

STATE OF WASHINGTON

OFFICE OF FINANCIAL MANAGEMENT

# 2012 Audit Resolution Report

STATEWIDE ACCOUNTING  
DECEMBER 2012



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**STATE OF WASHINGTON**  
**OFFICE OF FINANCIAL MANAGEMENT**

# **2012**

# **Audit Resolution Report**

**STATEWIDE ACCOUNTING**  
**DECEMBER 2012**

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STATE OF WASHINGTON

# AUDIT RESOLUTION REPORT

December 2012

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

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

This annual report is required by RCW 43.88.160 which states, "The director of financial management shall annually report by December 31<sup>st</sup> 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 regularly scheduled 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, 2011, and October 31, 2012. The audit reports issued during that period include 68 exceptions, one of which relates to fraud.

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

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**Schedule 1 – Audit Findings by Agency**

December 2012

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2011 F = Statewide Single Audit Report

2011 I = 2009-2011 Independent Audit Report

## Status of Resolution of Audit Findings

December 2012

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**Administrative Office of the Courts (AOC)**

**Agency: 055**

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**Audit Report:** 1006746

**Finding Number:** 005

**Finding:** The Administrative Office of the Courts did not adequately monitor state grants awarded to courts throughout the state.

**Resolution:** The Office is currently visiting three different courts each quarter to review grant recipients' original supporting documentation to ensure costs are allowable. This activity is an ongoing additional duty that will be performed periodically by the Comptroller. Documentation of the site visits is filed with the grant.

In addition, staff developed standardized cost and billing procedures that each recipient must follow in order to receive reimbursement.

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**Status of Resolution of Audit Findings**

December 2012

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Office of State Auditor (SAO)

Agency: 095

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**Audit Report:** 2009-2011 Independent Audit Report

**Finding Number:** 001

**Finding:** We noted several instances where local governments were not audited at least once in every three years as required by RCW 43.09.260.

**Resolution:** This finding was partially corrected as noted in the audit report. Most of the audits not completed within three years were due to a lack of response to audit assessments from entities with less than \$300,000 in annual revenues. In 2010 the State Auditor's Office centralized the audit assessment process and, at the end of 2010, started issuing disclaimer letters to those entities not responding. All entities will be contacted by the end of 2013.

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## Status of Resolution of Audit Findings

December 2012

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Office of State Auditor (SAO)

Agency: 095

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**Audit Report:** 2009-2011 Independent Audit Report

**Finding Number:** 002

**Finding:** We noted that the allocation of the State-wide Single Audit (SWSA) billings to various state agencies did not conform with SAO's billing allocation plan. This finding is limited to the billings related to the SWSA for the year ended June 30, 2010.

**Resolution:** This issue was limited to the first and second quarters of fiscal year 2010. The State Auditor's Office (SAO) had a change in personnel responsible for the allocation and verification of each quarter's billings. In March 2010, a formal process was put into place to ensure the allocation is updated at least annually based on the most current Schedule of Expenditures of Federal Awards (SEFA) available. The audit report contained five recommendations:

- Base the current SWSA allocation on the most recent SEFA published.
- Evaluate impact of changes to the audit plan based on the most current SEFA as soon as the new SEFA is available.
- Update the SWSA allocation if the SEFA changes the audit plan significantly.
- Accounting should ensure the allocation is updated in the billing system.
- Accounting should recalculate the invoiced amounts quarterly and verify those amounts reflect the current allocation.

With the exception of the second bullet, all of the above recommendations had been implemented by SAO more than two years prior to the finding being written. In the past, the current SEFA was only reviewed when it was needed to calculate the current allocation. This final recommendation was put into place during the current (2011-2013) biennium.

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Department of Commerce (COM)

Agency: 103

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**Audit Report:** 2011 F

**Finding Number:** 010

**Finding:** The Department of Commerce does not ensure the funding it provides to sub-recipients is reported and audited in accordance with federal regulations.

**Resolution:** The Department partially concurs with the finding. The Department agrees five sub-recipients did not submit audit reports as required, and this oversight was not caught. In June 2012, the Department contacted the five subrecipients and verified compliance with federal regulations by obtaining copies of audit reports.

Subrecipient contract terms and conditions identify the requirement that organizations receiving in excess of \$500,000 in federal funds must have an audit in accordance with federal regulations and submit copies to the Department. The Department has increased periodic reviews of subrecipients with expenditures of federal funds provided by the Department of \$500,000 or more by refining specific audit requirements and reporting functionality in its tracking systems to better follow up on delinquent reports. In July 2012, the Department added specific audit requirements and reporting functionality to its Contract Management System (CMS) to calculate, by contractor, all Department payments to contractors within the contractor's fiscal year. Any contractors receiving at or above \$500,000 in federal resources are flagged as requiring an audit. While the Department recognizes the audit requirement is for funds expended by the contractor, the amount disbursed to contractors is used as a trigger for the flag. The Department also created several reports to enhance follow up on delinquent reports and increase periodic review.

Since it is possible for subrecipients to receive less than \$500,000 from the Department plus additional funds from other sources to exceed the threshold for requiring an audit, the Department intends to remind subrecipients of this requirement; however, it has no method to determine when this threshold is met. During July 2012, the Department sent subrecipients a general reminder about the threshold for requiring an audit. The Department is satisfied that program funds expended during this period were appropriate and correct through the monthly invoice verification process, the required documentation review, and on-site monitoring conducted for each subrecipient.

The Department does not agree that it has the responsibility to ensure subrecipients are reporting all federal program funds in their Schedules of Expenditures of Federal Awards. Further, the Department does not believe it is required to re-audit an audit prepared by the subrecipient's certified public accountant. Generally accepted accounting principles and federal regulations enumerate many financial statement disclosure requirements with which auditees and auditors must comply. If the state auditors have concerns about the quality of an audit report, there are procedures for notifying the State Board of Accountancy of those concerns. The Department does not have the expertise to make such judgments.

## Status of Resolution of Audit Findings

December 2012

The Department believes timely and appropriate corrective action was completed for the four subrecipient audit findings. There are instances where the Department made the decision to accept the subrecipient's original response to the audit finding and, consequently, has not required any follow up. This course of action is within the Department's purview. The Department has refined specific corrective action and management decision documentation and reporting functionality in CMS to better centrally document timely and appropriate audit review and corrective action for subrecipient audit findings. By December 2012, the Department intends to implement central documentation and review of corrective action activities in CMS and update procedures.

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Department of Commerce (COM)

Agency: 103

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**Audit Report:** 2011 F

**Finding Number:** 022

**Finding:** The Department of Commerce, Community Services and Housing Division, did not comply with period of availability requirements for its Community Services Block Grant program.

**Resolution:** The Department concurs with the finding. Department program staff did not properly review the pre-coded payment documentation to ensure costs were within the proper period of availability. Subrecipients used an out-of-date pre-coded payment document template with closed 2009 award year coding. Neither program staff nor fiscal staff verified or corrected the old coding. As a result, \$57,072 was paid beyond the period of availability for 2009. Commerce fiscal staff did not properly review costs transferred from one grant year to another grant year to ensure costs were within the proper period of availability. Program staff inadvertently chose items outside the period of availability when requesting a transfer. Fiscal staff reviewing the work of newly trained fiscal staff did not properly verify backup documentation for the transfer. As a result, \$90,350 transferred was not properly identified within the period of availability for the 2009 award year.

In February 2012, fiscal and program staff reviewed and corrected the \$147,422 questioned 2009 grant year costs by transferring to the correct grant year per the period of availability. Appropriate costs within the period of availability for the 2009 grant were identified and subsequently transferred, resulting in zero net impact to the Community Services Block Grant 2009 award year.

The Department concurs with the auditor's recommendations to review payment costs for proper period of availability and stop providing pre-coded payment documents to subrecipients. The Department has reiterated document review and approval expectations with program and fiscal staff. During April 2012, all pre-coding was removed from payment document (invoice) templates and a request was sent to contractors asking them to stop using old pre-coded templates.

Understanding a federal program may have awards with overlapping/concurrent periods of availability, in January 2012 the Department added award tracking to its Contract Management System (CMS), including award first-in-first-out (FIFO) functionality to help reduce or eliminate cost transfers at award end. In June 2012, the Department began entering Community Services Block Grant awards in CMS using the FIFO functionality.

In July 2012, the Department added CMS system edits to notify users when attempting to use coding not associated with the contract. By March 2013, the Department intends to add additional CMS system edits to notify when an award end date is past, prior to allowing payment, and an edit to prevent payment 45 days beyond the award end date.

State of Washington

**Status of Resolution of Audit Findings**

December 2012

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**Status of Resolution of Audit Findings**

December 2012

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**Office of Financial Management (OFM)**

**Agency: 105**

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**Audit Report:** 1006746

**Finding Number:** 006

**Finding:** An excessive number of employees at state agencies have access to critical functions in the Human Resource Management System (HRMS).

**Resolution:** Refer to page 34 for the joint response from the Department of Enterprise Services and the Office of Financial Management on this finding.

**Status of Resolution of Audit Findings**

December 2012

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**Office of Financial Management (OFM)**

**Agency: 105**

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**Audit Report:** 1006746

**Finding Number:** 007

**Finding:** An excessive number of employees in state payroll offices have conflicting duties in the Human Resource Management System (HRMS).

**Resolution:** Refer to page 36 for the joint response from the Department of Enterprise Services and the Office of Financial Management on this finding.

**Status of Resolution of Audit Findings**

December 2012

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**Office of Financial Management (OFM)**

**Agency: 105**

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**Audit Report:** 1006746

**Finding Number:** 008

**Finding:** Users can make unauthorized changes to data in the Human Resource Management System (HRMS).

**Resolution:** Refer to page 37 for the joint response from the Department of Enterprise Services and the Office of Financial Management on this finding.

**Status of Resolution of Audit Findings**

December 2012

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**Office of Financial Management (OFM)**

**Agency: 105**

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**Audit Report:** 1006746

**Finding Number:** 009

**Finding:** The Human Resource Management System (HRMS) is not supported by a disaster recovery backup site.

**Resolution:** Refer to page 39 for the joint response from the Department of Enterprise Services, Consolidated Technology Services, and the Office of Financial Management on this finding.

**Status of Resolution of Audit Findings**

December 2012

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**Office of Financial Management (OFM)**

**Agency: 105**

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**Audit Report:** 1006746

**Finding Number:** 010

**Finding:** A number of manual processes in the Human Resources Management System (HRMS) should be automated.

**Resolution:** Refer to page 41 for the joint response from the Department of Enterprise Services and the Office of Financial Management on this finding.

**Audit Report:** 2011 F

**Finding Number:** 050

**Finding:** The Washington Commission for National and Community Service at the Office of Financial Management does not properly monitor subgrantees to ensure expenditures of AmeriCorps grant funding are allowable and adequately supported.

**Resolution:** Based on areas identified for improvement, the Washington Commission for National and Community Service (Commission) has or will carry out a series of program monitoring enhancements to improve consistency and internal controls, as follows:

- On July 19, 2012, at the Statewide Director meeting, the Commission explained:
  - Its corrective action policy for all new and continuing AmeriCorps subgrantees. This policy states that each monitoring file contains details on any finding, including any follow up and resolution to ensure the corrective action is completed in a consistent and timely manner.
  - Its policy regarding the percentage of AmeriCorps member files to be reviewed during all site monitoring visits. The policy includes a random selection process for selecting AmeriCorps members' files for review. (The Commission does not require 100 percent member file verification as part of the monitoring process.)
- On August 31, 2012, the Commission completed all risk assessments for program year 2012-13. All new subgrantees are considered high risk and will be monitored within three months after their contract has started.
- By January 31, 2013, all AmeriCorps subgrantees will have submitted eligibility certification confirmation on their AmeriCorps member rosters, signed by authorized program officials, stating that the AmeriCorps members have met the eligibility requirements beginning with the 2012-13 program year.

The Commission expects some AmeriCorps subgrantees will not begin their first enrollment until the end of January 2013, so they cannot begin their eligibility certification confirmation process until then for the program year 2012-13.

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## Status of Resolution of Audit Findings

December 2012

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 1006745

**Finding Number:** 002

**Finding:** Medicaid's payment system lacks adequate internal controls to prevent overpayments to providers of certain durable medical equipment.

**Resolution:** A system edit has been added to ProviderOne. The edit suspends oxygen claims for rentals past 36 months. Claims adjudicators manually check the dates on the suspended claims and deny claims for rental charges for unallowable months.

In addition, the Health Care Authority has identified for recoupment payments in excess of 36 months that occurred prior to implementation of the system edit.

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## Status of Resolution of Audit Findings

December 2012

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 1006745

**Finding Number:** 003

**Finding:** Untimely data sharing led to duplicate payments by Medicaid and L&I.

**Resolution:** The Health Care Authority (Authority) completed the collection of a sample of the overpayments that were identified in the audit as having been made by the Authority from July 2008 to the present. This was a one-time data exchange between the Department of Labor and Industries (L&I) and the Authority. After this analysis was completed, the Authority requested the full universe of the Authority's overpaid claims be shared so that recoupment could be done on those as well.

Currently the Authority is manually processing recoveries on over 7,000 matches at a rate of 50-70 case resolutions per month. This work is expected to continue into the second quarter of 2013, depending upon whether the monthly automated data match between L&I and the Authority is successful.

For ongoing improvement, the Authority and L&I are developing a monthly data match using current claims from the L&I's data warehouse. The two agencies are currently working to develop initial data sets with the effort expected to be completed by June 2013.

Refer also to the L&I resolution for this finding on page 44.

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## Status of Resolution of Audit Findings

December 2012

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 037

**Finding:** The Health Care Authority and the Department of Social and Health Services do not have adequate controls to correctly report all Medicaid expenditures that are eligible for additional Children Health Insurance Program (CHIP) funds.

**Resolution:** The Health Care Authority (Authority) agrees with the finding and has taken the following corrective action:

- In November 2011, the Authority retroactively transferred all eligible managed care claims to CHIP. The Authority is currently working with the Department of Social and Health Services' Aging and Disability Services Administration (ADSA) to ensure all eligible Medicaid claims for clients are transferred to CHIP.
- The Authority now monitors CHIP funds on a monthly basis, and an internal staff workgroup conducts an additional review using an Excel tracking spreadsheet with data from the state's accounting system (Agency Financial Reporting System) to ensure accuracy and proper use of funds.
- The Authority developed a report using data from its Medicaid Management Information System to identify claims by recipient aid category and federal poverty level based on net income.
- Effective July 1, 2012, the Authority implemented a new methodology for accounting for Section 107 children using eligibility data from ProviderOne. Section 107 clients are Medicaid eligible children under age 19 with family income that equals or exceeds 133 percent of the federal poverty level, but is below 200 percent.

Refer to page 71 for response from the Department of Social and Health Services.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 038

**Finding:** The Health Care Authority does not comply with state law and the federal Deficit Reduction Act of 2005, increasing the likelihood that the state is paying claims that should have been paid by liable third parties.

**Resolution:** The Health Care Authority (Authority) continues to disagree with this finding. The Authority maintains that it is in compliance with the Deficit Reduction Act of 2005 (DRA) and applicable state law. The Authority meets this standard by making data available to all insurers to use for third party liability (TPL) reporting and by matching data directly with those insurers most likely to provide third party coverage to Medicaid recipients.

To enhance its recovery effort, the Authority submitted a system change request to incorporate a tool that the federal Centers for Medicare and Medicaid Services (CMS) has identified for DRA data exchange requirements. This activity could not be pursued until CMS issued its guidance in June 2010. The Authority will implement the change request based on prioritization against all other system change requests in their order of importance.

The Authority's position on compliance was corroborated by an independent review conducted by Health Management Systems (HMS) in March 2010. That review stated, "HMS's review of the DSHS confirms a strong Medicaid TPL program..." This report also noted areas of industry best practices that the Authority could explore to enhance its cost avoidance and recovery. As a result of this review, the Authority entered into a contract with HMS to strengthen and improve its efforts in the area of TPL recoveries as HMS provides for enhanced data matching to better identify a client's medical insurance coverage. The contracted activities include: conducting electronic data exchanges with health insurers, and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of the Authority.

Although the Authority has been in compliance with the DRA since it was passed into law in April 2007, the above actions demonstrate how the Authority continues to improve ways to share Medicaid information with health insurers so the state is not paying for claims that should have been paid by a liable third party.

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## Status of Resolution of Audit Findings

December 2012

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 039

**Finding:** The Health Care Authority did not investigate information on potential Medicaid fraud or abuse in accordance with federal law, risking the loss of Medicaid resources.

**Resolution:** The Health Care Authority (Authority) does not agree with the finding that there is a "lack of timely follow through on returned surveys," as there are no federal timeline requirements for medical services verification surveys.

The Authority prioritizes its program integrity/surveillance and utilization resources in areas that have proven to yield a high return on investment. Data analytics have proven in the past to better identify suspicious provider patterns. Past investigations have been targeted on cases that have the highest potential to lead to a fraud or audit referral.

The auditor asked the Authority to review 10 surveys that the auditor believed merited a full investigation. Authority staff determined that several of the claims contained inaccurate information stemming from inaccurate information and conversion data linked to the implementation of ProviderOne, the Authority's new Medicaid Management Information System. Of the 10, only one was ultimately found to be worthy of a full investigation.

The Authority conducted an initial review on all returned surveys received between January 1 and June 30, 2011, to determine whether further review and prioritization of individual cases were warranted for detection of Medicaid fraud.

The Surveillance and Utilization Review unit triages returned medical services verification surveys to follow up as resources are available.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 040

**Finding:** The Health Care Authority's internal controls are insufficient to ensure payment rates for its Healthy Options managed care program are accurate.

**Resolution:** The Health Care Authority (Authority) continues to disagree with this audit finding. There are sufficient controls in place to ensure that managed care rates are set based on the verified managed care organizations' (MCO) actual costs of care. Actuarially certified, proprietary cost information is submitted directly to the Authority's actuary. The actuary verifies the information submitted by comparing it to audited financial statements submitted to the Office of the Insurance Commissioner and encounter data submitted to the Authority. As part of the verification, the actuary has the MCOs complete a reconciliation of cost information with encounter data. The actuary also does analysis of prior years, compares MCOs to each other, and resolves outliers that arise from its verification and analyses with the MCOs.

The MCOs each have fraud and abuse controls. The controls provide reasonable assurance that the data used in rate setting is accurate and complete. This assertion is supported by the fact that the Authority has had no findings regarding rate setting in the Centers for Medicare and Medicaid Services (CMS) reviews and has had its rates consistently approved by CMS with their full understanding of the rate setting methodology.

Even though the Authority disagrees with the finding, it has developed a plan for validation of encounter data which the Authority intends to implement by June 2013.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 041

**Finding:** The Health Care Authority does not perform a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal law.

**Resolution:** The Health Care Authority (Authority) disagrees with this finding. The auditor asserts that the Authority does not perform a retrospective drug use review of pharmaceutical claims data to identify patterns of fraud or abuse as required by federal law.

In fact, the Authority performs ongoing periodic examinations of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and Medicaid recipients, or associated with specific drugs or groups of drugs, as required by federal regulations.

The Authority agrees that the specific federal regulations cited by the auditor require the Authority to have a retrospective drug use review program through which it conducts ongoing periodic examinations, at least quarterly, of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, the auditor's analysis is in error because it fails to cite or apply a second federal regulation that acknowledges that the retrospective drug use review requirements in federal regulations cited by the auditor are duplicative of the Surveillance and Utilization Review requirements. The Surveillance and Utilization Review requirements expressly permit the Authority "to limit review activities to those that focus on what constitutes appropriate and medically necessary care to avoid duplication ...." This is precisely what the Authority has done. The Authority operates a robust Surveillance and Utilization Review program. The Authority, in full compliance with federal law, focuses its retrospective drug use review activities on ensuring appropriate and medically necessary care.

The auditor states that "[t]he Authority believes its review of the medical appropriateness of prescribing and dispensing drugs is sufficient to fulfill the fraud and abuse-related requirements of federal law." This is incorrect. Again, it is the Authority's Surveillance and Utilization Review program that fulfills the fraud and abuse-related requirements of federal law. In accordance with federal law the Authority's retrospective drug use review program focuses on what constitutes appropriate and medically necessary care and does not duplicate the fraud and abuse activities under the Surveillance and Utilization Review program. Other business units within the Authority perform analysis in the remaining areas of concern to the auditor, per federal regulations that allow states to limit the review activity of Drug Utilization Review staff to avoid duplication of activities related to fraud and abuse.

The auditor states that "[the Authority] has not provided us any information on how often or how it does that analysis." The Auditor also states that "the Authority is not analyzing

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pharmaceutical claim data and other records to identify patterns of fraud, abuse, or misuse of Medicaid funds..." Both of these statements are incorrect.

The Authority has extensive detection programs that address potential fraud and abuse by clients, prescribers, and pharmacies. The Office of Program Integrity's Payment Review Program, Surveillance and Utilization Review program, and Medical Audit unit analyze, review, and audit pharmacy claims data to identify potential Medicaid fraud, waste, or abuse. The Patient Review and Coordination Program analyzes client data to set restrictions on high risk clients and identify aberrant prescribing patterns by providers. A third party contractor compares provider data with peers and follows up with prescribers who show ongoing aberrance in their prescribing practices. And the Quality Management Team investigates complaints or information about quality of care issues or concerns, and evaluates and documents the information in a case tracking database.

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**Status of Resolution of Audit Findings**

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 042

**Finding:** The Health Care Authority did not adequately monitor sub-recipients to ensure Medicaid expenditures are allowable and supported.

**Resolution:** The Health Care Authority (Authority) agrees with the finding. To improve oversight, the Medicaid administrative match program added a fiscal component to all monitoring activities of school districts and local health jurisdictions.

Effective June 1, 2012, the fiscal monitoring activity includes the following for the time frame monitored:

- The actual salaries and benefits of participants selected through a random sampling process are compared to salaries and benefits claimed.
- Direct and indirect claimed costs are also reviewed.

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## Status of Resolution of Audit Findings

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State Health Care Authority (HCA)

Agency: 107

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**Audit Report:** 2011 F

**Finding Number:** 043

**Finding:** The Health Care Authority does not have adequate controls to ensure Medicaid is the payer of last resort.

**Resolution:** The Health Care Authority (Authority) disagrees with this finding. The Office of Program Integrity currently has two full time auditors dedicated to reviewing pharmacy third party liability (TPL) claims for inappropriate use of override codes. It may be that additional system enhancements could strengthen controls over the use of overrides. The Authority will continue to communicate with and educate pharmacy providers on the proper use of TPL override codes.

In addition, the Authority has strengthened and improved efforts in the area of TPL recoveries by contracting with Health Management Systems (HMS) to augment recovery efforts. This is done by performing enhanced data matching available through HMS to better identify a client's medical insurance coverage. The contracted activities include conducting electronic data exchanges with health insurers and verifying and updating the insurance eligibility of Medicaid recipients for billing liable third parties on behalf of the Authority.

With the enhanced data matching, the Authority has mitigated the potential loss of recoveries and the inappropriate use of override codes. This is a much more cost effective way to enforce TPL controls.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 044

**Finding:** The Health Care Authority improperly claimed \$111,108.98 in federal reimbursement for the Medicaid program.

**Resolution:** The Health Care Authority (Authority) agrees with this finding. The Authority concurs that of the 183 clients reported by the auditors, 152 clients appear to have received some benefits in error. While the payments cited by the auditor are a relatively small amount of the funds handled by the Authority, the Authority continues to target 100 percent accuracy in payments. In response to the finding:

- The Authority reviewed all the payments cited by the auditor to deceased persons or other ineligible people and identified and corrected payments made in error after the person's date of death or made to someone other than the rightful holder of the social security number (SSN) in question. Past findings involving SSN matching have often proven to be explainable, such as a widow continuing to cite a spouse's SSN.
- The Authority arranged repayment of any federal funds received in error following completion of the reviews in April 2012.

The Authority continues to strengthen procedures to improve accuracy of all payments and claims that are paid for unallowable services. The Authority provides some programs for nonqualified and undocumented aliens that utilize multiple funding streams to pay for services that are not allowed by federal matching dollars. A portion of the transaction errors identified by the auditors related to clients in programs that have these multiple funding streams.

When an error is discovered, it is corrected going forward; however, the Authority does not set up overpayments unless there is intentional fraud that is being prosecuted. The Authority strengthens procedures on an ongoing basis through Medicaid Eligibility Quality Control (MEQC) reviews and monthly reports. The Authority self-monitors errors through monthly reports sent to field staff for correction. When these reports are not corrected timely, there is a meeting between upper management from the Authority and the Community Service Division of the Department of Social and Health Services (DSHS). These reports are included in a monthly round up and sent to DSHS management.

The Authority will address the issue of questioned costs with the U.S. Department of Health and Human Services.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 045

**Finding:** The Health Care Authority does not have adequate controls to ensure controlled substances prescribed for Medicaid clients are authorized and allowable.

**Resolution:** The Health Care Authority (Authority) continues to disagree with this finding. There are no federal or state statutes that require a payer (e.g., the Authority) to validate the Drug Enforcement Administration (DEA) number of a prescriber. Therefore, the Authority disagrees that the lack of an edit that validates DEA for Schedule 2-5 drugs constitutes inadequate internal controls or that the lack of such validation renders the payment unallowable.

The Authority believes that responsibility for compliance with controlled substance requirements lies with the prescribing provider and the dispensing pharmacies. The federal Controlled Substance Act and the State Uniform Controlled Substance Act do not regulate payment for controlled substances, and there are no provisions in either that could be interpreted as a requirement relating to payment of claims for controlled substances. The following federal regulation clearly states that the prescribing practitioner is responsible for assuring that the prescription conforms in all essential respects to the law and regulation:

"A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription."

This finding indicates that "the Authority has procedures to ensure a prescriber of schedule 2 drugs has a DEA number, but the procedures do not verify whether the DEA number is valid." That statement is incorrect. The Authority's Pharmacy Point of Sale (POS) system maintains a prescriber network of known National Provider Identifier (NPI) to DEA associations, and it is updated by state staff as new associations become known. System functionality includes manual updates to a "blocked prescriber list" that identifies prescriber DEAs prevented from prescribing Schedule 2 drugs. Claims for Schedule 2 drugs are validated against the DEAs on the prescriber network. The problem identified by the auditor is not a lack of validation. Rather, the DEA regular file update is received into the POS on a monthly basis, resulting in a lag in the DEA effective dates and a discrepancy with the DEA file that the auditor used to conduct the audit. As noted in previous years, there continues to be no complete external file that accurately and completely associates NPI to DEA.

In addition to the POS edit that validates the DEA for Schedule 2 drugs, the Authority has a set of robust program integrity activities including pharmacy utilization review, pharmacy rules-based algorithms that identify improper payments, and data mining activities that

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identify patterns outside the norm. In the absence of any requirement to validate the DEA number for controlled substances, the Authority believes this set of program integrity activities provides adequate controls to ensure that controlled substances are authorized and allowable.

The Authority will address the issue of questioned costs with the U.S. Department of Health and Human Services.

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## Status of Resolution of Audit Findings

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 046

**Finding:** The Health Care Authority did not have adequate controls to ensure violations of Medicaid laws and regulations by providers are identified and are referred to the Medicaid Fraud Control Unit (MFCU), risking the loss of public resources.

**Resolution:** The Health Care Authority (Authority) disagrees with this finding. The Authority has adequate controls to ensure that violations of Medicaid law and regulations are identified and referred to the Medicaid Fraud Control Unit. This is supported by a review of cases in the Case Tracking System and the timeliness in which they are worked. The Case Tracking System is used to track a variety of cases; thus, the time frames in which those cases are resolved does not necessarily lead to the conclusion of inadequate controls.

Processes are in place to prioritize the work of Surveillance and Utilization Review Subsystem investigators, ensuring that the Authority is addressing those cases with the highest potential for fraud, waste, and abuse. These are also the cases that yield the highest return on investment.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 047

**Finding:** The Health Care Authority's internal controls are inadequate to ensure non-emergency medical transportation expenditures are allowable and adequately supported.

**Resolution:** The Health Care Authority (Authority) agrees with the finding, but notes that the solution to these issues is now in place. The auditor's report stated incorrectly that the trip information database has not improved.

During state fiscal year 2011, the Authority built a trip information database that can be used to verify that all Medicaid rules are followed and that all services the transportation brokers provide are legitimate, reasonable, and adequately supported. The database includes new data fields that will allow the Authority to more closely monitor transportation services, operations, and expenditures.

Brokers began adding information to the system in early 2011, and the Authority was able to test the new database with positive results between March 2011 and June 2011.

Other monitoring activities include:

- Desk audits using state auditor monitoring tools.
- Review of financial and operating reports.
- Review of fleet inventories and inspection schedules.
- Monthly review of brokers' invoices and reports.
- Review of broker reports of incidents and accidents.
- Review of brokers' annual independent audits.

From July 2011 through December 2011, the Authority conducted on-site monitoring of all six transportation brokers with the new trip information database and found all six to be in compliance with Medicaid rules and regulations.

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**State Health Care Authority (HCA)**

**Agency: 107**

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**Audit Report:** 2011 F

**Finding Number:** 048

**Finding:** The Health Care Authority does not have adequate controls to ensure providers meet initial and ongoing eligibility requirements to participate in the Medicaid program.

**Resolution:** The Health Care Authority (Authority) partially agrees with the finding and has implemented many of the audit recommendations.

The Provider Enrollment Unit now ensures appropriate provider licensing eligibility upon initial enrollment and throughout the provider's enrollment. The Authority also has established a data-sharing agreement with the Department of Health (DOH) that automatically updates providers' licensing information. This ensures the Provider Enrollment Unit consistently receives the most current provider licensing information daily. If a DOH license has expired, the Authority is notified and the ProviderOne payment system ends the taxonomy associated with the provider's file, preventing further payments.

As of March 25, 2011, the Patient Protection and Affordable Care Act introduced new screening procedures for providers and suppliers. The Act identifies durable medical equipment (DME) providers as moderate to high risk business partners who warrant unscheduled, unannounced site visits. The Authority is finalizing written policies and procedures to comply with the Act. The Authority estimates it will meet this requirement in January 2013. The Authority also has requested computer system changes that will add mandatory data fields needed for compliance with the federal law.

The Authority has resumed site visits with newly enrolled DME providers. The Authority is also planning revalidation site visits for DME suppliers not currently enrolled with Medicare or another state's Medicaid agency. The Centers for Medicare and Medicaid Services only requires these providers to be revalidated once every five years. Federal law allows the Authority to rely on screening, including site visits, conducted by Medicare or another state's Medicaid agency.

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Department of Personnel (DOP)

Agency: 111

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**Audit Report:** 1006746

**Finding Number:** 006

**Finding:** An excessive number of employees at state agencies have access to critical functions in the Human Resource Management System (HRMS).

**Resolution:** This finding named the Office of Financial Management (OFM) and the Department of Personnel (DOP). Effective October 1, 2011, the portion of the Department of Personnel previously responsible for the HRMS system was consolidated into the Department of Enterprise Services (DES). This is a joint response from OFM and DES.

DES is pleased that the State Auditor's Office (SAO) reviewed the previously reported audit finding (Report number 1000619, dated February 2, 2009) and found that most of the user access conditions have been adequately addressed.

Controlling DES User Access with Conflicting Duties: DES created and implemented a special process that grants limited access to essential staff for centralized payroll processing. Consistent with best practices, special temporary "fire-fighting" access can also be assigned to limited users and a process was created to log and monitor that access. These "fire-fighting" controls mitigate the risks posed by this necessary expanded access to address emergency payroll processing issues. DES purchased an automated risk management tool to facilitate logging and monitoring of critical functions. During the evaluation period, it was determined the software could not provide sufficient functionality. DES is in the process of cancelling the contract with this vendor and continues to seek other options for automated risk management tools. DES expects to have the evaluation process for an automated tool started by December 2013.

Fully Documenting Custom Transaction Codes: DES developed a prototype report that is responsive to the audit findings but incomplete until staff meet with the auditors to clarify their specific requirements. This meeting is expected to occur by February 2013. Once requirements are established, the prioritization process can begin and resources can be allocated.

User Access Mitigating Controls at State Agencies: To assist agencies in mitigating their risk associated with user access, OFM provided recommendations to state agencies based on internal control best practices. Additionally, audit trail reports are available in HRMS for effective agency management oversight to mitigate the risks. OFM developed and provides group training on this topic and added resources to the OFM website, including best practices, checklists, agency self-assessments and other online tools. Ongoing agency communication related to best practices is disseminated through the statewide Personnel Payroll Association which serves as the HRMS user group.

**Status of Resolution of Audit Findings**

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Department of Personnel (DOP)

Agency: 111

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**Audit Report:** 1006746

**Finding Number:** 007

**Finding:** An excessive number of employees in state payroll offices have conflicting duties in the Human Resource Management System (HRMS).

**Resolution:** This finding named the Office of Financial Management (OFM) and the Department of Personnel (DOP). Effective October 1, 2011, the portion of the Department of Personnel previously responsible for the HRMS system was consolidated into the Department of Enterprise Services (DES). This is a joint response from OFM and DES. DES substantially agrees with the auditor's assessment and is continuing to work toward resolution of this finding.

Controlling DES User Access with Conflicting Duties: DES created and implemented a special process that grants limited access to essential staff for centralized payroll processing. Consistent with best practices, special temporary "fire-fighting" access can also be assigned to limited users and a process was created to log and monitor that access. These "fire-fighting" controls mitigate the risks posed by this necessary expanded access to address emergency payroll processing issues. DES purchased an automated risk management tool to facilitate logging and monitoring of critical functions. During the evaluation period, it was determined the software could not provide sufficient functionality. DES is in the process of cancelling the contract with this vendor and continues to seek other options for automated risk management tools. DES expects to have the evaluation process for an automated tool started by December 2013.

Controls to Mitigate User Access Conflicting Duties at State Agencies: To assist each agency with their internal control responsibilities, OFM developed and provides training on the effective implementation of internal controls for payroll. OFM also added resources to its website, including best practices, checklists, detective controls, agency self-assessments, and other online tools. Additionally, audit trail reports are available in HRMS for effective agency management oversight. Ongoing agency communication related to best practices is disseminated through the statewide Personnel Payroll Association which serves as the HRMS user group.

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Department of Personnel (DOP)

Agency: 111

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**Audit Report:** 1006746

**Finding Number:** 008

**Finding:** Users can make unauthorized changes to data in the Human Resource Management System (HRMS).

**Resolution:** This finding named the Office of Financial Management (OFM) and the Department of Personnel (DOP). Effective October 1, 2011, the portion of DOP previously responsible for the HRMS system was consolidated into the Department of Enterprise Services (DES). This is a joint response from OFM and DES.

DES and OFM have made progress to reduce the risks associated with the previously reported audit finding (Report number 1000619, dated February 2, 2009).

Preventative Control of Supervisory Review and Pre-approval of All Transactions: The core computer system within HRMS is an industry standard commercial software, which uses best practice designs for efficient and effective payroll processing. The audit-recommended process – a supervisory review and approval of all transactions before processing – was designed for less efficient and obsolete batch processing systems. Given the core software design and required operational efficiency, this recommendation may not be cost-effective to widely implement or operate.

DES studied the options and available resources, determining that in the short term, agencies must generally work within the software's existing functionality. DES will continue to search for cost-effective options within delivered functionality to require approval of some transactions entered into HRMS. It is noted that a recognized industry best practice is to minimize modification to off-the-shelf (delivered) functionality. In addition to the up-front programming cost, custom development increases the complexity of future system maintenance and support, and may not be supported by the vendor in future upgrades. DES is undergoing an evaluation of an enhancement software pack being offered by the vendor that may offer some potential reports to provide this functionality. The evaluation process of this enhancement software will be complete by the end of May 2013. DES will determine at that time whether this software will allow tracking of user changes or provide the reports to track these changes successfully.

State Agencies' Mitigating Controls over Payroll Transactions: To assist agencies in mitigating their risk associated with user transaction authority, OFM provides training for state agencies that includes payroll reviews based on internal control best practices. Multiple payroll processing and transaction audit trail reports are available in HRMS for effective agency management oversight. Ongoing agency communication related to best practices is disseminated through the statewide Personnel Payroll Association which serves as the HRMS user group.

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## Status of Resolution of Audit Findings

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Department of Personnel (DOP)

Agency: 111

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**Audit Report:** 1006746

**Finding Number:** 009

**Finding:** The Human Resource Management System (HRMS) is not supported by a disaster recovery backup site.

**Resolution:** This finding named the Office of Financial Management (OFM), the Department of Personnel (DOP), and the Department of Information Services (DIS). Effective October 1, 2011, the portion of DOP previously responsible for the HRMS system was consolidated into the Department of Enterprise Services (DES). Also effective October 1, 2011, the portion of the Department of Information Services that operated HRMS was moved to Consolidated Technology Services (CTS). This is a joint response from OFM, DES, and CTS.

DES assembled a state payroll disaster recovery team to identify a short-term solution in the event of a disaster. DES payroll identified files that are updated every pay period and records them with encryption security separately onto laptops. These laptops are assigned to specific staff that maintain them and carry them home with them at night. Staff can either produce a regular payroll while "off site" or, in the event of a total disaster, provide the resources to run the last successful payroll and have it produced on tape on the east coast. That tape would be then be provided for OFM and the State Treasurer's Office to process and the state payroll would be produced. This team continues to work on areas that need clarification.

DES purchases data processing services from CTS to operate HRMS. CTS does provide a backup system on site, but it is vulnerable to certain disasters, such as an earthquake or a complete power outage of the state data center. This backup system is not the best practice of a ready-to-use, remote backup site. This audit recommendation would be expensive to implement because CTS would need to expend significant capital funds to initiate remote, "hot" backup site services.

Budget requests for a remote, hot backup site were submitted in prior years, but were not funded. For many years, the recovery of HRMS from a disaster or other catastrophic system failure has been planned within existing resources and documented. (Resource constraints have not allowed any testing of these conceptual plans.) These contingency plans are not efficient or effective and carry more risks in the event of a major disaster. DES will continue to work with OFM and CTS to request funding from the Legislature for CTS to initiate a remote hot backup site.

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Department of Personnel (DOP)

Agency: 111

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**Audit Report:** 1006746

**Finding Number:** 010

**Finding:** A number of manual processes in the Human Resources Management System (HRMS) should be automated.

**Resolution:** This finding named the Office of Financial Management (OFM) and the Department of Personnel (DOP). Effective October 1, 2011, the portion of DOP previously responsible for the HRMS system was consolidated into the Department of Enterprise Services (DES). This is a joint response from OFM and DES.

DES agrees with the auditor's assessment and will continue making improvements to automate manual processes wherever cost effective and advisable. However, it should be noted that system automation often requires modification or custom development and a recognized industry best practice is to minimize modification of off-the-shelf (delivered) functionality. Custom development increases the complexity of system maintenance and support, and may not be supported by the vendor in future upgrades. Additionally, there are business reasons associated with, and variations among, current collective bargaining agreements that preclude automation of certain functions.

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## Status of Resolution of Audit Findings

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**Housing Finance Commission (HFC)**

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**Agency: 148**

**Audit Report:** 2011 F

**Finding Number:** 007

**Finding:** The Washington Housing Finance Commission did not ensure funding it provided to subrecipients of the Tax Credit Assistance Program was reported and audited in accordance with federal regulations.

**Resolution:** The Commission concurs with the determination of the auditor that the Commission did not ensure subrecipients received federal audits as required. As noted by the auditor, the Commission subsequently corrected the error by receiving and reviewing such audits and will continue to do so for any subsequent years in which the Commission provides Tax Credit Assistance Program funds to a subrecipient.

Additionally, the Commission will increase diligence in communicating federal grant information to subrecipients, including providing the Catalog of Federal Domestic Assistance numbers and adding clarity on federal requirements for subrecipient audits.

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**Audit Report:** 1006745

**Finding Number:** 001

**Finding:** The Department of Labor and Industries' medical payment system lacks adequate internal controls to prevent overpayments to providers of interpreter services and physical and occupational therapy services.

**Resolution:** The Department completed work to recoup all identified physical and occupational therapy (PT/OT) and interpretive service overpayments.

New system controls were implemented on June 30, 2011, to prevent overpayments for PT/OT services including payment for services in excess of the daily cap. The Department's Internal Audit unit will perform a follow-up review to validate the effectiveness of the new system controls. This review will be done after implementation of the medical provider network in early 2013.

The following actions were taken to address potential overpayments for interpretive services:

- a. Bill payment staff implemented a retrospective review process for interpretive services including interpreter travel charges. The review focuses on the issues identified by the state auditors (for example, provider payments in excess of 480 minutes per day, no interpretive services appointment record, excessive travel charges). The Department determines an appropriate sample size to query based on which specific audit issue is being reviewed. Instructions for creating the reports used for the review are stored in a shared drive rather than a desk manual.
- b. Designated lead workers or supervisors perform the review and process adjustments for any overpayments. The supervisors report the results to the Medical Information Payment System operations manager. Any exceptions to the payment policy are documented using the existing process for payments outside of policy.
- c. The Department has undertaken significant preventive activities to improve interpreter compliance with billing policies and submittal of required documentation. These include billing workshops as well as billing consultations, pre-payment reviews, and checks for documentation targeted to specific interpreters who have had compliance issues.
- d. Providers with recurring billing errors, as identified through retrospective reviews, will be referred for education which may include the requirement to attend a billing workshop.

In January 2012, all lead workers were trained on the new procedures and the first monthly retrospective review was conducted.

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**Audit Report:** 1006745

**Finding Number:** 003

**Finding:** Untimely data sharing led to duplicate payments by Medicaid and L&I.

**Resolution:** All identified Department of Labor and Industries (L&I) overpayments have been recouped.

L&I is currently working with the Health Care Authority (HCA) to develop a data exchange to identify potential duplicate payments on an ongoing basis. Starting January 2012, L&I and HCA staff have met monthly to develop a process to regularly exchange medical payment data for clients covered by both agencies. The work group identified the data elements needed, and a data sharing agreement was signed July 9, 2012. The two agencies are currently working to develop initial datasets with the effort expected to be completed by June 2013. The data exchange must be in place in order for L&I to systematically identify potential overpayments due to duplication of payments.

Refer also to the HCA resolution for this finding on page 19.

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## Status of Resolution of Audit Findings

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Department of Labor and Industries (L&I)

Agency: 235

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**Audit Report:** 1006745

**Finding Number:** 004

**Finding:** The Workers' Compensation program pays providers when clients do not show up for appointments.

**Resolution:** In January 2012, a project team was formed to scope the extent of the recommended changes and develop a comprehensive implementation plan.

A six-month study on why injured workers do not show for independent medical examination (IME) appointments was conducted on 616 claims. The top four reasons they do not show were: worker was ill or had an emergency (22 percent); incorrect worker address/didn't receive the appointment letter (21 percent); transportation issues (14 percent); worker refused to go (7 percent).

In March 2012, all claim staff received IME refresher training emphasizing the quickest, most effective way to get information to resolve medical and/or vocational issues which can include IMEs. The required steps a claim manager must take every time an injured worker does not show for an IME or there is a late cancellation were also reviewed. The "no-show" issue was also addressed in detail to include:

- Reminder for claim managers (CMs) to verify the injured worker's address before requesting an IME to ensure the appointment letter is sent to the correct address.
- Claim file is to be documented with a log entry and action plan to include the steps that must be followed when "no-shows" occur.
- A management update to all staff dated March 19, 2012, "Failure to Appear for an IME" was presented and discussed. Staff was also provided with a handout reminding them of the procedures.

On May 8, 2012, IME letters were revised to provide a clear objective of the purpose of the examination, incorporating changes recommended from stakeholders including CMs, IME schedulers, and IME providers.

During September and October 2012, an "IME Pre-Call" pilot was conducted in seven claim units. Pre-calls were to be attempted for each IME being requested and a letter would be sent if staff was unable to reach the injured worker or attorney. Pilot data has been compiled and follow-up reviews are underway to see if the injured worker attended the IME and, if not, why. A complete analysis will be completed by December 31, 2012, with recommendations about whether this process should be considered as an approach to reduce no-shows.

On November 12, 2012, an updated policy on failure to appear for IMEs was sent to external stakeholders for comment. Feedback was requested by November 16, 2012.

A monthly management report is being finalized to capture the sequence of IME actions on a claim. This report will be used to identify IME requests with a no-show billing so

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supervisors can monitor whether appropriate action is being taken. Procedures and expectations of supervisors will be implemented in December 2012.

Another revision to the IME appointment letter is expected by mid-2013. These changes should positively impact the transportation issues identified as one of the leading causes for injured workers not showing up for IME appointments.

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## Status of Resolution of Audit Findings

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**Military Department (MIL)**

**Agency: 245**

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**Audit Report:** 2011 F

**Finding Number:** 005

**Finding:** The Military Department did not support \$155,647 in payroll costs in accordance with federal regulations for its National Guard Operations and Maintenance grant.

**Resolution:** The Department concurs with this finding. The following actions were completed by July 20, 2012:

- The Department changed its hiring procedures to include a notation on the Personnel Action Form to include whether or not the employee is required to submit quarterly certifications. This notation is noted by the program hiring authority.
- The Payroll Section maintains a listing of employees who are required to submit quarterly certifications.
- The Payroll Section is responsible for collecting the required certifications on each employee and maintaining appropriate records.

The U.S. Property and Fiscal Office (USPFO), the federal granting agency, was forwarded a copy of the draft finding. The USPFO performed an internal review of the situation in August 2012. They determined that sufficient internal controls were implemented as a result of the audit finding and are not requiring the Department to repay the \$155,647.

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## Status of Resolution of Audit Findings

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**Military Department (MIL)**

**Agency: 245**

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**Audit Report:** 2011 F

**Finding Number:** 006

**Finding:** The Military Department does not have controls to ensure it complies with Davis-Bacon (prevailing wage) requirements.

**Resolution:** The Department concurs with this finding. The following actions have been taken to correct this deficiency:

- The responsibility for monitoring compliance with Davis-Bacon (prevailing wage) requirements has been assigned to the Contracting section of the Department.
- The Contracting section staff is familiar with Davis-Bacon reporting requirements and has incorporated the submission and review of weekly certified payrolls into contracts requiring such reporting.
- The Contracting section is responsible for collecting certified payrolls and will monitor compliance.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 1006746

**Finding Number:** 002

**Finding:** The Department of Social and Health Services does not perform timely reconciliations of the State Payroll Revolving Account, resulting in losses and errors.

**Resolution:** The Department has taken several steps to correct the deficiencies identified in this audit.

In May 2010, the Department reviewed and made changes to the processes that were in place for the collection of overpayments and reconciliation of insurance payments. The monitoring of both was given increased priority by the Department.

In November 2011, the Department centralized its payroll function for western Washington institutions into headquarters. This change provides more consistency in the various payroll processes.

During fiscal year 2012, the Department made significant progress in payroll reconciliation. An example of this progress is the health insurance liability general ledger for which over half of the beginning balance was reconciled and cleared. In most cases, the Department is meeting its goal of reconciling current month activity within 30 days. For the occasional circumstances where a reconciliation cannot be completed within 30 days, it is completed within 60 days.

Additionally, process improvements, reporting tools (such as the payroll posting report, flexible employee data reports, and a movement/turnover report), and other practices have helped in managing the payroll activity and reducing the number of irregularities that need to be corrected within the current activity.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 1006746

**Finding Number:** 003

**Finding:** The Department of Social and Health Services does not adequately monitor access to critical systems to prevent unauthorized access or misuse.

**Resolution:** The Department has taken or will take the following corrective actions:

In August 2010, the Department implemented the user maintenance module in the Support Enforcement Management System (SEMS). Implementation of this module ensured that employees did not have more rights than their supervisor. In addition, the module has security profiles for each type of user based on job duties and location to ensure the appropriate level of access. The Department began generating reports from the user maintenance module in September 2010. The SEMS analyst for access control reviews the electronic report for mismatched profiles.

The Department also initiated a process, which is ongoing, that revokes a user's access to SEMS, Automated Client Eligibility System (ACES), and Electronic Jobs Automated System (eJas) when it is no longer required.

By December 2011, the Department:

- Implemented Unisys Security System which tracks access to critical files and reports on them daily.
- Confirmed the Department's mainframe database access is limited to the database administrators.
- Restricted access to programs in SEMS, eJAS, and ACES by entering the production code in a secured library.
- Ensured there was an appropriate separation of duties between those who create and pay vouchers. The system ensures that staff who initiates a voucher cannot also approve the voucher. The monthly voucher report is reviewed by internal audit staff.

In February 2012, the Department implemented policies and standards to deal with the operation of production platforms and library maintenance.

In June 2012, the Department began restricting direct access to SQL platforms to database administrators.

In October 2012, the Department's Economic Services Administration (ESA) released an employee system access checklist. The checklist is meant to be completed upon an employee's initial hire, when there are system access changes, and annually. The annual checklist is required for all ESA staff as part of the annual evaluation process. Each supervisor or their designee is responsible for ensuring it has been completed for their staff.

State of Washington

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 1006746

**Finding Number:** 004

**Finding:** The Department of Social and Health Services' Economic Services Administration systems are vulnerable to misappropriation and inappropriate data changes.

**Resolution:** The Department is in agreement with the auditor's recommendation about implementing change management systems. In March 2012, the Department implemented policies and standards to deal with the operation of production platforms and library maintenance for releasing code to production.

The new Automated Clearing House (ACH) Manager application has been released, requiring unique logins and generating an audit trail. The supervisor or lead of the electronic funds transfer (EFT) group looks at the electronic audit trail when there is a discrepancy in totals between what is in the ACH Manager application and what is on the bank report. The audit trail is also reviewed if an EFT payment goes into suspense or is misapplied. In addition, there are spot checks done during the month.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 001

**Finding:** The Department of Social and Health Services, Economic Services Administration did not have controls in place to comply with federal regulations regarding costs of salaries charged to federal grants.

**Resolution:** The Department concurs with this finding. The Department has taken action and will continue to address the deficiencies identified in the audit.

In March 2012, the Department:

- Reviewed and reduced the number of split coded positions which will limit the need for adjustments.
- Identified one staff in headquarters who will be responsible for ensuring time certification policies and procedures comply with federal requirements.

In April 2012, the staff person responsible for time certification started reviewing salary charges on a monthly basis to ensure costs are transferred as appropriate. Also, ongoing quarterly reviews will be completed to reconcile time spent with actual expenditures.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 002

**Finding:** The Department of Social and Health Services, Economic Services Administration did not issue retroactive food assistance payments in accordance with federal law.

**Resolution:** The Department concurs with this finding. In April and May 2011 the Department trained field staff on the proper calculation of retroactive payments. The same training is required for new employees responsible for issuing benefits.

By March 2012, all exceptions identified in the audit were reviewed by Department staff who determined the correct supplement amount for which the client was eligible. For those payments determined to be unallowable, the Department established an overpayment that was issued to the client.

By January 2013, the Department is planning to update the Automated Client Eligibility System (ACES) with an edit that will prevent retroactive benefit payments beyond the allowable 12-month period.

The Department will address the issue of the questioned costs with the U.S. Department of Agriculture.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 013

**Finding:** The Department of Social and Health Services is not complying with federal requirements for suspension and debarment for its federal Vocational Rehabilitation Program.

**Resolution:** The Department concurs with this finding. The Department's Division of Vocational Rehabilitation (DVR) requires a Service Tracking and Recording System authorization for purchase (AFP) when purchasing client services.

DVR added a suspension and debarment clause to the terms and conditions of the AFP. Also, language was added to the beginning of the AFP and to the terms and condition that states the AFP is a binding contract. By accepting the terms of the AFP, the vendors are certifying that they are not debarred or suspended by any federal department/agency. If the vendor becomes suspended or debarred during the term of the authorization, the vendor is required to notify the Department.

Per contract monitoring plans, DVR conducts suspension and debarment monitoring on contracts over \$25,000.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSSH)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 021

**Finding:** The Department of Social and Health Services, Division of Child Support, did not comply with federal regulations on documentation for employee salaries and wages charged to the Child Support Enforcement Program.

**Resolution:** The Department concurs with this finding; however, the Department does not concur with the questioned costs.

In October 2011, the Department implemented the following procedures to ensure only allowable salaries and benefits are charged to the Child Support Enforcement Grant:

- All employees who do not work 100 percent on the grant are required to complete monthly time sheets, recording the actual hours worked on each program.
- Employees whose job duties change or who are reassigned during the certification period are required to complete time sheets beginning the month the change occurs and each month thereafter.
- Fiscal staff began and continue working with program staff to ensure that time sheets are completed and submitted for all affected employees.
- Cost coding was changed for those employees serving in developmental job assignments outside of the child support program, removing them from the grant.
- From October 2011 forward, semiannual certifications are allowed only for employees who work 100 percent on the grant.

When the U.S. Department of Health and Human Services (HHS) contacts the Department about questioned costs identified in this audit, the Department will negotiate repayment and take action as recommended by HHS.

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**Status of Resolution of Audit Findings**

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**Department of Social and Health Services (DSHS)**

**Agency: 300**

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**Audit Report:** 2011 F

**Finding Number:** 023

**Finding:** The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to child care providers.

**Resolution:** Refer to page 82 for the joint response from the Departments of Early Learning and Social and Health Services on this finding.

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Department of Social and Health Services (DSHS)

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**Audit Report:** 2011 F

**Finding Number:** 024

**Finding:** The Department of Social and Health Services, Children's Administration, is not ensuring the eligibility of clients receiving Adoption Assistance payments.

**Resolution:** The Department concurs with this finding. The Department has trained staff and conducted spot checks of payments. In February 2012, the Children's Administration sent a memo that included procedures and controls for setting up and managing adoption support payments to all adoption support staff and managers. Also, an in-service training was conducted with staff to review procedures and controls.

In September 2012, the Department reviewed all payments on the exception list. Those paid in error have been referred to the Office of Financial Recovery for collection. The federal portion of the incorrect payments was returned to the federal grantor.

In December 2012, the Department implemented system controls in FamLink (the Department's child welfare and payment system) that suspend payments after a child turns 18 years. The new controls will ensure payments can only be resumed after staff has manually confirmed the payments made for the adopted child are warranted. Additionally, staff must ask a separate fiduciary employee to continue the payments.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 026

**Finding:** The Department of Social and Health Services paid Medicaid providers for services that were not provided to Medicaid beneficiaries.

**Resolution:** The Department concurs with this finding. The Department will continue its work to strengthen processes that may provide a timelier and more consistent way to inform field staff about deceased clients. More specifically, the Department has taken or will take the following actions:

- In March 2012, the Invalid Payment Report was implemented and is being utilized on an ongoing basis.
- In April 2012, all exceptions identified in the audit were reviewed and overpayments were established for all unallowable payments.
- In November 2012, the Department finalized its overpayment policy. It has been implemented and shared with staff.

The Department will work with the U.S. Department of Health and Human Services to determine if any costs charged to Medicaid funds must be reimbursed.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 027

**Finding:** The Department of Social and Health Services, Office of Financial Recovery, did not have adequate controls to ensure the federal share of overpayments made to Medicaid providers is refunded to the federal government in an accurate and timely manner.

**Resolution:** The Department concurs with this finding. Corrective action was implemented by the Department in October 2011. At that time, all Department administrations and partners (Health Care Authority) received the first quarterly notification from the Department's Office of Financial Recovery (OFR) that all overpayments were to be submitted to OFR for collection and reimbursement to the federal government as required by administrative policy and law. Also, the notification was sent to all parties again in January 2012.

In October 2011, OFR also started a quarterly notification process that reminds Department administrations to submit all overpayments to OFR in a timely manner. This will allow OFR to repay the federal government in a timely manner. The second quarterly notification was sent to all parties in January 2012, and this is an ongoing quarterly activity.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 028

**Finding:** The Department of Social and Health Services did not ensure that all individuals who received Medicaid benefits had valid Social Security numbers.

**Resolution:** This finding involved two administrations within the Department: the Children's Administration (CA) and the Economic Services Administration (ESA). Both concur with the finding and have implemented corrective actions.

Children's Administration

- Reviewed the four exceptions identified in the audit. CA determined three cases were closed because clients did not apply for social security numbers (SSN); the fourth client applied for an SSN in August 2011.
- Communicated to staff who verifies SSNs the Department's procedures along with additional tools that have been developed to identify SSNs.

Economic Services Administration

- In January 2012, the Automated Client Eligibility System (ACES) was updated to allow SSN verification at the time of application screening. Staff can verify an applicant's SSN through a real-time cross match with the Social Security Administration database by way of the State Online Query (SOLQ).
- In February 2012, the two exceptions identified in the audit were reviewed and corrected.

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**Department of Social and Health Services (DSHS)**

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**Agency: 300**

**Audit Report:** 2011 F

**Finding Number:** 029

**Finding:** The Department of Social and Health Services does not have adequate internal controls to ensure Medicaid payments to in-home service providers are allowable and supported.

**Resolution:** The Department does not concur with this finding. It is the Department's opinion there are adequate controls in place. Current controls are:

- Individual providers submit a signed invoice through the mail or through the state's Interactive Voice Response System to the Department for payment. This serves as verification and documentation that they have provided the services for which they are requesting payment. The Department retains these invoices/records as the record that providers have attested to the number of service hours provided to the recipient.
- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.
- Recipients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Recipients are advised they can choose when those hours are provided and direct the individual provider when to provide them. Case managers also advise recipients to contact them if they are not receiving the hours (or care) for which they are eligible.
- Recipients are expected to keep copies of time sheets for their individual providers. Case managers periodically review these time sheets and verify with the recipient that authorized services have been provided. Case managers are instructed to document the review of time sheets and the discussion of service verification in a Service Episode Record.
- Time sheet auditing has been added to the annual quality assurance monitoring cycle.
  - In August 2011, all individual providers delivering personal care services received a written reminder of their obligation to keep a record of the date/time that in-home services are provided to Aging and Disability Services Administration (ADSA) recipients and complete and retain copies of their time sheets.
  - In September 2011, ADSA audited a statistically valid sample of individual provider time sheets to ensure that services billed were consistent with time sheet documentation submitted. In instances where the billed hours differed from time sheet records or time sheets were not provided, service receipt was verified with the recipient. Corrective actions were taken which included contract termination and processing overpayments.

To supplement these controls, the Department took or will take the following additional actions to ensure Medicaid payments to in-home service providers are allowable and supported:

- In October 2012, the Department completed a telephone survey of a randomly selected, statistically valid sample of in-home providers. The Department verified with the selected recipients that Medicaid billed services were received.

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- By December 2012, the Department will audit a randomly selected sample of individual provider time sheets to determine if services billed are consistent with time sheet documentation that was submitted.

In July 2012, the Department learned the U.S. Department of Health and Human Services (HHS) will not determine the status of questioned costs until the audit makes its way through the Federal audit clearinghouse. It could be one to two years before HHS makes a decision on questioned costs. When HHS reviews the audit, the Department will work with them on questioned costs.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 030

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, did not ensure the level of in-home care services is appropriate and clients are still eligible for assistance at least annually.

**Resolution:** The Department partially concurs with this finding. The Department agrees that a very small percentage of assessments (56 out of 57,472) were late. However, the Department does not concur with the questioned costs as each client for whom payments were made remained eligible for Medicaid services during the period the assessment was out of date. The Department believes it has strong internal controls to ensure that level of care assessments for clients receiving in-home care are performed at least every twelve months.

In July 2012, the Department learned the U.S. Department of Health and Human Services (HHS) will not determine the status of questioned costs until the audit makes its way through the Federal audit clearinghouse. It could be one to two years before HHS makes a decision on questioned costs. When HHS reviews the audit, the Department will work with them on questioned costs.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 031

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, charged approximately \$36,000 to the Medicaid program for services provided to ineligible individuals.

**Resolution:** The Department concurs with this finding. The Department inadvertently did not account for the July 2010 Children's Health Insurance Program (CHIP) expenditure correction. This was corrected in December 2011 by returning funds to Medicaid and charging the enhanced CHIP funding.

Also in July 2011, the Department established new payment codes for state only and CHIP enhanced clients. This ensures only eligible Medicaid expenditures are charged to the Medicaid program.

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## Status of Resolution of Audit Findings

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 032

**Finding:** The Department of Social and Health Services does not have an adequate process to identify ineligible Medicaid expenditures for nonqualified aliens at the time of payment, resulting in \$52,104 in questionable costs.

**Resolution:** The Department concurs with this finding. The Department acknowledged that Medicaid funds were used to serve nonqualified alien clients. Procedures have been implemented to prevent this from occurring in the future.

In November 2011, the Department corrected the exceptions identified in the audit. All questioned costs have been reimbursed to Medicaid.

In April 2012, the Department developed new payment codes that are used to move alien clients to state only funded programs.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 033

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls to ensure the accuracy of financial eligibility determinations for Medicaid clients receiving home and community based services.

**Resolution:** The Department concurs with this finding. The Department has taken the following actions to correct the deficiencies identified in the finding:

- In February 2012, the Department convened a meeting of the Home and Community Services (HCS) director, regional financial coordinators, and the headquarters financial eligibility manager. All HCS offices will use the Audit 99 program to audit the financial determinations processed by all financial services specialists. Audit 99 is used to track case audits at the local office level. Data can be rolled up for regional and statewide reports.
- In June 2012, all HCS office staff was notified that Audit 99 was to be utilized when auditing the work of the financial services specialists.
- In August 2012, a management bulletin was issued to all HCS financial staff. The bulletin listed the requirements for auditing the work of financial services specialists. Once a financial services specialist becomes proficient, there will be two audits per month of their work.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 034

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, did not perform background checks for some in-home care individual providers in accordance with state law.

**Resolution:** The Department concurs with this finding. The Department will work to ensure that each Area Agency on Aging (AAA) has a strong tracking system in place to ensure that all providers have current background checks and that authorizations are terminated when providers are noncompliant with background check requirements. The Department took the following actions:

- In July 2012, determined no payments or contacts were required to be terminated because providers obtained all background checks.
- In August 2012, finalized and distributed to field staff a management bulletin (Internal Background Check Processes for AAAs).

In July 2012, the Department learned the U.S. Department of Health and Human Services (HHS) will not determine the status of questioned costs until the audit makes its way through the Federal audit clearinghouse. It could be one to two years before HHS makes a decision on questioned costs. When HHS reviews the audit, the Department will work with them on questioned costs.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 035

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration does not have adequate controls to ensure Medicaid recipients have received the services for which Medicaid is billed.

**Resolution:** The Department does not concur with this finding and is of the opinion there are strong controls in place currently to ensure that recipients receive services for which Medicaid is being billed. These controls are as follows:

- Case managers complete an assessment that results in an authorization of hours that cannot be exceeded by a provider invoice.
- Recipients receive a copy of the service summary that tells them the number of hours of service they are eligible to receive. Recipients are advised they can choose when those hours are provided and direct the individual provider when to provide them. Case managers also advise recipients to contact them if they are not receiving the hours (or care) for which they are eligible.
- Recipients are expected to keep copies of time sheets for their individual providers which are periodically reviewed by case managers.
- Time sheet auditing has been added to the Department's annual quality assurance monitoring cycle.
- The Department, through its Payment Review Program, runs algorithms to detect possible fraudulent claims. Overpayments are initiated and referrals are made to the Medicaid Fraud Control Unit as appropriate.
- The Social Service Payment System will not process payments in excess of hours authorized.

Also, the Department added service verification monitoring to the quality assurance monitoring cycle. Starting in October 2012, the Department is verifying with the selected recipients that Medicaid billed services were received. If the Department finds that billed services were not provided, corrective action is taken. Such action includes, as appropriate, processing of overpayments, procuring the needed services that were not provided, terminating contracts with the providers, and referrals to the Medicaid Fraud Control Unit for further action.

By December 2012, the Department will:

- Audit a randomly selected sample of individual provider's time sheets to determine if services billed are consistent with time sheet documentation submitted.
- Determine if an automated solution is a possibility.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 036

**Finding:** The Department of Social and Health Services, Aging and Disability Services Administration, does not have adequate controls in place to ensure all applicant-owned assets are counted when Medicaid eligibility is determined.

**Resolution:** The Department does not concur with this finding. The Department does not agree that federal rules require verification of financial statements for the previous five years, unless a transfer has been declared or there are inconsistent facts in the record or other problems with the application. The Department submitted its policies and procedures to the Centers for Medicare and Medicaid Services (CMS) and asked if they met federal guidelines. The Department believes that the response from CMS validates its position.

Even though the Department does not agree with the finding, it executed a contract with LexisNexis for its software that provides records of property and vehicles owned or transferred during the last five years and beyond. Screening through the LexisNexis database was implemented June 14, 2012. Statewide training was completed in early June. Ongoing training will be scheduled as needed by regional "experts" and LexisNexis contracted trainers.

On June 14, 2012, a management bulletin was sent to all field staff about using the LexisNexis system. Program managers are monitoring access to the system. Regional offices are responsible for monitoring policy compliance through their case audits.

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## Status of Resolution of Audit Findings

December 2012

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Department of Social and Health Services (DSHS)

Agency: 300

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**Audit Report:** 2011 F

**Finding Number:** 037

**Finding:** The Health Care Authority and the Department of Social and Health Services do not have adequate controls to correctly report all Medicaid expenditures that are eligible for additional Children Health Insurance Program (CHIP) funds.

**Resolution:** The Department of Social and Health Services (DSHS) concurs with the finding. The Department developed systems to appropriately expend CHIP funds for Section 214 and other children. Section 214 clients are children under age 19 who became eligible for Medicaid under Section 214 of the Children's Health Insurance Program Reauthorization Act in 2009. Most children who gained coverage from Section 214 were previously ineligible because they had not been lawfully residing within Washington state for five years.

The Health Care Authority (HCA) developed a new methodology to determine eligibility for Section 107 children. Section 107 clients are Medicaid eligible children under age 19 with family income that equals or exceeds 133 percent of the federal poverty level, but is below 200 percent. For these children, claims must be first made against Medicaid, after which the state can apply for CHIP funds/reimbursement. DSHS plans to begin using the report based on the new methodology in January 2013.

Refer to page 20 for response from Health Care Authority.

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Department of Health (DOH)

Agency: 303

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**Audit Report:** 2011 F

**Finding Number:** 017

**Finding:** The Department of Health does not monitor sub-recipients of the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness programs.

**Resolution:** The Department partially concurs with the finding, and has or will implement corrective action to:

- Collect all required federal reports from subrecipient entities that are required to provide them, and ensure that they are reviewed. Where subrecipient entities do not comply with this requirement, the Department will initiate appropriate sanctions consistent with the federal compliance supplement.
- Follow up on issues identified through both the federal audits and subrecipient monitoring in a more timely and coordinated manner and formalize this process in policy and procedure. The Department wishes to emphasize that these efforts are in place, and that it is collecting questioned costs related to subrecipient monitoring activities.
- Notify subrecipients of grant information as described in the federal compliance supplement.
- Increase the scope of the document review performed in contracted monitoring visits, in a measured way, beginning with the calendar year 2012 fiscal monitoring visits.
- Collect summary level expenditure information as part of its invoicing process for subrecipients participating in its consolidated contracting process.
- Consider similar summary level documentation requirements for nonprofits and Native American tribes with whom the Department has subrecipient relationships.

The Department is also reviewing federal Office of Management and Budget guidance in light of certain regulatory interpretations by the auditor, and will formalize Department subrecipient monitoring practices, including follow up, in policy and procedure. The estimated completion date is June 2013.

The Department will work with its federal grantor to resolve the questioned costs identified by the auditor.

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## Status of Resolution of Audit Findings

December 2012

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Department of Health (DOH)

Agency: 303

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**Audit Report:** 2011 F

**Finding Number:** 018

**Finding:** The Department of Health did not comply with federal reporting requirements for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness Programs.

**Resolution:** In response to this finding, the Department's Grants Management Office has:

- Developed written procedures for preparing the Federal Financial Report (FFR) which include filing timeline, completion instructions, and review instructions. Additionally, FFR backup documents are stapled or otherwise attached to the FFR to prevent being lost or misplaced.
- Developed written instructions for completing the Federal Cash Transaction Report (FCTR). Additionally, FCTR backup documents are stapled or otherwise attached to the FCTR to prevent being lost or misplaced.

The Department's Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness Programs have improved the documentation of the procedures for completing required reports.

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## Status of Resolution of Audit Findings

December 2012

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Department of Health (DOH)

Agency: 303

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**Audit Report:** 2011 F

**Finding Number:** 019

**Finding:** The Department of Health did not maintain the federally required documentation for \$189,000 in payroll costs charged to the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness Programs.

**Resolution:** The auditors first identified the time keeping record issue for the program managers in the 2010 state fiscal year single audit which was released in March 2011. Effective January 1, 2011, when the Department became aware of the time keeping record issue, it was corrected and the Department believes this issue is resolved.

The 2011 state fiscal year single audit also noted that a number of program employees began keeping time sheets during 2011 and also completed quarterly payroll certifications. The auditors classified this as an exception and a questioned cost because the two documents did not agree. This error has also been corrected.

The Department will work with the federal grantors to resolve the questioned costs identified by the auditors.

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**Status of Resolution of Audit Findings**

December 2012

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**Department of Health (DOH)**

**Agency: 303**

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**Audit Report:** 2011 F

**Finding Number:** 020

**Finding:** The Department of Health does not have sufficient internal controls to ensure federal requirements for matching and level of effort are met for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness programs.

**Resolution:** The Department concurs with the finding. In response to the auditor's recommendation, the Department developed and implemented additional means of tracking the matching-related transactions for the Public Health Emergency Preparedness and National Bioterrorism Hospital Preparedness grants.

The Department is working to determine how to properly present the maintenance of funding requirement with an estimated completion in December 2012.

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## Status of Resolution of Audit Findings

December 2012

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Department of Health (DOH)

Agency: 303

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**Audit Report:** 2011 F

**Finding Number:** 025

**Finding:** The Department of Health did not survey hospitals in accordance with state law, which could increase the risk of Medicaid clients receiving substandard care services.

**Resolution:** The Department concurs with this finding. The Department is creating a dedicated hospital survey team that will have sufficient staff resources to complete hospital surveys within the required time frames. This survey team should be in place by February 2014.

The Department explored funding sources and expanded recruitment efforts in order to attract and pay for more resources to support this team. The Department's goal was to add two additional inspectors, and that recruitment process was completed in September 2012.

The Department is conducting a thorough study of its survey process to explore potential efficiencies in the face of ever-increasing regulatory burdens due to heightened federal standards, hospital growth, and other factors. This study should be completed by April 2013.

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## Status of Resolution of Audit Findings

December 2012

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Department of Health (DOH)

Agency: 303

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**Audit Report:** 2011 F

**Finding Number:** 049

**Finding:** The Department of Health charged the National Bioterrorism Hospital Preparedness Program for activities that occurred after the grant period had ended.

**Resolution:** The Department concurs with the finding, but wishes to indicate that the corrective action to the 2010 finding was implemented as soon as possible after the auditors identified this issue in March 2011.

The Department has reviewed its internal controls that are intended to prevent payments from being charged to grants that have exceeded their period of availability. These controls include the closing of account coding on or before the 90th calendar day unless a written extension has been provided by the federal grantor.

These controls were implemented in March 2011, subsequent to the completion of the auditor's field work for the state fiscal year 2010 single audit. The transactions that the auditor identified as not compliant while conducting the 2011 single audit occurred in the interim between the beginning of the fiscal year 2011 and when the Department became aware of the control issue.

The Department will work with the federal grantor to resolve questioned costs identified by the auditors.

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## Status of Resolution of Audit Findings

December 2012

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Department of Services for the Blind (DSB)

Agency: 315

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**Audit Report:** 2011 F

**Finding Number:** 014

**Finding:** The Department of Services for the Blind is not complying with federal requirements for suspension and debarment for its federal Vocational Rehabilitation Program.

**Resolution:** The Department concurs with this finding and took the following steps to ensure all vendors receiving more than \$25,000 in vocational rehabilitation funds are not suspended or debarred:

- Expanded its general terms and conditions (GT&Cs) to include suspension and debarment certification language.
- Attached the expanded GT&Cs to all service delivery outcome plans and contracts.
- Started monthly reviews to determine if a current vendor has received more than \$25,000 in grant funds in the preceding twelve months. If so, staff will verify the vendor has signed the GT&Cs providing the necessary certification.
- Trained staff to ensure these procedures are implemented.

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## Status of Resolution of Audit Findings

December 2012

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Department of Services for the Blind (DSB)

Agency: 315

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**Audit Report:** 2011 F

**Finding Number:** 015

**Finding:** The Department of Services for the Blind did not comply with federal requirements regarding services charged to the Vocational Rehabilitation Program.

**Resolution:** The Department acknowledges the finding. The Department provided training to vocational rehabilitation counselors on the importance of meeting individual plans for employment (IPE) timelines while acknowledging that, in providing individualized services, circumstances may arise that don't allow timelines to be adhered to. In those cases, documentation needs to describe the justification for delay to signing a plan. Training was provided at the April 25 and October 10, 2012, counselor meetings. As well, IPE timelines for each caseload are reviewed monthly with counselors. This is to ensure that timelines are met or justification for delay is documented.

Training was also provided encouraging the best practice of service item description within the plan, with best estimated costs listed.

In March 2012, the Department submitted to the U.S. Department of Education Rehabilitation Services Administration (RSA) a request for determination on whether the tools and methods developed by the Department for documenting estimated IPE goods and services costs, modification of cost estimates, service date ranges, extension of general timeliness guidelines and active client involvement in decision making meet necessary requirements.

RSA replied in a letter received by the Department on October 1, 2012, that the Department met necessary requirements and the finding is considered closed. The letter states that as procedural training to staff was implemented, all client services provided were allowable under the grant; and all consumers listed in the audit were eligible for services; they consider the finding closed. No recovery of funds is sought by RSA.

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## Status of Resolution of Audit Findings

December 2012

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**Superintendent of Public Instruction (SPI)**

**Agency: 350**

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**Audit Report:** 2011 F

**Finding Number:** 011

**Finding:** The Office of Superintendent of Public Instruction's internal controls over sub-recipient monitoring is not adequate to ensure only proper and allocable costs are charged to the Title I program.

**Resolution:** The Office does not concur with this finding. The U.S. Department of Education (DOE) concurred that Office processes met federal requirements and did not sustain the finding.

The Office has no intention of placing unnecessary burdens that are not efficient, effective, or required on districts. The Office takes the responsibility to be accountable for public funds it administers very seriously and has developed a risk-based system of monitoring districts which is efficient and effective for identifying improper use of those funds. The Office plans to continue to utilize this approach in the future.

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**Department of Early Learning (DEL)**

**Agency: 357**

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**Audit Report:** 2011 F

**Finding Number:** 016

**Finding:** The Department of Early Learning did not comply with time and effort requirements for its Special Education Grants for Infants and Families for the Early Support for Infants and Toddlers Program.

**Resolution:** The Department acknowledges that two payroll certifications (for one employee) out of the entire Early Support for Infants and Toddlers (ESIT) program were not obtained. After this was discovered, the Department contacted the employee who responded that 100 percent of his time was devoted to the work funded under the Special Education Grant. However, this retroactive certification was not allowed by the auditor.

This specific employee completed a certificate for every period while the program was at the Department of Social and Health Services. However, when the program transferred to the Department of Early Learning, the follow through did not occur and his certificates were never received by the fiscal manager. This was a clear indication that the Department needed to tighten up its process for ensuring a certificate is completed for all the ESIT staff.

Steps have already been taken to ensure this does not happen again. The ESIT fiscal program manager implemented the following procedures:

- Developed a certification tracking grid containing a list of ESIT program staff and ESIT information technology (IT) staff.
- Scanned and electronically stored all certificates.
- Delivered original hard copy certificates to the Fiscal Office for recording and filing.

The Department will continue to use the tracking grid as a checklist to ensure that all certificates are obtained from ESIT program staff and ESIT IT staff.

The U.S. Department of Education is not requiring the Department to pay back the questioned costs.

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**Department of Early Learning (DEL)**

**Agency: 357**

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**Audit Report:** 2011 F

**Finding Number:** 023

**Finding:** The Department of Early Learning and the Department of Social and Health Services do not have adequate internal controls over direct payments to child care providers.

**Resolution:** As reported in past audit reports, the Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) have taken steps to improve control over child care payments, such as increasing communications to the public on fraud-reporting options and researching options for a new electronic attendance tracking system. DEL and DSHS' Office of Fraud and Accountability have been working closely on payment and fraud related issues. Electronic attendance as a project was formally funded by the Legislature beginning July 2012 and is anticipated to go live no later than July 2015.

The agencies implemented or will implement additional measures as follows:

- In January 2012, DEL added five new staff specifically to audit child care subsidy payments by comparing subsidy child care provider billings with attendance records. DEL is seeking budgetary authority to expand this to 10 full time equivalents (FTEs) by using federal Child Care Development Block grant money to fund the additional five FTEs.
- DEL auditors expand the audit scope when they identify a child care provider that billed incorrectly. Providers are randomly selected for audit and include high billing providers from all three types: centers, family homes, and license exempt providers. This is an ongoing activity. Results of audits and subsequent expanded audits for July-October 2011 include over \$420,000 in identified overpayments.
- In accordance with the terms of the collective bargaining agreement with Service Employees International Union 925, DEL contracts with a third party to provide training on subsidy billing to licensed family home and license-exempt providers. Training has been updated to reflect changes in rules in the past several months and is anticipated to be relaunched by early December 2012.
- DEL will also contract with a third party to develop online training for subsidy billing for child care center billing staff. A child care center billing training booklet has been finalized and is available on line.
- DEL continues to work with the third party contractor to complete the training for centers. Upon completion of the family home and license-exempt training, the foundation will be established for the development of the online training for centers.

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State of Washington

**Status of Resolution of Audit Findings**

December 2012

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University of Washington (UW)

Agency: 360

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**Audit Report:** 2011 F

**Finding Number:** 012

**Finding:** The University of Washington did not comply with the eligibility requirements of federal student financial aid programs.

**Resolution:** The University's School of Social Work has strengthened its internal control structure. Duties have been segregated so that the assistant dean for Student Affairs, who had complete control of the independent study process, no longer approves independent study course proposals. The directors of the Masters of Social Work and the Bachelor of Social Work Programs now approve all independent study course proposals. To ensure compliance with this policy, two steps are in place. First, on day 10 of each quarter, the files of all students enrolled in independent study courses are reviewed to ensure that the independent study course proposals are properly documented and approved. Second, periodic checks are conducted by the associate dean for Academic Affairs on a sample of students enrolled in independent study courses to ensure that proposals are properly documented and approved.

The University currently provides guidance to students regarding their eligibility for student financial aid via a number of communication mechanisms including secure websites with individual student eligibility information; written, verbal, and email communication from financial aid counselors; and printed publications and websites relating to general financial aid information. In the future, typically at the beginning of the Fall quarter, alerts will be sent to undergraduate and graduate academic department advisors directing them to University policies regarding financial aid eligibility. These alerts will also serve to remind them that they should direct students who have questions or concerns about financial aid to the Office of Student Financial Aid.

On March 9, 2012, the University received the final program review determination letter from the U.S. Department of Education (DOE) for the questioned costs related to the Pell Grant Program. The total amount of repayment that they requested is \$10,669 (which is the amount of overpayment plus interest). Payment was sent to DOE on April 17, 2012.

On March 9, 2012, the University received the final program review determination letter from (DOE) for the Federal Direct Student Loan Program. The total amount of repayment that they requested is \$9,531. This figure takes into consideration the amount of loans improperly awarded (\$102,418), the expected repayment amount of the loans to be received from students after applying the institutional default rate and accrued interest. Payment was sent to DOE on April 17, 2012.

The University sent a check to the Department of Social and Health Services on February 14, 2012, in the amount of \$13,562 to repay the questioned costs on the Foster Care Title IV-E grant.

State of Washington

**Status of Resolution of Audit Findings**

December 2012

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## Status of Resolution of Audit Findings

December 2012

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Department of Transportation (DOT)

Agency: 405

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**Audit Report:** 2011 F

**Finding Number:** 009

**Finding:** The Department of Transportation did not support over \$768,000 in payroll costs in accordance with federal regulations for the Formula Grants for Other Than Urbanized Areas.

**Resolution:** The Department appreciates the auditor's work regarding the Formula Grants for Other Than Urbanized Areas. The Department is considered an innovative leader by the Federal Transit Administration (FTA) for its grant administration methods, which include administering a number of closely related grant programs. At this time, the Department has taken all corrective actions within its authority to ensure compliance with federal regulations. The Department is awaiting required authorization from the federal grantor to implement its planned correction.

On July 1, 2011, the Department's Public Transportation Division (PTD) began charging direct payroll costs to grant programs based on actual time worked in accordance to federal regulations. The Department continues to work with the FTA to seek approval of the formalized direct payroll cost allocation plan the PTD submitted in 2009, known as a substitute system. In addition, the Department requested acknowledgement that administrative costs allocated to the Formula Grants for Other Than Urbanized program from 2009-2011 were appropriate. The FTA has not requested that any funds be repaid.

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**State Parks and Recreation Commission (PARKS)**

**Agency: 465**

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**Audit Report:** 1006746

**Finding Number:** 001

**Finding:** The Washington State Parks and Recreation Commission is not adequately monitoring concessionaire revenue to ensure all money due to it is collected.

**Resolution:** The following actions have been taken to address the issues and recommendations identified by the audit:

1. On June 24, 2010, the Commission adopted new policies for managing concessions including new rental fee schedules to be based on appraised, fair market rent.
2. In October 2010, the Commission contracted with a third party appraiser to assess all major concession agreements and establish market rents. Twelve third-party appraisals have been completed as of November 2012. Due to cost constraints, third-party appraisals are only used for concession leases with an estimated annual rental value over \$5,000.
3. In March 2011, the boilerplate concession agreement was revised and approved by the Commission's Assistant Attorney General to include an annual periodic adjustment of rent.
4. In June 2011, all concession agreement financial requirements (invoices, billings, late notices, and collections) were transferred from the Lands Program to Financial Services. This included an upgrade of the Lands System to include financial data and automated billings and notices to vendors.
5. The Commission awarded one new concession agreement since June 2011. The total is now 53. Status of conversion of concession agreements to a flat rate rental structure as of November 2012 is shown below:
  - Forty-four agreements have been converted to a flat rate.
  - Six agreements are currently in negotiation.
  - Three concessionaires elected to enforce the legal requirements of the agreement until the term expires and fees remain as a percentage of gross revenue.
6. The Commission's plan to monitor the three concessions not agreeing to a contract amendment until current term expires is as follows:
  - Two concessionaires submit copies of their State Combined Excise Tax Return with the concession payment. Financial Services verifies that the gross revenue on the tax return matches the gross revenues on the concession payment document. Discrepancies are referred to the Concessions Program Manager. One of these agreements expires in 2039; the other expires in 2043.
  - The final concessionaire submits an income statement prepared by the company. The Commission is working with the concessionaire to develop a satisfactory method to independently verify gross revenues and expects to reach a resolution by June 2013. This agreement expires in 2027.

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## Status of Resolution of Audit Findings

December 2012

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**Recreation and Conservation Funding Board (RCFB)**

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**Agency: 467**

**Audit Report:** 2011 F

**Finding Number:** 003

**Finding:** The Recreation and Conservation Office did not support more than \$220,000 in payroll costs as required by federal regulations for the Pacific Coast Salmon Recovery-Pacific Salmon Treaty Program.

**Resolution:** The Recreation and Conservation Funding Board (Board) concurs with this finding and took the following corrective action:

- Payroll costs are drawn as they occur. This change covers direct salaries and benefits. The Board started drawing indirect costs to cover administrative salaries and benefits effective July 2011.
- Verified that the Board's handling of the payroll costs complied with federal regulations specified in "Cost Principles for State, Local and Indian Tribal Governments."
- Updated all staff on the audit outcomes and trained fiscal staff on the detailed changes to processes.
- Discussed the questioned costs with U.S. Department of Commerce, National Oceanic and Atmospheric Administration in May 2012. Final resolution is pending.

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## Status of Resolution of Audit Findings

December 2012

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**Recreation and Conservation Funding Board (RCFB)**

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**Agency: 467**

**Audit Report:** 2011 F

**Finding Number:** 004

**Finding:** The Recreation and Conservation Office did not support more than \$62,000 in administrative costs as required by federal regulations for the Pacific Coast Salmon Recovery Pacific Salmon Treaty Program.

**Resolution:** The Recreation and Conservation Funding Board (Board) concurs with this finding and took the following corrective action:

- Based all administrative costs on the Board's federally approved indirect rate. The Board draws administrative costs as they occur and started drawing indirect costs to cover administrative salaries and benefits effective July 2011.
- The Board contacted the U.S. Department of Commerce, National Oceanic and Atmospheric Administration (NOAA) grants staff in May 2012, and they indicated that an amendment to the grant agreement to include indirect costs in the grant budget was not required.
- In May 2012, the Board shared with NOAA grants staff the base of the administrative costs (agency pass-through).
- Updated all staff on the audit outcomes and trained fiscal staff on the detailed changes to processes needed.
- Discussed the questioned costs with the NOAA in May 2012. Final resolution is pending.

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## Status of Resolution of Audit Findings

December 2012

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**Employment Security Department (ESD)**

**Agency: 540**

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**Audit Report:** 2011 F

**Finding Number:** 008

**Finding:** The Employment Security Department did not comply with U.S. Department of Labor requirements for determining the accuracy of Unemployment Insurance benefit payments.

**Resolution:** The Department has made the necessary improvements to ensure all benefit accuracy measurement (BAM) investigations are accurate, complete, and compliant with U.S. Department of Labor requirements.

Improvements completed include the following:

- Revised processes to improve claimant and employer response rates.
- Continued increase in supervisory case review and oversight.
- Enhanced staff knowledge through training, sharing of best practices, and peer case file reviews.
- Retention of experienced and knowledgeable investigators.
- Increased communication and cooperation with other units in the Department, BAM staff in other states, and external regulators.
- Increased reference resources available within the Department.
- Updated the BAM procedural manual and unit forms.

All corrective actions were completed or implemented by September 30, 2012.

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## Status of Resolution of Audit Findings

December 2012

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**Employment Security Department (ESD)**

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**Agency: 540**

**Audit Report:** 2011 F

**Finding Number:** 051

**Finding:** The Employment Security Department did not ensure all background checks were performed for AmeriCorps members as required by federal regulations.

**Resolution:** The Department has revised processes for ensuring all background check documentation for AmeriCorps members is properly retained and on file prior to enrollment in the program. Improvements include the following:

- Created background check policy and procedures to ensure compliance with program documentation requirements.
- Revised records retention processes by maintaining all background check documentation centrally in the program headquarters office.
- Improved internal controls by ensuring independent reviews are conducted on all member files.
- Increased staff and subrecipient awareness of documentation requirements through training, ongoing communication, and increased monitoring and technical assistance.
- Hired an additional staff member to focus on compliance monitoring and assist in implementing new procedures.

The Department does not agree that members served under this grant were ineligible and will work with the grantor agency on resolving the issue of questioned costs.

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**Schedule 2 – Fraud Findings by Agency**

December 2012

| <b>AGENCY<br/>NUMBER</b> | <b>AGENCY</b>                            | <b>AUDIT<br/>NUMBER</b> | <b>FINDING<br/>NUMBER</b> | <b>PAGE</b> |
|--------------------------|--|-------------------------|---------------------------|-------------|
| 300                      | Department of Social and Health Services | 1007720 .....           | 001 .....                 | 95          |

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**Status of Resolution of Reported Fraud Findings**

December 2012

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**Department of Social and Health Services (DSHS)**

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**Agency: 300**

|                           |   |
|---------------------------|---|
| <b>Audit Report:</b>      | 1007720   |
| <b>Finding Number:</b>    | 001   |
| <b>Finding:</b>           | The Fiscal Analyst performed incompatible duties related to the handling of checks and cash, preparing accounting records and completing bank reconciliations with no independent review.   |
| <b>Fraud Amount:</b>      | \$304,755   |
| <b>Recovery to Date:</b>  | \$0 (There has been no recovery to date. The individual is currently incarcerated and might not begin making restitution payments until released from prison. After release, the individual will be monitored by the Bureau of Prisons for up to 20 years to ensure restitution payments are made.)   |
| <b>Resolution/Status:</b> | <p>The facility at which the fraud occurred, Frances Haddon Morgan Center (FHMC), was officially closed December 31, 2011. FHMC served residents until November 16, 2011, with the last eight employees being transferred or laid off on December 31, 2011. The misappropriation of funds was discovered during an internal audit conducted by the Department's internal audit program.</p> <p>The audit of FHMC was included in the Department's fiscal year 2011 Audit and Consultation Plan and was initiated in November 2010, covering the period from January 2010 to November 2010. During the second day of field work, one of the auditors verified irregularities in the documentation related to two accounts. Consequently, the scope of the audit was expanded and the auditors reviewed activity for all major streams of cash flow including the state's accounting system (Agency Financial Reporting System), payroll records, cash receipting records, and a residential trust fund account. The expanded scope resulted in the field work continuing through February 28, 2011.</p> <p>When the irregularities were discovered, the Superintendent of FHMC suspended the operations of the business office and placed the three staff on administrative leave. The fiscal technician and office assistant senior were subsequently brought back while the fiscal analyst was dismissed from the position. The Department's internal audit report was released in April 2011.</p> <p>The State Auditor's Office (SAO) conducted a special investigation of the misappropriation of funds at FHMC by reviewing the Department's audit and investigation. The SAO report, released in May 2012 agreed with the Department's audit scope, methodology, and conclusions. SAO recommended the Department strengthen internal controls over cash receipting and payments. The Department concurred with SAO's report and stated so in its response.</p> <p>The Department's internal audit report made several recommendations meant to improve internal controls at FHMC. The administrator of FHMC began implementing corrective actions during the course of the audit. Once the SAO audit report was released, additional corrective actions were developed</p> |

## Status of Resolution of Reported Fraud Findings

December 2012

addressing segregation of banking duties, checking account activities, cash handling, and resident trust funds. Also, reconciliation and internal audits were transferred to the Rainier School Business Office. Finally, the Department implemented a centralized business process which removed some business functions from local facilities. All corrective actions were implemented at FHMC by October 2011, approximately two months before the facility was officially closed.

**Personnel Action Taken:** The employee was terminated on February 4, 2011.

**Criminal Action Taken:** The former employee who misappropriated the funds pled guilty to five counts of embezzlement, theft, and conversion of public money, property, or records. In June 2012, the individual was sentenced in U.S. District Court to 33 months in prison, three years of supervised release, and ordered to pay \$304,755 in restitution for theft of government funds.

**Amount to be Recovered:** \$304,755 in misappropriated funds. The audit costs were not included in the restitution order. The judge recognized the time and effort put into the case by the Department and other agencies, but chose not to include the audit costs in the restitution order.

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