding. As part of the preparation efforts for the group two deployment, the State Board formalized the validation tracking process. Since January 2019, the State Board has been tracking the data validation approval by the deploying college for each test cycle. The State Board also requires a formal sign-off by each affected college for data validation prior to deployment. This process will be applied to all future deployments. Additionally, as part of the cutover activities, system backups are maintained for each college's data prior to commencing deployment activities and after the deployment activities have been completed. These backups are stored in a separate system location that is accessible to colleges for 30 days after the system goes live. The backups will be retained for 24 months and are available to be restored if needed for analysis.
		Completion Date:	January 2019, subject to audit follow-up
		Agency Contact:	John Boesenberg Deputy Executive Director, Business Operations PO Box 42495 Olympia, WA 98504-2495 (360) 704-4303 jboesenberg@sbctc.edu

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-004	Finding:	The State Board for Community and Technical Colleges did not design controls in the data interface process between ctcLink and AFRS to prevent and detect errors.
		Corrective Action:	Since July 2017, the State Board for Community and Technical Colleges (State Board) has been working on developing and implementing an automated process to accurately and completely upload ctcLink financial transactions into the state's accounting system, Agency Financial Reporting System (AFRS). As of April 2019, the State Board implemented an automated AFRS customized upload process as a result of the yearlong design and testing effort. This upload process provided the State Board the ability to extract college data, process errors and report data through June 2019 to the Office of Financial Management. On July 1, 2019, a newly re-designed global chart of accounts system was implemented, which has significantly improved the college system's ability to consistently track and report revenues and expenses. However, this implementation impacted the AFRS upload process; requiring the customization to be re-configured to work with the new chart of accounts. As of October 2019, testing of the re-configured customization was completed and was successfully deployed. The Board will: • Continue to fine-tune the automated upload process. • Provide training for college clients on the newly implemented process. • Continue to provide technical assistance to all colleges in their efforts to reconcile accounting records with the state accounting system.
		Completion Date:	October 2019, subject to audit follow-up
		Agency Contact:	John Boesenberg Deputy Executive Director, Business Operations PO Box 42495 Olympia, WA 98504-2495 (360) 704-4303 jboesenberg@sbctc.edu

State Board for Community and Technical Colleges — Agency 699

Audit Report	Finding Number	Finding and Corrective Action Status	
1024858	2018-005	Finding:	The general ledger balances from ctcLink did not reflect actual cash balances from the banks.
		Corrective Action:	The State Board for Community and Technical College (State Board) has been working with the pilot colleges to identify and correct issues causing variances between the cash general ledger balance and the bank balances. As of December 2018, the State Board: • Identified and corrected an issue centered around the configuration of charges and payments affecting student accounts. • Modified the configuration controlling the accounting date to make reconciling transactions simpler. • Developed and provided training for college staff on how to reconcile the financial aid payments made on students' accounts and the expenditures related to those payments, which frequently was a cause of cash discrepancy. Despite these efforts, the pilot colleges continued to express concerns over the variances between their general ledger balances and bank cash balances. In March 2019, the State Board accounting staff and pilot colleges conducted an in-depth review of each college's cash-related transactions and bank statements over a two-month period. This review did not identify any system issue that may have caused the variances between cash in the accounting records and bank statements. Nevertheless, this process led to opportunities for training and business process alignment. As of July 2019, the State Board: • Set up two accounts to separately track system and manual entries processed by the pilot colleges. This will help to isolate the cause of any future variance. • Developed custom queries to extract financial, student and human resource data to assist colleges in their reconciliation process. The State Board will continue to monitor the progress and work with college staff to identify issues that cause the cash variances, and provide the appropriate technical assistance as needed.
		Completion Date:	July 2019, subject to audit follow-up
		Agency Contact:	John Boesenberg Deputy Executive Director, Business Operations PO Box 42495 Olympia, WA 98504-2495 (360) 704-4303 jboesenberg@sbctc.edu

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Schedule 2 – Fraud Findings by Agency

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Office of the Attorney General — Agency 100

Audit Report	Finding Number	Fraud Finding and Resolution	
1023721	001	Finding:	The Attorney General's Office initiated a fraud investigation and, as required by state law, notified the State Auditor's Office (SAO) regarding a potential loss of public funds. Based on documentation provided by the Office, SAO investigated and determined a nonprofit organization under a grant agreement contract with the Office misappropriated state grant funds between January 2015 and July 2017.
		Fraud Amount:	$149,662
		Amount to be Recovered:	$173,179
		Recovery to date:	$132,761
		Resolution /Status:	The Office does not concur with the finding that reported lack of internal controls in place to verify that expenses had been incurred before issuing payments. The Office has an established process to require organizations to submit invoices under penalty of perjury to certify that reimbursement requests cover only expenses already incurred. The Office has demonstrated continual efforts to make improvements to internal processes, and appreciates SAO recommendations to strengthen internal controls. Upon discovering the fraud, the Office: • Stopped payments to the nonprofit organization after March 2018. • Referred the case to law enforcement for criminal investigation. • Requested the Legislature to remove the singularly appropriated funds to the nonprofit organization. The Office will: • Continue to recover the remaining misappropriated funds. • Request the nonprofit organization's bank statements from January 2015 through February 2018. • Request the nonprofit organization to surrender assets purchased with grant funds.
		Personnel Action Taken:	The Office discontinued reimbursements to the nonprofit organization.
		Criminal Action Taken:	The case was referred to law enforcement in March 2019. The Office may also resort to file a civil action lawsuit to recover the remaining misappropriated funds.
		Agency Contact:	Melanie Nevares Accounting Director and Audit Liaison PO Box 40107 Olympia, WA 98504-0107 (360) 586-0778 melanie.nevares@atg.wa.gov

Department of Fish and Wildlife **Agency 477**

Audit Report	Finding Number	Fraud Finding and Resolution	
1024027	001	Finding:	The Department investigated and determined an employee misappropriated state funds by improperly using state fuel cards between December 2009 and October 2017.
		Fraud Amount:	$64,192
		Amount to be Recovered:	$79,277
		Recovery to date:	$ 0
		Resolution /Status:	The Department took immediate action to improve internal controls over the use of fleet credit cards. The following controls were implemented since the fraud occurred: • Inactivated PIN codes of employees who no longer worked for the Department. • Established a process to automatically inactivate PIN codes for departing employees. • Included license plate information when fleet card charges are posted to the financial records. • Contracted with only one fleet credit card vendor. • Updated fuel card policies to ensure sufficient safeguards and to clearly define card custodian responsibilities. The Department also performed additional reviews of other fuel cards to ensure no other losses have occurred. By December 2019, the Department will implement the following additional internal controls: • Establish Department policy to prohibit sharing of PIN codes when issuing new fleet fuel cards to authorized employees. • Require supervisors to conduct monthly reviews and monitoring of fleet card charges. • Review exception reports provided by the card vendor and follow up with appropriate actions.
		Personnel Action Taken:	The Department placed the employee on administrative leave following an investigative interview in November 2017, and terminated the employee's employment in January 2018.
		Criminal Action Taken:	The Department referred the case to the Cowlitz County Prosecuting Attorney's Office.
		Agency Contact:	Mario Cruz Director of Internal Audit PO Box 43200 Olympia, WA 98504-3200 (360) 902-2420 Mario.Cruz@dfw.wa.gov

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Bellevue College **Agency 627**

Audit Report	Finding Number	Fraud Finding and Resolution	
1022530	001	Finding:	The Bellevue College did not have adequate internal controls to safeguard public resources, resulting in a loss of $22,518 of small assets between January 1, 2012, and November 1, 2016.
		Fraud Amount:	$22,518
		Amount to be Recovered:	$24,700
		Recovery to date:	$0
		Resolution /Status:	The State Ethics Board conducted an investigation and concluded that the former Public Safety Director improperly used his position as Director to access property and resources of the College as well as by using employee time for private benefit or gain. To address the audit recommendations, the College implemented the following procedures to improve internal controls: • Conduct annual asset reviews of all department inventories. • Establish purchase card controls with merchant category code (MCC) restrictions that prohibit purchases considered not normal or customary for the college. Exceptions to the MCC code restrictions require purchasing approval in advance. • Require purchasing department staff to review purchases prior to fulfillment. • Require reporting loss of public funds immediately in accordance with state law.
		Personnel Action Taken:	The employee resigned in November 2016.
		Criminal Action Taken:	The College reported this case to the Bellevue Police Department, but no charges were filed.
		Agency Contact:	James A Craswell Interim Executive Director of Finance 3000 Landerholm Circle SE Bellevue, WA 98007 (425) 564-4250 James.craswell@bellevuecollege.edu

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