SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-002 The University of Washington did not have adequate internal controls to ensure key personnel commitments specified in grant proposals or awards were met.

Assistance Listing Number and Title:	Various, Research and Development Cluster – University of Washington
Federal Grantor Name:	Various
Federal Award/Contract Number:	Various
Pass-through Entity Name:	Various
Pass-through Award/Contract Number:	Various
Applicable Compliance Component:	Special Tests and Provisions: Key Personnel
Known Questioned Cost Amount:	None

Background

The federal government sponsors research and development (R&D) activities under a variety of types of awards. Most commonly, these are grants, cooperative agreements, and contracts to achieve objectives agreed upon between the federal awarding agency and the non-federal entity. The types of R&D conducted under these awards vary widely. Grants for R&D are awarded to non-federal entities on the basis of applications or proposals submitted to federal agencies or pass-through entities. An award is then negotiated that will include the purpose of the project, the amount of the award and the terms and conditions.

R&D awards may include staffing proposals that specify key personnel who will work on the project, as well as the extent of their planned involvement. One of these key personnel is typically a principal investigator (PI) who contributes to the scientific development or execution of a project in a substantive, measurable way. The non-federal entity is required to meet key personnel commitments specified in the award and may be required to obtain approval from the grantor for certain types of changes.

The University of Washington is the largest recipient of federal R&D awards in the state of Washington. The University expended funds from 2,396 separate awards for the R&D grants, with

expenditures totaling approximately $1.02 billion of the almost $1.17 billion expended statewide during the audit period.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The University did not have adequate internal controls to ensure key personnel commitments specified in grant proposals or awards were met.

To determine if the University complied with key personnel requirements, we reviewed the University's internal controls over monitoring key personnel time and effort, and also examined grant awards to determine if key personnel identified in the application/proposal and award were involved in the project as required.

We used a statistical sampling method to randomly select and examine 59 unique budget numbers assigned to R&D programs out of a total population of 7,486. We examined these samples and found:

- Four instances where we could not determine whether the University properly monitored key personnel time and effort to ensure that they met award requirements identified in the grant application/proposal and award were involved in the project as required.
- Two instances where key personnel were not involved in the project as required. Specifically, we found:
  - One award for which the PI was required to spend approximately 16 percent of their time on the award, but spent less than 5 percent
  - One award where the PI was required to spend 2 percent of their time on the award, but only spent .67 percent

We consider these internal control deficiencies to be a significant deficiency.

This issue was not reported as a finding in the prior audit.

Cause of Condition

While we determined the University had policies and procedures to ensure that key personnel are involved in the grant projects as required, there were not policies or procedures to ensure that there was sufficient University-level oversight to ensure key personnel commitments were met.

Effect of Condition

By not establishing adequate internal controls, the University cannot reasonably ensure it meets the key personnel requirement.

Recommendation

We recommend the University improve its internal controls to ensure key personnel identified in the application/proposal and award were involved in the project as required. In addition, if the University identifies key personnel commitments are not going to meet required levels, ensure that federal awarding agency approval is obtained when required.

University's Response

The University has established internal controls to ensure compliance with program requirements through the effort certification and project reporting processes, and budget reconciliation requirements. However, we agree there are areas for improvement int terms of staff and PI training, and available resources to monitor contribution and documentation of committed levels of effort.

The University will implement the following improvements:

- *The University offers multiple training courses to research administrators and principal investigators on management of sponsored awards. We will update our training materials and provide additional training on documentation of effort for PIs and key personnel, and prior approval requirements for reductions in effort.*
- *Update guidance and instructions for effort certifications to ensure all devoted effort is properly accounted for during the effort certification process.*
- *Develop exception reports to provide additional oversight to monitor deviations from committed effort for PIs and key personnel.*

Auditor's Remarks

We thank the University for its cooperation and assistance throughout the audit. We will review the status of the University's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 308, Revision of budget and program plans, states in part:

> (a) The approved budget for the Federal award summarizes the financial aspects of the project or program as approved during the Federal award process. It may include either the Federal and non-Federal share (see definition for *Federal share* in § 200.1) or only the Federal share, depending upon Federal awarding agency requirements. The budget and program plans include considerations for performance and program evaluation purposes whenever required in accordance with the terms and conditions of the award.
>
> (b) Recipients are required to report deviations from budget or project scope or objective, and request prior approvals from Federal awarding agencies for budget and program plan revisions, in accordance with this section.
>
> (c) For non-construction Federal awards, recipients must request prior approvals from Federal awarding agencies for the following program or budget-related reasons:
>
>> (1) Change in the scope or the objective of the project or program (even if there is no associated budget revision requiring prior written approval).
>>
>> (2) Change in a key person specified in the application or the Federal award.
>>
>> (3) The disengagement from the project for more than three months, or a 25 percent reduction in time devoted to the project, by the approved project director or principal investigator.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-003 The Office of Superintendent of Public Instruction did not have adequate internal controls over accountability for USDA-donated foods.

Assistance Listing Number and Title:	10.553 School Breakfast Program 10.555 National School Lunch Program 10.555 COVID-19 National School Lunch Program 10.556 Special Milk Program for Children 10.559 Summer Food Service Program for Children 10.582 Fresh Fruits and Vegetable Program
Federal Grantor Name:	U.S. Department of Agriculture
Federal Award/Contract Number:	217WAWA3N1099; 217WAWA3N1199; 217WAWA1L1603; 227WAWA3N1099; 227WAWAN119; 227WAWA1L1603
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Accountability for USDA-Donated Foods
Known Questioned Cost Amount:	None

Background

The Child Nutrition Cluster programs help states administer food services that provide healthy and nutritious meals to eligible children in public and nonprofit private schools, residential care institutions and summer programs, as well as encourages the domestic consumption of nutritious agricultural commodities.

The Office of Superintendent of Public Instruction administers the state's Child Nutrition Cluster programs. The Office spent about $578 million, including non-cash assistance, in federal funds on

eligible child nutrition meals during fiscal year 2022. The Office passed through most of the assistance to school food authorities (SFA) and other sponsors as subawards.

The United States Department of Agriculture (USDA) makes donated agricultural commodities available for use in operating all child nutrition programs, except the Special Milk Program for Children. The Office contracts with four warehouses to perform its storage and distribution duties.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Office did not have adequate internal controls over accountability for USDA-donated foods. The prior finding numbers were 2021-003, 2020-004 and 2019-005.

Description of Condition

The Office did not have adequate internal controls over accountability for USDA-donated foods.

We conducted an inventory reconciliation using the Office's state fiscal year physical inventory records from 2021 and 2022, USDA food order records, and distribution records. We determined the Office performed an annual physical inventory for all four warehouses. However, we found the Office:

- Did not perform monthly reconciliations between the federal government distribution report, the Office's internal inventory tracking spreadsheet and the warehouse documentation
- Did not keep supporting records for inventory loss adjustments

We identified 91 food items with negative adjustments. We reviewed 14 adjustments and found five were not supported and five were only partially supported. We also found that four out of the 239 food items we examined contained discrepancies. We noted a total variance of four (quantity in cases) out of 32,491 cases. The Office undercounted by three cases and overcounted by one case.

We consider these internal control deficiencies to be a significant deficiency.

Cause of Condition

In response to the prior audit finding, the Office developed a corrective action plan that included procuring a new or updated electronic food distribution system. However, at the time of the audit, the Office was still in the process of procuring a new or updated electronic food distribution system that includes tracking and reporting capabilities to assist with the reconciliation process.

Effect of Condition

Without proper reconciliation between physical inventories and inventory records, the Office cannot ensure it identifies inventory discrepancies and properly accounts for the loss of donated foods. Additionally, failure to maintain records required by federal law may require the Office to pay USDA the value of the food or replace it in kind.

Recommendations

We recommend the Office:

- Strengthen established internal controls to ensure it reconciles physical inventory with inventory records on a monthly basis
- Follow up on the inventory discrepancies identified

Office's Response

OSPI concurs with this finding. We have implemented internal policies and procedures for the reconciliation of USDA Foods on an annual basis, meeting USDA requirements for state agencies operating this program. We will review our current process for monthly inventory review and explore the opportunities to strengthen internal controls around reconciling physical inventory with inventory records, and additionally, to follow up on any inventory discrepancies that are identified.

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 7 CFR Part 250, *Donation of Foods for Use in the United States, Its Territories and Possessions and Areas Under Its Jurisdictions*, section 12, Storage and inventory management at the distributing agency level, describes storage and inventory management requirements for state distributing agencies.

Title 7 CFR Part 250, *Donation of Foods for Use in the United States, Its Territories and Possessions and Areas Under Its Jurisdictions*, section 16, Claims and restitution for donated food losses, describes the distributing agency's responsibilities for identifying and seeking restitution from responsible parties for the loss of donated foods.

Title 7 CFR Part 250, *Donation of Foods for Use in the United States, Its Territories and Possessions and Areas Under Its Jurisdictions,* section 19, Recordkeeping requirements, describes the distributing agency's requirements for maintaining donated food distribution records and the period of retention of records.

Title 7 CFR Part 250, *Donation of Foods for Use in the United States, Its Territories and Possessions and Areas Under Its Jurisdictions*, section 21, Distributing agency reviews, describes the distributing agency's scope of review requirements for on-site review and identification and correction of deficiencies identified in its reviews.

State of Washington
July 1, 2021 through June 30, 2022

2022-004 The Department of Health did not have adequate internal controls to ensure payments to providers were allowable, met cost principles, and were within the period of performance for the Special Supplemental Nutrition Program for Women, Infants, and Children.

Assistance Listing Number and Title:	10.557 Special Supplemental Nutrition Program for Women, Infants, and Children 10.557 COVID-19 Special Supplemental Nutrition Program for Women, Infants, and Children
Federal Grantor Name:	U.S. Department of Agriculture
Federal Award/Contract Number:	217WAWA7W6003; 217WAWA7W6006; 217WAWA7W7003; 217WAWA7W1003; 217WAWA7W1006; 227WAWA7W1003; 227WAWA7W1006; 227WAWA1W5003
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Period of Performance
Known Questioned Cost Amount:	None

Background

The Department of Health operates the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC is funded exclusively with federal grants from the U.S. Department of Agriculture. WIC serves pregnant women, new and breastfeeding moms, and children younger than 5 years old who are at or below 185 percent of the federal poverty level. WIC provides:

- Nutrition ideas and tips on how to eat well and be more active
- Breastfeeding support, such as access to a peer counselor and breast pumps (varies by clinic)

- Health screenings and referrals
- Monthly benefits for healthy food, such as milk, cereal, fruits and vegetables

In fiscal year 2022, the Department spent more than $106.2 million in federal program funds, about $29.8 million of which it disbursed to subrecipients.

To help carry out the program's objectives, the Department issues consolidated contracts to Local Health Jurisdictions that are classified as subrecipients. A consolidated contract is for one subrecipient that combines funding for multiple federal programs.

Subrecipients are awarded federal funds on a reimbursement basis only. The Department assigns each subrecipient a risk level based on standardized criteria, and it maintains a matrix that specifies the documentation that subrecipients at each risk level are required to submit with every reimbursement. There are varying requirements among low, moderate, and high-risk subrecipients for each of the following expense categories:

- Salaries and benefits
- Equipment ($5,000 or more)
- Materials, supplies, and other
- Travel (in-state and out-of-state)
- Contracts and sub-subrecipients
- Administrative/indirect costs

The Department's Fiscal Monitoring Unit (FMU) also conducts fiscal reviews of each subrecipient to review source documentation to ensure payments are for allowable activities and within the period of performance.

During the audit period, subrecipients submitted invoices to the Department's accounting unit where staff, on a weekly basis, compiled a list of all consolidated contract invoices into one email. The emails were sent to Department program staff requesting review to ensure the payment was allowable and within the period of performance. The emails consisted of 30 to 50 invoice requests with hundreds of pages of supporting documentation. The accounting unit considered each invoice listed in the email as approved if program staff did not respond. To address concerns about an invoice, program staff were required to email the accounting unit within 10 business days to withhold payment until the items in question were resolved.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure provider payments were allowable and met cost principles

for the WIC program. The issue was reported as a finding in the prior audit. The prior finding number was 2021-004.

Description of Condition

The Department did not have adequate internal controls to ensure payments to providers were allowable, met cost principles, and were within the program's period of performance.

Department program staff were required to use the documentation matrix when reviewing subrecipient payments to ensure they were for allowable activities, met cost principles, were within the period of performance and included required supporting documentation. However, program staff did not communicate their approval to the accounting unit that issues payment. As a result, the Department paid the subrecipients without knowing whether these expenditures had been reviewed and approved by the program staff.

We consider this internal control deficiency to be a significant deficiency.

Cause of Condition

Management did not establish sufficient internal controls to ensure payments to subrecipients were reviewed and approved prior to paying them. The Department's established procedures allowed for the accounting unit to pay providers without evidence the program staff reviewed and determined the payment was allowable, within the grant's period of performance, and adequately supported.

Effect of Condition

Without establishing adequate internal controls that require program staff to communicate approval to the accounting unit prior to payment, the Department cannot reasonably ensure it is using federal funds for allowable purposes and within the period of performance.

Recommendation

We recommend the Department improve internal controls to ensure program staff document and communicate approval to the accounting unit to ensure expenditures are for allowable activities and within the period of performance prior to payment.

Department's Response

We appreciate the State Auditor's Office (SAO) audit of the Women, Infants and Children Special Supplemental (WIC) grant. The Department is committed to ensuring our programs comply with federal regulations and understand that it is SAO's point of view that we did not have adequate

controls over consolidated contract provider payments to ensure allowability in meeting cost principles and period of performance.

The Department respectfully disagrees with SAO's assessment of a significant deficiency in internal controls over the consolidated contract provider payment process to ensure allowability in meeting cost principles and meeting period of performance with our WIC program. When accounting staff send the A19 consolidated contract invoices to the applicable programs WIC quality assurance (QA) program staff review invoice support for allowability and period of performance and keep a log with a breakdown of the total payment requested for WIC. If the payment has no issues or concerns, it is logged in the log and staff initial the entry to denote no issues and that full payment can be made. If there is a question on allowable cost, period of performance, a need for additional backup documentation or an error program QA staff will log the issue and amount/s in question and escalate the log to the WIC Deputy Program Director in accordance with the WIC programs escalation policy. Program will then communicate with the LHJ and document the correspondence. If the issues remain by the end of the ten day window, WIC Program Staff will contact the accounting consolidated contract payment desk to withhold the specific amount of payment until the issue is resolved. Once resolved staff initial and date the log to denote the issue has been resolved and email accounting to release the payment amount in question.

It should be noted that the current process over provider payments at the Department of Health has been in place for well over a decade and has been through several annual audits by the State Auditor's Office and separate federal reviews of the program by our federal funders without issue. The defined process of consolidated contract payments was in response to issues arising with timely payment of funds to our local government partners. The consolidated contracts are an essential tool in providing such funding on a large scale. This process balances many needs in tracking payments, providing documentation to the programs for review as well as allowing for timely distribution of funding to the local health jurisdictions for state and federal programs in order to serve the citizens of the State of Washington. It also simplifies the invoicing and payment process as well as reconciliation between DOH and the Local Health Jurisdictions (LHJs).

This, along with the following additional overall internal monitoring and policy processes support our overall assurance of the allowability of payments:

- *Detailed budgets for WIC are submitted by the subrecipient, by project, reviewed and approved by Program staff annually and as A19's are submitted program fiscal staff keep updated budget to actual spreadsheets, and while they review the support provided by the subrecipient, they ensure amounts submitted by project are reasonable and are in alignment with expectations for the budget period submitted.*
- *The WIC program has an allowable cost policy chapter, purchase and procurement chapter, that is provided to the subrecipients.*

- *Program staff regularly provide technical assistance, policies, and training to WIC subrecipients related to both allowability and compliance as it relates to programmatic processes. Each of the subrecipients of funds receives a monitoring visit from our Fiscal Monitoring Unit (FMU) once every two years. During the course of these visits monitoring staff perform walk-throughs and assessments of the internal controls surrounding the A19 payments process and typically select the most recent three A19's submitted for funding and agree all charges to the source documentation from the subrecipient for allowability using the costs principles and criteria as a basis.*
- *WIC program monitoring staff also perform biannual monitoring visits at a minimum and perform critical reviews of program activities to ensure WIC processes and costs charged to the program are for allowable purposes and are in alignment with programmatic rules related to the Women, Infants and Children Program.*
- *The agency's Fiscal Monitoring Unit (FMU) regularly provides technical assistance and training, not only to WIC fiscal program staff, but to the subrecipients while onsite and at the request of the entities receiving WIC funding.*

Auditor's Remarks

In its response, the Department acknowledges the accounting unit issues payments to subrecipients without receiving an approval from program staff that the payment is allowable and met period of performance requirements. This is a weakness in the design of internal controls and, in our judgement, increases the risk that payments are made without assurance a program level review of the supporting documentation occurred.

We reaffirm our finding, and we will follow up on the status of the Department's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-005 The Employment Security Department did not have adequate internal controls to ensure it submitted accurate monthly reports for the Unemployment Insurance program.

Assistance Listing Number and Title:	17.225 Unemployment Insurance 17.225 COVID-19 Unemployment Insurance
Federal Grantor Name:	U.S. Department of Labor
Federal Award/Contract Number:	UI-34528-20-60-A-53; UI-34748-20-55-A-53 UI-34890-20-55-A-53; UI-35682-21-55-A-53 UI-35737-21-55-A-53; UI-35977-21-60-A-53 UI-37098-21-55-A-53; UI-37256-22-55-A-53 UI-37313-22-55-A-53; UI-38013-22-60-A-53 UI-38163-22-55-A-53; UI-38511-22-55-A-53 UI-38580-22-75-A-53
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Unemployment Insurance (UI) program was created by the Social Security Act, and provides benefits under the Unemployment Compensation program to unemployed workers for periods of involuntary unemployment. It provides a stabilizing effect on the economy by maintaining the spending power of eligible workers while they are between jobs.

The Employment Security Department administers the state's UI program. During fiscal year 2022, the Department paid more than $2.8 billion dollars in unemployment insurance benefits to more than 454,000 people.

The *Unemployment Insurance Reports Handbook No. 401*—published by the U.S. Department of Labor (DOL), Employment and Training Administration, Office of Unemployment Insurance – outlines the requirements for states to submit financial and performance reports to the federal government so it can evaluate their UI programs. The ETA 9055 – Appeals Case Aging – Lower

and Higher Authority Appeals report (OMB No. 1205-0359) is submitted monthly, and it provides information on the inventory of lower and higher-authority single claimant appeals cases that have been filed in court but not yet decided. These reports provide the federal government with information about the number of days from the date an appeal was filed through the end of the month covered by the report, as well as the average and median age of the pending appeals cases. The Department prepares this report using data obtained through interagency data-sharing agreements with the Washington State Office of Administrative Hearings and the Washington State Administrative Office of the Courts.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls. This issue was not reported as a finding in the prior audit.

Description of Condition

The Department did not have adequate internal controls to ensure it submitted accurate monthly reports for the UI program.

During fiscal year 2022, the Department was required to submit monthly ETA 9055 performance reports to DOL. The Department did not require or perform a secondary review of the reports before submitting them. A single Department employee manually prepared the information contained in the reports and submitted them to the federal grantor, and no one verified they were accurate and complete before submission.

We consider this internal control deficiency to be a significant deficiency.

Cause of Condition

Management did not monitor the completion of these reports to determine whether internal controls would be sufficient to detect and correct any potential data entry errors. In addition, management relied on staff knowledge and information received directly from other agencies being accurate and complete.

Effect of Condition

By not establishing adequate internal controls to ensure monthly performance reports are complete and accurate, the Department is at an increased risk of inaccurately reporting data to the federal grantor.

Recommendation

We recommend the Department implement internal controls to ensure it has an effective review process in place before submitting monthly reports to the federal grantor.

Department's Response

The Department concurs with this finding.

The Department will implement a secondary review of these reports to verify the data pulled from relevant sources is accurately represented prior to submitting to the federal reporting system.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

The U.S. Department of Labor, Employment and Training Administration, Office of Unemployment Insurance, *Unemployment Insurance Reports Handbook No. 401*, Section V: Benefits Time Lapse and Quality, states in part:

> ETA 9055 – APPEALS CASE AGING
>
> Section V-5
>
> D. General Reporting Instructions
>
> Appeals Case Aging measures require states to report data on the universe of all single claimant appeals cases that have not been decided prior to the end of the reporting period. Edit checks can be found in Handbook 402, Unemployment Insurance Required Reports User's Manual, Appendix C.
>
> 4. Pending Lower Authority Single Claimant Appeals Case Aging.

a. Includes all lower authority single claimant appeals cases, including those remanded by the higher authority for a hearing and decision reopened appeals cases not decided at the end of the month.

5. Pending Higher Authority Single Claimant Appeals Case Aging.

a. Includes all higher authority single claimant appeals cases, including remanded and reopened appeals cases, not decided at the end of the month. An appeals case that has been remanded to the lower authority for additional evidence and will be returned to the higher authority for a decision is reported in this inventory. An appeals case that has been remanded to the lower authority for a new hearing and decision is not a pending higher authority appeals case and should not be counted as such.

Office of Management and Budget, 2 CFR Part 200, Appendix XI, Compliance Supplement, Unemployment Insurance, states in part:

L. Reporting

2. Performance Reporting

States are required to submit periodic reporting to evaluate the performance of the states' UI programs. The auditor should test the information included in the key reports included below that ensure the timeliness of benefits paid. Detailed information on these reports can be accessed under: https://wdr.doleta.gov/directives/attach/ETAH/ETHand401_5th.pdf

Report Name	Frequency of Submission	Reference Core Measure	Sections for Test
ETA 9050 – Time Lapse of All First Payments except Workshare	Monthly	First Payment Time Lapse 14/21 days, Interstate and Intrastate UI, UCFE, and UCX, full and partial weeks	Section A. Do not include Workshare
ETA 9052 – Nonmonetary Determination Time Lapse Detection	Monthly	Nonmonetary Determinations 21-Day Timeliness	Sections A, B and C

ETA 9055 – Appeals Case Aging – Lower and Higher Authority Appeals	Monthly	Average Age of Pending Lower and Higher Authority Appeals	Section A. Exclude the test for states that do not have Higher Authority Appeals.

State of Washington
July 1, 2021 through June 30, 2022

2022-006 The Employment Security Department did not have adequate internal controls over and did not comply with federal requirements to conduct case reviews for the Benefit Accuracy Measurement program of the Unemployment Insurance program in a timely manner.

Assistance Listing Number and Title:	17.225 Unemployment Insurance 17.225 COVID-19 Unemployment Insurance
Federal Grantor Name:	U.S. Department of Labor
Federal Award/Contract Number:	UI-34528-20-60-A-53; UI-34748-20-55-A-53; UI-34890-20-55-A-53; UI-35682-21-55-A-53; UI-35737-21-55-A-53; UI-35977-21-60-A-53; UI-37098-21-55-A-53; UI-37256-22-55-A53; UI-37313-22-55-A53; UI-38013-22-60-A-53; UI-38163-22-55-A-53; UI-38511-22-55-A-53; UI-38580-22-75-A-5
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: UI Benefit Payments
Known Questioned Cost Amount:	None

Background

The Unemployment Insurance program was created by the Social Security Act, and it provides benefits under the Unemployment Compensation program to unemployed workers for periods of involuntary unemployment. The program provides a stabilizing effect on the economy by maintaining the spending power of eligible workers while they are between jobs.

The Improper Payment Elimination and Recovery Act of 2010 requires the state workforce agencies to maintain a quality control system. The Benefits Accuracy Measurement (BAM) program is the U.S. Department of Labor's quality control system designed to assess the accuracy of unemployment insurance benefit payments and denied claims in separation status. The program

estimates error rates and dollar amounts of benefits improperly paid or denied by projecting the results from investigations in a state.

The Employment Security Department administers the state's Unemployment Insurance program. During fiscal year 2022, the Department paid more than $2.8 billion dollars in unemployment insurance benefits to more than 457,000 people.

Under the BAM program, the Department is required to draw a weekly sample of payments and denied claims. The Department must complete this sampling promptly and conduct an in-depth investigation of the claims to determine the degree of accuracy in administering the state's Unemployment Compensation program and compliance with federal law (20 CFR § 602.21(d)). The Department has established a dedicated BAM unit to meet these requirements.

The *Benefit Accuracy Measurement State Operations Handbook*, which is published by the U.S. Department of Labor's Employment and Training Administration, indicates the time frame and requirements for conducting BAM program case sampling for paid claims. States must complete reviews of:

- 70 percent of the sampled cases within 60 days of the week ending date of the batch; and
- 95 percent of the sampled cases within 90 days of the week ending date of the batch; and
- 98 percent of sampled cases within 120 days of the ending date of the annual report period.

In addition, states must sample denied claims and review:

- 60 percent of the sampled cases within 60 days of the week ending date of the batch;
- 85 percent of the sampled cases within 90 days of the week ending date of the batch; and
- 98 percent of the sampled cases within 120 days of the end of the calendar year.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported that the Department did not have adequate internal controls over and did not comply with federal requirements to conduct case reviews for the BAM program of the Unemployment Insurance program in a timely manner. The prior finding numbers were 2021-005 and 2020-011.

Description of Condition

The Department did not have adequate internal controls over and did not comply with federal requirements to operate a BAM program and assess the accuracy of unemployment insurance benefit payments.

The Department did not effectively recruit, develop and retain staff to ensure it materially complied with the BAM program's case review requirements.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department did not adequately staff its BAM unit with resources sufficient to meet BAM program requirements. Management said the BAM unit has struggled to maintain adequate staffing due to attrition and funding. Also, once staff are hired into the unit, it takes considerable time to train new employees to effectively complete case sampling. Staff appointed to assist the Department's BAM unit in response to the prior audit findings left employment during the current audit period, making it more difficult for the Department to complete investigations in a timely manner. The Department was unable to fill these vacant positions during the audit period.

Effect of Condition

The Department did not comply with the federally required timelines for completing its case sampling. We performed testing to determine whether the Department complied with federal requirements for investigating paid claims and denied claims in a timely manner.

For paid claims, we found the Department:

- Completed only 198 (45 percent) of its 440 sampled cases within 60 days of the week ending date of the batch, failing to meet the federal requirement of 70 percent
- Completed only 294 (67 percent) of its 440 sampled cases within 90 days of the week ending date of the batch, failing to meet the federal requirement of 95 percent
- Completed only 319 (73 percent) of its 440 sampled cases within 120 days of the ending date of the annual report period, failing to meet the federal requirement of 98 percent
- Failed to complete investigations for the remaining 29 (seven percent) of its 440 sampled cases during the audit period

We also found the Department completed only 91 of its 109 (83.5 percent) sampled cases of denied claims in separation within 90 days of the week ending date of the batch, failing to meet the federal requirement of 85 percent.

By not complying with the federally required timelines for completing case sampling, the Department cannot fully evaluate the accuracy of its claim decisions and is less likely to detect fraudulent payments.

Recommendation

We recommend the Department allocate the necessary staffing resources to ensure it complies with the U.S. Department of Labor's timelines for BAM case sampling.

Department's Response

The Department concurs with this finding and recommendation.

The BAM unit has, since 2019, continued to improve on the staffing model within the unit and ensure compliance is met through training, sufficient staffing, and contingency planning. The BAM Unit currently has one vacancy and is expected to have further challenges with upcoming retirements. The Agency is currently in a hiring pause for UI Administrative funding, furthering the challenge to fully staff the unit and meet requirements. The unit anticipates if fully staffed, this capacity would ensure the USDOL Acceptable Levels of Performance (ALPs) are met.

ESD continues to partner and frequently communicate with USDOL Regional Offices to discuss staffing and training models. The Quality Assurance Manager and the Case Review Supervisor are committed to routinely monitor caseload, workload, and the overall assurance of meeting the BAM operations performance goals and measures as set forth by USDOL.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 20 CFR Part 602, *Quality Control in the Federal-State Unemployment Insurance System*, section 21, Standard methods and procedures, establishes the requirements for states to conduct

representative case sampling for quality control study of unemployment benefit claims, which state in part:

§602.21 Standard methods and procedures.

Each State shall:

a. Perform the requirements of this section in accordance with instructions issued by the Department, pursuant to 602.30(a) of this part, to ensure standardization of methods and procedures in a manner consistent with this part;

b. Select representative samples for QC study of at least a minimum size specified by the Department to ensure statistical validity (for benefit payments, a minimum of 400 cases of week paid per State per year);

c. Complete prompt and in-depth case investigations to determine the degree of accuracy and timeliness in the administration of the State UC law and Federal programs with respect to benefit determinations, benefit payments, and revenue collections; and conduct other measurements and studies necessary or appropriate for carrying out the purposes of this part;

f. Furnish information and reports to the Department, including weekly transmissions of case data entered into the automated QC system and annual reports, without, in any manner, identifying individuals to whom such data pertain;

The U.S. Department of Labor, Employment and Training Administration *Benefit Accuracy Measurement State Operations Handbook – ET Handbook No. 395, 5th Edition,* Chapter VI – Investigative Procedures, Section 13: Completion of Cases and Timely Data Entry, states in part:

The following time limits are established for completion of all cases for the year. (The "year" includes all batches of weeks ending in the calendar year.):

- A minimum of 70 percent of cases must be completed within 60 days of the week ending date of the batch, and 95 percent of cases must be completed within 90 days of the week ending date of the batch; and
- A minimum of 98 percent of cases for the year must be completed within 120 days of the week ending date of the calendar year.

The U.S. Department of Labor, Employment and Training Administration *Benefit Accuracy Measurement State Operations Handbook – ET Handbook No. 395, 5th Edition,* Chapter VIII – Denied Claims Accuracy (DCA), Section 7: Completion of DCA Cases and Timely Data Entry, states in part:

As in paid claims, prompt completion of investigations is important to ensure the integrity of the information being collected by questioning claimant and employers before the passage of time adversely affects recollections. However, due to the fact that contacting the claimant and obtaining claimant information is more difficult than in paid claims, the timeliness standards differ as the following indicates:

- A minimum of 60 percent of cases must be completed within 60 days of the week ending date of the batch, and 85 percent of cases must be completed within 90 days of the week ending date of the batch; and
- A minimum of 98 percent of cases for the year must be completed within 120 days of the ending date of the Calendar Year.

State of Washington
July 1, 2021 through June 30, 2022

2022-007 The Employment Security Department did not have adequate internal controls over and did not comply with requirements to ensure it submitted complete and accurate quarterly performance reports for the Workforce Innovation and Opportunity grant.

Assistance Listing Number and Title:	17.258 Workforce Innovation and Opportunity Adult Program 17.259 Workforce Innovation and Opportunity Youth Activities 17.278 Workforce Innovation and Opportunity Dislocated Worker Formula Grants
Federal Grantor Name:	U.S. Department of Labor
Federal Award/Contract Number:	AA-33263-19-55-A-53; AA-34801-20-55-A-53; AA-36352-21-55-A-53; AA-33263-19-55-A-53; AA-34801-20-55-A-53; AA-36352-21-55-A-53; AA-33263-19-55-A-53; AA-34801-20-55-A-53; AA-36352-21-55-A-53
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Employment Security Department (Department) receives federal funding for the Workforce Innovation and Opportunity Act (WIOA) grant from the U.S. Department of Labor (DOL). WIOA authorizes formula grant programs to states to help job seekers access employment, education, training and support services to succeed in the labor market. WIOA provides employment and training programs for adults, dislocated workers, youth, and Wagner-Peyser Act employment services administered by DOL.

DOL requires that the Department complete performance reports using a standardized Participant Individual Record Layout (PIRL). The Department must file the PIRL every quarter using DOL's Workforce Integrated Performance System. DOL also requires that states develop data validation procedures related to the PIRL that include:

- Written description of the process for identifying and correcting errors or missing data, which may include electronic data checks;
- Regular data validation training for appropriate program staff;
- Monitoring protocols, consistent with 2 CFR § 200.328;
- A regular review of program data for errors, missing data, out-of-range values and anomalies;
- Documentation that missing and erroneous data identified during the review process have been corrected; and
- Regular assessment of the effectiveness of the data validation process and revisions to the process as needed.

The Department uses the Efforts to Outcome (ETO) system to determine if participants are eligible for programs under the WIOA grant. Local Workforce Development Boards (LWDBs) enter participant information into ETO, and DOL requires the Department to perform validation procedures to ensure participant data is accurate and complete. Additionally, ETO tracks participants' progress while in the program and upon completion. The Department uses data captured in ETO to compile the data elements reported on the PIRL.

In state fiscal year 2022, the Department spent about $66 million in federal WIOA grant funds.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure it submitted complete and accurate quarterly performance reports for the WIOA grant. The prior audit finding numbers were 2021-007 and 2020-012.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure it submitted complete and accurate quarterly performance reports for the WIOA grant.

The Department did not establish an effective review process to ensure data elements of the PIRL quarterly reports were accurate and complete before submitting them to DOL. The Department also did not have adequate written data validation procedures for the PIRL report, as DOL requires.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

A contracted vendor extracts participant data from a large database and then uses customized code to transform it to produce the data the Department uses to create the PIRL reports. The Department did not review the changes applied to the data extraction process to ensure accurate reporting of WIOA participant information.

Effect of Condition

We verified the Department submitted all four quarterly PIRL reports to the DOL, as required during fiscal year 2022. We obtained and examined all four reports to determine if the Department accurately prepared them. To identify a population of WIOA participants, data elements 903, 904, and 905 are critical because they represent whether a client participated in the program. Each data element must be completed with one of the following allowable coding options:

- 0 – Participant did not receive services
- 1 – Yes, Local Formula
- 2 – Yes, Statewide
- 3 – Yes, Both Local Formula and State
- 4 – Reportable Individual

We found participants listed in the quarter one report were missing one or more data elements for 903, 904 and 905. The following tables show the proportion of the fields that were blank compared to the total number of fields.

Data Element 903

Quarter	Blanks	Total	Percent
1	167,035	336,693	**49.61%**
2	0	322,723	**0.00%**
3	0	316,816	**0.00%**
4	0	303,472	**0.00%**

Data Element 904

Quarter	Blanks	Total	Percent
1	167,189	336,693	**49.66%**
2	0	322,723	**0.00%**
3	0	316,816	**0.00%**
4	0	303,472	**0.00%**

Data Element 905

Quarter	Blanks	Total	Percent
1	167,200	336,693	**49.66%**
2	0	322,723	**0.00%**
3	0	316,816	**0.00%**
4	0	303,472	**0.00%**

We could not determine the total population of WIOA participants for testing for quarter one because these data elements were incomplete and inaccurate. Further, we could not complete testing over the quarter two, three and four PIRL reports. When we attempted to design our testing over the key data elements, Department management said they could not ensure that the participant information reported would be materially accurate and complete due to the complexity of information that flows into data elements 903, 904 and 905, and due to the Department not validating the changes it made to the ETO data extraction process for effectiveness. Therefore, we could not perform further testing to determine whether the reports were accurate and complete.

Since the key data elements were incomplete and inaccurate, we could not test to determine the level of material noncompliance. Without complete data, the Department cannot demonstrate compliance with reporting requirements nor accurately inform its federal grantor of its current level of program participation.

Recommendations

We recommend the Department:

- Update its written validation procedures for the PIRL report to meet DOL requirements
- Provide training and technical assistance to LWDBs on PIRL data element reporting requirements to ensure they enter all required information into ETO
- Establish a review process to ensure it submits complete and accurate quarterly PIRL reports

Department's Response

The Department concurs with the finding.

We would like to thank the Office of the State Auditor (SAO) for their work on this area to ensure job seekers in Washington state can access employment, education, training, and support services to succeed in the labor market.

We have outlined our response below with respect to the recommendations made by SAO.

The Department is conducting a balance of performing and implementing these recommendations concurrently with the WIT replacement project, which is estimated for completion in December 2024.

SAO recommendation*: Update written validation procedures for the PIRL report to meet DOL requirements.*

The Data Integrity, Policy and Monitoring teams have completed their Data Element Validation (DEV) policy update, submitted it to DOL and are actively executing DEV per DOL expectations.

DOL has not provided guidance or definitions through a Training Employment Guidance Letter or Training Employment Notice related to the designation of a reportable individual. Once issued, we can more effectively train stakeholders, update policy, and hold local areas accountable to what a reportable individual count would be.

We will also work with our vendors who provide the data extract from Efforts to Outcome to ensure scripting produces the required outcome.

SAO recommendation*: Provide training and technical assistance to LWDB's on PIRL data element reporting requirements to ensure they enter all required information into ETO.*

ESD's Data Integrity team has established a technical assistance PIRL reporting process focused on continuous improvement practices including data analysis training efforts. This process has been in place since Q2 2021.

ESD will direct stakeholders to the current training processes and procedures which are shared on the Workforce Professional Center website. The agency is already working on a project to create an ETO Registration 101. This work will create a process that will add consistency and a more complete approach to the pre-requisite requirements of our customers as they are added to ETO. This is estimated to be complete in March 2023.

The Data Integrity team will also be available for 1:1 specialized technical assistance, regarding their continuous improvement practices and pertinent data analysis, as requested by local areas and one-stop centers.

SAO recommendation*: Establish a review process to ensure it submits complete and accurate quarterly PIRL reports.*

The Data Integrity team is heavily involved in the automation and standardization of the Quarterly Report Analysis (QRA) process. Thus far, we have concentrated on setting up a sustainable process and we are working on evaluating all defined areas in the most recent QRAs provided to date. In addition, the Data Integrity team will continue to identify and fix issues when using WIPS and Performance Measure Analysis (for credentials and measurable skill gains).

The QRA is in its pilot phase with DOL, and Washington State has proactively established a system and reporting structure prior to it being formally required by DOL. We are seeking and receiving technical assistance with DOL as it relates to the PIRL to further establish internal controls and effectively manage data validation, quality, and integrity.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Training and Employment Guidance Letter (TEGL) *WIOA No. 07-18, dated December 19, 2018* - Operating Guidance for the Workforce Innovation and Opportunity Act, states in part:

> Guidance for Validating Jointly Required Performance Data Submitted under the Workforce Innovation and Opportunity Act (WIOA)
>
> 4. Joint Data Validation Framework. Data validation is a series of internal controls or quality assurance techniques established to verify the accuracy, validity, and reliability of data. Establishing a joint data validation framework based on a consistent approach shared by the Departments will ensure that all program data are consistent and accurately reflect the performance of each core program in each State. To that end, the purposes of validation procedures for jointly required performance data are to:
>
> - Verify that the performance data reported by States to the Departments are valid, accurate, reliable, and comparable across programs;
> - Identify anomalies in the data and resolve issues that may cause inaccurate reporting;
> - Outline source documentation required for common data elements; and
> - Improve program performance accountability through the results of data validation efforts.
>
> While States must utilize a data validation strategy, the specific design, implementation, and periodic evaluation of that strategy is left to the discretion of the State so long as those strategies or procedures are consistent with these guidelines.
>
> Data validation helps ensure the accuracy of the annual statewide performance reports, safeguards data integrity, and promotes the timely resolution of data anomalies and

inaccuracies. As such, it is recommended that States incorporate their data validation procedures into their internal controls procedures, which are required by 2 Code of Federal Regulations (CFR) §200.303. State VR agencies should also consider related guidance issued in Rehabilitative Services Administration (RSA) Policy Directive 16-04.

Each State must develop data validation procedures that include:

- Written procedures for data validation that contain a description of the process for identifying and correcting errors or missing data, which may include electronic data checks;
- Regular data validation training for appropriate program staff (e.g., at least annually);
- Monitoring protocols, consistent with 2 CFR §200.328, to ensure that program staff are following the written data validation procedures and take appropriate corrective action if those procedures are not being followed;
- A regular review of program data (e.g., quarterly) for errors, missing data, out of-range values, and anomalies;
- Documentation that missing and erroneous data identified during the review process have been corrected; and
- Regular assessment of the effectiveness of the data validation process (e.g., at least annually) and revisions to that process as needed.

Performance Accountability, Information, and Reporting System – OMB Control No.1205-0526, can be found at https://www.dol.gov/agencies/eta/performance/reporting

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-008 The Washington State Department of Transportation did not have adequate internal controls to ensure supervisors reviewed and approved payroll journals for the Highway Planning and Construction Cluster.

Assistance Listing Number and Title:	20.205 Highway Planning and Construction 20.205 COVID-19 Highway Planning and Construction 20.219 Recreational Trails Program 20.224 Federal Lands Access Program
Federal Grantor Name:	U.S. Department of Transportation
Federal Award/Contract Number:	Too numerous to list. All approved subaward projects under the Federal Highway Administration Stewardship and Oversight Agreement.
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	None

Background

The Washington State Department of Transportation, Payments & Deductions Unit, administers federal funding under the Highway Planning and Construction Cluster for employee payroll related to state highway construction projects. The Department spent about $614 million on highway projects during fiscal year 2022. Of that amount, the Department used about $68 million for employee payroll.

As part of the Highway Planning and Construction Cluster, the Department is allowed to request federal reimbursement for salaries and benefits for program activities. The Department defines its

labor and payroll reporting requirements in its *Payroll Manual*. Employees' time and effort are tracked in the DOTtime timekeeping system, which allows the Department to charge hours worked and wages paid to the appropriate federal project. The Unit creates payroll journals twice monthly, and emails them to the Department's regional timekeepers. The journals are sent prior to payroll processing; supervisors must sign the journals, and timekeepers are required to return them to the Unit within two weeks after they are initially sent. The Unit is responsible for maintaining a payroll calendar, which is sent to the timekeepers to document the due dates.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls to ensure supervisors reviewed and approved payroll journals for the Highway Planning and Construction Cluster.

During the audit period, the Department issued 1,056 payroll journals for staff participating in federal projects. We used a statistical sampling method, and randomly selected and examined 57 journals to determine whether an appropriate supervisor reviewed and approved them. We found 11 payroll journals (19 percent) were not approved and returned timely to the Unit during payroll processing. These approvals were between one and 54 days overdue. We also found seven journals (12 percent) were not approved by the assigned supervisor during the audit period. All seven journals were not approved until after we requested the documentation, and they were at least six months overdue.

We consider this internal control deficiency to be a significant deficiency.

This issue was not reported as a finding in the prior audit

Cause of Condition

Management did not monitor to ensure that supervisors reviewed, approved and returned payroll journals to the Unit, as Department policy requires. In addition, regional management did not consistently follow up on requests from the Unit to begin reviewing payroll journals, and Department management did not implement internal controls to ensure supervisors performed the required approvals timely.

Effect of Condition

By not establishing effective internal controls to ensure payroll transactions are reviewed for appropriateness in a timely manner, the Department does not have adequate assurance that its payroll distributions are accurate.

Recommendations

We recommend the Department:

- Improve internal controls to ensure supervisors review, approve and return payroll journals to the Unit, as policy requires
- Consider updating its existing policies to include provisions for when supervisors must review, approve and return payroll journals for payroll processing
- Monitor the review of payroll journals to ensure supervisors provide the required responses

Department's Response

The Washington State Department of Transportation (WSDOT) appreciates the State Auditor's Office (SAO) audit of the Highway Planning and Construction Cluster and values the Auditor's assessment regarding the Description and Effects of Condition as they pertain to Payroll Journals. The Department is committed to ensuring that we have adequate internal controls established to ensure payroll journals are reviewed and returned in a timely manner.

WSDOT's current process was developed to ensure that payroll distributions are certified in a timely manner. Payroll journals are generated and sent to the designated signers using a link to Adobe Acrobat Sign, via email on Day 4 of payroll processing. The signer will receive an automated follow-up email each day that the document remains unsigned. Once signed the document is routed back to Payroll via Adobe Acrobat Sign. Payroll staff responsible for the journals also have an audit system in place, where they monitor the return of signed documents. Each signed document also contains an audit report that identifies the sender and the signer, the time and date the original email request was sent, the date and time the document was signed, and when the document workflow has been completed.

In an effort to ensure increased compliance with this policy, we will review existing controls and evaluate the current audit process of monitoring the review and return of the payroll journals. We will also review the Payroll Manual to ensure directions, guidelines, and expectations around the signing of the payroll journals is clearly defined and determine whether provisions for when managers must sign and return the journals for payroll processing is appropriate for reducing the risk to payroll distributions within the Highway Planning and Construction Cluster.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Washington State Department of Transportation, *Payroll Manual (M 13-08.06)*, April 2021 version, states in part:

Chapter 2 Roles and Responsibilities

2-4 Timekeepers

It is the responsibility of the timekeeper to:

12. Be the point of contact and provide payroll and labor documentation as requested.
13. Ensure Payroll Journals have the appropriate signatures and are returned to HQ Payroll Office.

2-5 Supervisors

It is the responsibility of the employee's supervisor/org manager to:

6. Review the payroll journal.
7. Approve by signing the Payroll Journal that it is correct to the best of your knowledge.

State of Washington
July 1, 2021 through June 30, 2022

2022-009 The Washington State Department of Transportation did not have adequate internal controls over and did not comply with requirements to conduct program monitoring of subrecipients of the Highway Planning and Construction Cluster.

Assistance Listing Number and Title:	20.205 Highway Planning and Construction 20.205 COVID-19 Highway Planning and Construction 20.219 Recreational Trails Program 20.224 Federal Lands Access Program
Federal Grantor Name:	U.S. Department of Transportation
Federal Award/Contract Number:	Too numerous to list. All approved subaward projects under the Federal Highway Administration Stewardship and Oversight Agreement
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Washington State Department of Transportation (Department), Local Programs Office, administers federal funding under the Highway Planning and Construction Cluster to local agencies throughout the state for highway construction projects. The Department spent about $614 million on highway projects during fiscal year 2022. Of that amount, it passed through about $248 million to local agencies through subawards.

Federal regulations require the Department to monitor the activities of its subrecipients to ensure they use subawards for authorized purposes and that activities comply with terms and conditions of the subaward and achieve performance goals. Specifically, monitoring efforts must include reviewing financial and programmatic reports required by the pass-through entity.

The Department also maintains its own requirements for subawards of federal funds, published in the Local Agency Guidelines (LAG) Manual. This manual outlines additional requirements the Department imposes on all subrecipients, including the requirement to undergo project audits, documentation reviews during the project period of performance, and project management reviews (PMRs) prior to closure of each federally funded construction project.

The Department revised the LAG Manual in June 2021 to provide for the selection of PMRs using a risk-based approach. The Department selects PMRs from ongoing projects it believes are at the highest risk of noncompliance. However, the U.S. Department of Transportation, Federal Highway Administration (FHWA), has stipulated in its Stewardship and Oversight Agreement (Agreement) with the Department that a PMR is conducted at least once every three years for each subrecipient.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with federal requirements to conduct program and fiscal monitoring of subrecipients for the Highway Planning and Construction Cluster. The previous finding numbers were 2021-008, 2020-016 and 2019-015.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to conduct program monitoring of subrecipients for the Highway Planning and Construction Cluster.

The Department did not ensure it completed PMRs for every subrecipient every three years, as required by the Agreement. During the audit period, the Department was required to complete PMRs for 12 of its subrecipients. We found the Department did not perform any of the required PMRs for these subrecipients during the audit period. The Department suspended all PMRs scheduled during state fiscal year 2022 and reinstated its review schedule in September 2022, which was after the audit period.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department worked with FHWA to switch to a risk-based PMR scheduling approach, but did not receive official concurrence to change this approach during the audit period. Department management made a conscious decision to switch to the risk-based approach before receiving

official approval from FHWA to allow for a different selection methodology than the one outlined in the Agreement signed by the Department and FHWA.

Effect of Condition

Without establishing adequate internal controls, the Department cannot reasonably ensure its subrecipients are using federal funds for allowable purposes. Additionally, without monitoring each subrecipient's use of federal funds, the Department does not have reasonable assurance that the subrecipient has complied with the terms and conditions of the subaward.

Failure to monitor each subrecipient's use of federal grant funds also violates the terms and conditions of the Agreement, which could result in the termination or suspension of the federal grant award.

Recommendations

We recommend the Department:

- Update its policies and procedures for subrecipient monitoring to comply with FHWA regulations
- Improve internal controls to ensure it completes project management reviews for every active subrecipient at least once every three years, as required under the Agreement

Department's Response

The Washington State Department of Transportation (WSDOT) appreciates the State Auditor's Office audit of the Federal Highway Program. WSDOT is committed to ensuring our programs comply with federal regulations.

The Department appreciates the Auditor's perspective on the Description of Condition and Effects of Condition in the finding. Technically, the finding is correct for fiscal year 2022 based on the language in the Stewardship Agreement with FHWA. FHWA is reluctant to formally open the Stewardship and Oversight Agreement for revisions, as a new nationwide "template" is under development. During fiscal year 2022, the Department executed a memo agreement with FHWA to update our PMR process to a leading practice. This new process includes a "risk-based approach" which will improve the effectiveness of our subrecipient monitoring efforts. As a result, the reviews and resources will be focused on the high-risk agencies or projects rather than a three-year review cycle. Our risk-based program approach began in calendar year 2021 via an initial memo agreement with FHWA and was approved for use going forward via the July 2022 memo agreement with FHWA.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will follow up on the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 23 CFR, Chapter 1 – Federal-Aid Highways, Section 106: Project approval and oversight, states in part:

> (g) Oversight Program.—
>
> 4) Responsibility of the states.—
>
> (A) In general.—The States shall be responsible for determining that subrecipients of Federal funds under this title have—
>
> (i) adequate project delivery systems for projects approved under this section; and
>
> (ii) sufficient accounting controls to properly manage such Federal funds.

Title 23 CFR, Part 635 – Construction and Maintenance – Contract Procedures states in part:

> § 635.102 Definitions.
>
> As used in this subpart:
>
> *Local public agency* means any city, county, township, municipality, or other political subdivision that may be empowered to cooperate with the State transportation department in highway matters.
>
> *State department of transportation (State DOT)* means that department, commission, board, or official of any State charged by its laws with the

responsibility for highway construction. The term "State" should be considered equivalent to State DOT if the context so implies. In addition, State Highway Agency (SHA), State Transportation Agency (STA), State Transportation Department, or other similar terms should be considered equivalent to State DOT if the context so implies.

§ 635.105 Supervising agency.

(a) The State DOT has responsibility for the construction of all Federal-aid projects, and is not relieved of such responsibility by authorizing performance of the work by a local public agency or other Federal agency. The State DOT shall be responsible for insuring that such projects receive adequate supervision and inspection to insure that projects are completed in conformance with approved plans and specifications.

The U.S. Department of Transportation's Stewardship and Oversight Agreement on Project Assumption and Program Oversight by and Between the Federal Highway Administration (Washington Division) and the Washington State Department of Transportation, states in part:

Section XI. State and Local Public Agency Oversight Requirements and Reporting Requirements

B. State DOT Oversight of Locally Administered Projects

WSDOT provides oversight through their Local Programs Division. This dedicated staff manages the program by providing guidance, training, and technical assistance to the Local Agencies.

The Local Agency Guidelines (LAG) manual describes the processes, documents, and approvals necessary to administer federal-aid projects by local transportation agencies. The manual also outlines WSDOT's oversight and review activities. The Division reviews and approves twice a year the LAG Manual to ensure it complies with FHWA Order 5020.2 (Stewardship and Oversight of Federal-Aid Projects Administered by Local Public Agencies, August 14. 2014).

By agreeing to accept federal aid funds, the local agency understands its roles and responsibilities with respect to carrying out the federal aid program. WSDOT is permitted to delegate certain activities, under its supervision, to local agencies (cities, counties, private organizations, or other state agencies) under federal regulation 23 CFR 1.11 and 635.105; however, WSDOT accepts responsibility for delegated activities.

WSDOT has a certification process that allows local agencies to administer a federal aid project based on past performance, current staffing, overall capability, and

knowledge of FHWA and state requirements. The certification acceptance process is outlined in Chapter 13 of the Local Agency Guidelines Manual (LAG).

WSDOT is also required to conduct verification activities to assure that local agency federal aid projects are implemented in conformance with federal aid requirements.

WSDOT conducts Project Management Reviews (PMR) to assess whether the certified agency administered the project in accordance with federal aid requirements. A PMR reviews all phases of a project from environmental, consultant services, design, to construction. WSDOT and the Division jointly develop the checklists for the PMRs. The Division includes items identified as part of our risk assessment process and items listed as stewardship indicators. The PMR review is conducted at a minimum every three years on the local agency's project with the most risk associated with it and the local agency's certification acceptance is reevaluated.

WSDOT has retained some project level approval actions and conducts various reviews such as, construction inspections, billing reviews, and work-zone traffic control reviews. In addition WSDOT conducts documentation and a final inspection on every local agency federal aid project.

WSDOT submits annually a Stewardship Report that summaries their verification activities, PMRs, other reviews, and stewardship indicators. The annual Stewardship Report addresses any findings or issues, as well corrective action plans if needed.

The Washington State Department of Transportation's *Local Agency Guidelines* manual (M 36-63.40 – June 2021), Chapter 53 – Project Closure, states in part:

53.3 Project Reviews

In order to ensure that local agencies are administering FHWA funded projects in reasonable compliance with FHWA requirements and regulations and the Local Agency Guidelines manual, WSDOT will perform procedural reviews on federal funded local agency ad-and-award projects. Projects will be selected from the available projects awarded to the local agency based upon the assigned risk level documented in the risk assessments performed at the end of each project by the Region LPE.

These reviews will be:

- Project Management Reviews (PMR) performed by HQ Local Programs
  - CA Agencies must have a PMR performed every three years. (Meaning the HQ Local Program will select a qualifying project from the list of awarded federal projects. The project selection will occur near the beginning of third federal fiscal year cycle and with the actual review occurring near completion of construction.)

– PMRs will be performed in one of two ways, in person file reviews or electronic file reviews.

– Documentation Reviews are performed by the Region Local Programs Engineer with the frequencies of the reviews being based upon the risk assessment performed on each phase of the projects.

State of Washington
July 1, 2021 through June 30, 2022

2022-010 The Washington State Department of Transportation did not have adequate internal controls over and did not comply with requirements to issue management decisions for audit findings to subrecipients of the Highway Planning and Construction Cluster.

Assistance Listing Number and Title:	20.205 Highway Planning and Construction 20.205 COVID-19 Highway Planning and Construction 20.219 Recreational Trails Program 20.224 Federal Lands Access Program
Federal Grantor Name:	U.S. Department of Transportation
Federal Award/Contract Number:	Too numerous to list. All approved subaward projects under the Federal Highway Administration Stewardship and Oversight Agreement
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Washington State Department of Transportation, Local Programs Office, administers federal funding under the Highway Planning and Construction Cluster to local agencies throughout the state for highway construction projects. The Department spent about $614 million on highway projects during fiscal year 2022. Of that amount, it passed through about $248 million to local agencies through subawards.

Federal regulations require the Department to monitor its subrecipients' activities. This includes verifying that subrecipients that spend $750,000 or more in federal awards during a fiscal year obtain a single audit. The audit must be completed and submitted to the Federal Audit Clearinghouse within 30 calendar days after receiving the auditor's report(s), or nine months after the end of the subrecipient's audit period, whichever is earlier.

Additionally, for the awards it passes on to subrecipients, the Department must follow up and ensure its subrecipients take timely and appropriate corrective action on all deficiencies detected through audits, onsite reviews and other means. Within six months of the Federal Audit Clearinghouse accepting the audit report, the Department must also issue a management decision for audit findings related to the federal award it provided to the subrecipient. These requirements help ensure the Department and its subrecipients use federal award funds for authorized purposes and within the provisions of contracts or grant agreements.

The Local Programs Office communicates annually with all active subrecipients, informing them of the requirement to receive a single audit or program-specific audit in accordance with 2 CFR § 200.501, and to ensure that they promptly transmit a copy of the audit report to the Department. The Local Programs Office also uses a tracking system to identify amounts passed through to subrecipients; to document audit activity for the subrecipients, including the date(s) on which audit reports were due and ultimately received by the Department; and to monitor if subrecipients received single audit findings.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure subrecipients received required single audits, findings related to federal program awards were followed up on, and management decisions were issued. The prior finding numbers were 2021-010, 2020-015 and 2019-017.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to issue management decisions for audit findings to subrecipients of the Highway Planning and Construction Cluster.

The Department had five subrecipients that received single audits, which resulted in findings that the Department was required to issue management decisions for during the audit period. We used a non-statistical sampling method, and randomly selected and examined four of the five subrecipients. We examined the Department's audit notes and records to determine if it had issued management decisions for these single audit findings. We found the Department did not issue management decisions for one of the subrecipients (25 percent) that received findings.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

Management did not ensure the Department met the federal requirement to issue management decisions for single audit findings to subrecipients. While the Department did review single audit reports filed for its subrecipients and internally communicated about them, the Local Programs Office did not correctly respond to all findings related to its programs that required management decisions.

The subrecipient in question reported the noncompliance to the Local Programs Office prior to the audit finding being issued. Department staff discussed the issue internally and determined the subrecipient's corrective actions already taken would have resolved the deficiency. While the Department appropriately reviewed the subrecipient's response to the audit finding, it did not follow up and issue a formal, written management decision to the subrecipient upon receiving the auditor's report, as required.

Effect of Condition

Not issuing a management decision when required means the Department did not determine the effect of noncompliance on the federal program and did not require subrecipients to correct the identified deficiencies. By failing to ensure subrecipients establish corrective actions and monitor those corrections for effectiveness, the Department cannot determine whether subrecipients have materially complied with all federal requirements that pertain to the subaward.

Recommendations

We recommend the Department:

- Review all subrecipient audit reports to determine if there are findings related to federal programs
- Follow up on and issue management decisions for all subrecipient audit findings related to the Highway Planning and Construction Cluster
- Ensure subrecipients develop and perform acceptable corrective actions to adequately address all audit recommendations

Department's Response

We appreciate the State Auditor's Office (SAO) audit of the Federal Highway Program. The Department is committed to ensuring our programs comply with federal regulations related to subrecipient monitoring.

Our Local Programs Division had a different understanding of the requirement to issue Management Decision Letters (Decision Letters). We typically issue Decision Letters to all subrecipients that receive Single Audit findings related to WSDOT federal grant awards. For the subrecipient in question, the subrecipient had contacted Local Programs upon realizing a discrepancy in their advertisement practices, which was prior to the issuance of SAO's audit report

and finding. WSDOT evaluated their advertisement practice, reviewed and approved the county's corrective action plan, and implemented a training plan with the county. Since these activities preceded the issuance of SAO's report containing the audit finding, WSDOT elected to forgo a formal Decision Letter.

We will continue to review all single audits issued for our subrecipient agencies and send Decision Letters based on SAO's recommendation.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 332, Requirements for pass-through entities, establishes requirements the pass-through entity must follow when issuing subawards to subrecipients.

Title 2 CFR Part 200, Uniform Guidance, section 339, Remedies for noncompliance, describes remedial actions that the Federal awarding agency or pass-through entity may take if the non-federal entity fails to comply with the U.S. Constitution, Federal statutes, regulations or the terms and conditions of a Federal award.

Title 2 CFR Part 200, Uniform Guidance, section 521, Management decisions, establishes when a management decision must be issued in relation to audit findings relating to Federal awards.

State of Washington
July 1, 2021 through June 30, 2022

2022-011 The Washington State Department of Transportation did not have adequate internal controls over and did not comply with quality assurance program requirements to ensure materials conformed to approved plans and specifications, and that only qualified personnel performed testing for projects funded by the Highway Planning and Construction Cluster.

Assistance Listing Number and Title:	20.205 Highway Planning and Construction 20.205 COVID-19 Highway Planning and Construction 20.219 Recreational Trails Program 20.224 Federal Lands Access Program
Federal Grantor Name:	U.S. Department of Transportation
Federal Award/Contract Number:	Too numerous to list. All approved subaward projects under the Federal Highway Administration Stewardship and Oversight Agreement.
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Quality Assurance Program
Known Questioned Cost Amount:	None

Background

The Washington State Department of Transportation administers federal funding under the Highway Planning and Construction Cluster to local agencies throughout the state for their highway construction projects. The Department spent about $614 million on highway projects during fiscal year 2022.

Federal regulations require that the Department have a quality assurance (QA) program, approved by the Federal Highway Administration (FHWA), for construction projects on the National

Highway System to ensure that materials and workmanship conform to approved plans and specifications. Verification sampling must be performed by qualified testing personnel employed by the Department or its designated agent, excluding the contractor.

The Department's QA program requirements are outlined in the Construction Manual, which is approved by the FHWA. This manual documents how materials are tested for acceptance before being incorporated into construction projects. Materials can be accepted in various ways, such as sample testing, a visual inspection documented by the Field Note Record or Inspector's Daily Report, or a certification of compliance from the manufacturer. If a materials test is required, the Department must ensure that only qualified people perform the testing, including independent testers, consultants or certified Department employees.

To ensure that materials incorporated into a project meet approved plans and specifications, the Department prepares a list of prescribed materials to be used on the project. The Department uploads this list to a program called the Record of Materials (ROM). The ROM sets forth the materials and quantities that are expected to be used on the project, and it documents the proper acceptance criteria, including any test(s) personnel are required to perform on a material. Once created, Project Engineers responsible for managing the construction project update the ROM to indicate the type and quantity of materials incorporated into the project so management can ensure the materials test(s) that are required for acceptance have occurred.

To ensure that only qualified people perform the testing, testers must pass a certification exam, which consists of a written and performance exam. After passing both, the testers are entered into the Qualified Tester Database and are certified for five years, after which they must recertify by passing both exams again. There are two different types of tester qualifications: module and method. Module testers are proficient in multiple method tests that can encompass all method tests for a particular material, whereas method testers may only be proficient in particular tests for any given material.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with QA program requirements to ensure materials conformed to approved plans and specifications, and that only qualified personnel performed materials testing for projects funded by the Highway Planning and Construction Cluster. The prior finding numbers were 2021-011, 2020-017 and 2019-019.

Description of Condition

The Department did not have adequate internal controls over and did not comply with QA program requirements to ensure materials conformed to approved plans and specifications, and that only

qualified personnel performed testing for projects funded by the Highway Planning and Construction Cluster.

Project Engineers did not maintain the ROM for all materials used in projects

We used a statistically valid sampling method to randomly select 57 out of the 1,091 materials that were used on federally funded projects during state fiscal year 2022. For each material, we reviewed the ROM to verify the assigned Project Engineer updated the quantity placed and paid in accordance with the Construction Manual. We found that Project Engineers did not maintain the ROM for 22 materials (39 percent) in accordance with the Construction Manual.

Materials acceptance testing did not conform to standard specifications and the Construction Manual

For the 57 randomly selected materials, we requested the supporting documentation for acceptance and/or testing of the material. We found one material (2 percent) where testing did not occur, and the Department was unable to provide documentation justifying the item did not require testing.

Entry of tester certification into Qualified Tester Database

We used a statistically valid sampling method to randomly select 55 of the 383 testers that became initially certified or recertified during the audit period to verify that the exam results of each tester were reviewed and approved prior to being entered into the qualified tester database. We found:

- Twelve exams were reviewed after the audit period.
- Four reviews were completed, but they lacked supervisor signatures.
- Two testers were missing exams.

Ten of our samples were data entry errors, and the testers' tests occurred outside of the audit period. This was due to the Department not being able to provide us with a definitive population of testers certified or recertified during the audit period.

Testing personnel were not properly certified

We used a statistically valid sampling method to randomly select 58 out of 1,311 testers that were actively certified in the Department's qualified tester database. We requested and reviewed test documentation to verify whether the testers had all required documents to support their certification. We found four testers (7 percent) did not have complete supporting documents. Specifically:

- One tester did not have evidence of completing a written and performance exam.
- Three testers had exams that did not indicate the date of completion; therefore, we could not confirm the exams occurred before or during the audit period.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Project Engineers did not maintain the ROM for all materials used in projects

Management did not ensure Project Engineers were adequately trained in maintaining the ROM and did not monitor to ensure it was properly maintained.

Materials acceptance testing did not conform to standard specifications and the Construction Manual

Management did not adequately monitor to ensure required materials testing and acceptance occurred in accordance with the Construction Manual.

Testing personnel were not properly certified

Project Engineers did not ensure tester qualifications were current, and management did not ensure they were properly entered into the database.

Effect of Condition

By not adequately monitoring project materials to ensure they conform to approved plans and specifications, the Department does not have reasonable assurance that materials incorporated into projects conform to standard specifications and the Construction Manual.

By not properly verifying and documenting the testers' qualifications, the Department risks improper materials testing. This could result in the Department using materials that may not conform to approved plans and specifications.

Recommendations

We recommend the Department:

- Improve internal controls to ensure materials incorporated into federal aid projects conform to standard specifications and the requirements outlined in the *Construction Manual*
- Strengthen its monitoring to ensure Project Engineers accurately and completely maintain the ROM for each project
- Strengthen internal controls to ensure testers have completed all required exams—and that they have proper documentation of passing these exams—before entering them into the Qualified Tester Database
- Continue to review all testers in the Qualified Tester Database to ensure they meet the minimum requirements

Department's Response

The Washington State Department of Transportation (WSDOT) appreciates the State Auditor's Office (SAO) audit of the Federal Highway Program and the federally required Quality Assurance (QA) program. The Department is committed to ensuring our programs continue to comply with federal regulations and recognizes that there are always opportunities for improvement to its QA program.

Exceptions noted in the audit reflect the importance of documentation in our QA program. Our response to each type of exception follows:

Maintenance of the Record of Materials (ROM)

The construction contracts awarded in FY22 utilizing federal funding contained more the 4,900 materials, with almost 1,100 of them requiring testing. The State Auditor tested 57 materials and initially found 22 where the Department did not maintain aspects of the ROM. The Department agrees that there is always room for improvement in its processes; however, for the majority of the 22 instances where the ROM was not updated timely, the project offices were able to provide documentation to support the proper approval, acceptance, and field verification of the materials tested or that materials testing was not required, and one material (2%) was identified where testing did not occur.

Materials Acceptance

The State Auditor tested 57 materials of the approximately 1,100 requiring testing for FY22 and found one material (2.0%) that the Department could not provide documentation to support that testing occurred or was not required.

Testing Personnel Certifications

The State Auditor reviewed 55 of 383 testers for entry of data into the qualified tester database and 58 testers out of 1,311 testers actively certified in the qualified tester database. For two (3.6%) of the materials testers for entry of data into the qualified tester database the exams could not be located and one (1.7%) of the materials testers for actively certified testers in the qualified tester database did not have a written and performance exam. Other noted exceptions included lack of signatures, missing dates of completion and data entry errors.

The Department continues to work closely with the Federal Highway Administration (FHWA) on our QA program and has received positive feedback from them on the strength of our program. The Department is working towards replacing its ROM legacy system. The new system will automate many processes and should help to strengthen controls over the QA program.

The Department will continue to put improvements in place for the QA program based on the SAO audit recommendations for documenting materials testing and tester certifications. We recently

delivered training to Project Engineering staff on material documentation and the single audit issues, and will continue to offer training, in-person, remotely, and through the monthly Material QA Section newsletter, to emphasize QA program requirements.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit.

While we agree with the Department that the materials for the 22 instances when the ROM was not maintained by the Project Engineer ultimately met acceptance criteria for payment without monitoring project offices to ensure the ROM is updated as required, management does not have assurance that materials incorporated into federal projects have met acceptance criteria.

We reaffirm our finding, and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 23 CFR Part 637, *Construction Inspection and Approval,* establishes the following applicable requirements:

Section 637.201 Purpose

To prescribe policies, procedures, and guidelines to assure the quality of materials and construction in all Federal-aid highway projects on the National Highway System.

Section 637.205 Policy

(a) **Quality assurance program.** Each STD shall develop a quality assurance program which will assure that the materials and workmanship incorporated into each Federal-aid highway construction project on the NHS are in conformity with the requirements of the approved plans and specifications, including approved changes. The program must meet criteria in (Section 637.207) and be approved by the FHWA.

(b) **STD capabilities.** The STD shall maintain an adequate, qualified staff to administer the quality assurance program. The State shall also maintain a central laboratory. The State's central laboratory shall meet requirements in (Section 637.209(a)(2)).

(c) **Verification sampling and testing.** The verification sampling and testing are to be performed by qualified testing personnel employed by the STD or its designated agent, excluding the contractor and vendor.

(d) **Random samples.** All samples used for quality control and verification sampling and testing shall be random samples.

Section 637.207 Quality assurance program

(a) Each STD's quality assurance program shall provide for an acceptance program and an independent assurance (IA) program consisting of the following:

(1) Acceptance program.

i. Each STD's acceptance program shall consist of the following:

A. Frequency guide schedules for verification sampling and testing which will give general guidance to personnel responsible for the program and allow adaptation to specific project conditions and needs.

B. Identification of the specific location in the construction or production operation at which verification sampling and testing is to be accomplished.

C. Identification of the specific attributes to be inspected which reflect the quality of the finished product.

ii. Quality control sampling and testing results may be used as part of the acceptance decision provided that:

A. The sampling and testing has been performed by qualified laboratories and qualified sampling and testing personnel.

B. The quality of the material has been validated by the verification sampling and testing. The verification testing shall be performed on samples that are taken independently of the quality control samples.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

The Department of Transportation *Construction Manual (M41-01)*, Chapter 9: *Materials*, states in part:

9-1 General
The quality of materials used on the project will be evaluated and accepted in various ways, whether by testing of samples, visual inspection, or certification of compliance. This chapter details the manner in which these materials can be accepted. Requirements for

materials are described in *Standard Specifications for Road, Bridge, and Municipal Construction* M 41-10 Section 1-06 and Division 9.

It is the Project Engineer's responsibility to accept materials in accordance with this chapter. For materials tests that do not meet specification requirements, the Project Engineer shall contact the State Construction Office which will coordinate with the State Materials Engineer or Assistant State Materials Engineer to determine the appropriate action.

9-1.2C Record of Materials

The Record of Materials (ROM) is used to track material type, make/model, approval, acceptance, field verification documentation, Certificate of Materials Origin, and other materials documentation.

The Project Office utilizes the ROM program to track all permanently incorporated materials that are placed in on the Contract. Temporary materials are also tracked in the ROM when the contract documents contain temporary material requirements. The Project Engineer is responsible for the accuracy of the ROM, other documentation methods used, and Certification of Materials. Acceptance requirements shown in the ROM can be modified by referencing the properly submitted QPL page or the approved Request for Approval of Materials. Reviewing the contract plans and provisions may identify additional materials documentation requirements as well as construction items that shall be added to the ROM and tracked for completion throughout the course of the project work.

In order to ensure clarity upon completion of the work and to allow for easy certification of the project by both the Project Engineer and the Region, the ROM needs to be maintained throughout the course of the project. "Maintained" and "maintain" means the ROM is updated to reflect materials placed within 30 calendar days of the material payment. This includes material type, make/model, approval, acceptance, field verification documentation, Certificate of Materials Origin and other materials documentation. For materials used in the Contract, the Project Office is required to maintain the Status Work Completed (WC)/Documentation Complete (DC) / Not Used (NU) fields in the ROM.

The Project Office is required to maintain quantities paid, quantities placed, quantities field verified for materials that have sampling frequencies, WSDOT Fabrications Inspection items, where the Acceptance Criteria requires quantities such as Manufacturer Certificate of Compliance, or when quantities are noted in the initial materials and acceptance criteria.

9-5.3 WAQTC Testing Technician Qualification Program

The Region Independent Assurance Inspectors are responsible for maintaining the Tester Qualification database information for their Region WAQTC Testers as well as maintaining the WAQTC internal certifications and records (physical and digital).

9-5.4 Method Qualified Tester Program

The Region Independent Assurance Inspectors are responsible for maintaining the Tester Qualification database information for their Region Method Testers as well as maintaining the Method internal certifications and records (physical and digital).

State of Washington
July 1, 2021 through June 30, 2022

2022-012 The Washington State Department of Transportation did not have adequate controls over and did not comply with requirements to perform risk assessments for subrecipients of the Formula Grants for Rural Areas program.

Assistance Listing Number and Title:	20.509 Formula Grants for Rural Areas 20.509 COVID-19 Formula Grants for Rural Areas
Federal Grantor Name:	U.S. Department of Transportation
Federal Award/Contract Number:	WA-2017-66-00; WA-2018-77-00; WA-2018-77-01; WA-2019-901-00; WA-2020-038-00; WA-2020-132-01; WA-2021-052-00; WA-2021-130-00; WA-2021-022-00_SF
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Washington State Department of Transportation administers the Section 5311 program—Formula Grants for Rural Areas—to rural transportation areas by providing financial assistance for operating, planning, administrative expenses, and the acquisition, construction, and improvement of facilities and equipment. In addition, Section 5311 specifically provides for the support of rural intercity bus services, as well as funding for training, technical assistance, research, and related services to support the rural transit service. The Department spent about $82 million in program funds during fiscal year 2022. Of that amount, it passed through about $39.5 million to subrecipients through subawards.

Pass-through entities are required to monitor subrecipients' activities to ensure they are properly using federal funding. To determine the appropriate level of monitoring, federal regulations require

the Department to perform risk assessments to determine each subrecipient's risk of noncompliance with federal statutes and regulations, and the subaward's terms and conditions.

During fiscal year 2022, the Department awarded about $69 million in new subawards to 27 subrecipients for Section 5311 rural routes and services throughout the state. The Department's Public Transportation Division is responsible for issuing subawards to rural transit subrecipients and completing risk assessments for those receiving Section 5311 funding. The Department's *Consolidated Grant Guidebook* communicates the requirements for conducting assessments of each subrecipient's risk of noncompliance. In March 2022, the Department updated the guidebook to require risk assessments to be conducted at least every two years.

The Public Transportation Division maintains a tracking spreadsheet to monitor active subrecipients and related information, such as subawards issued, progress reporting, risk assessments and other monitoring information. Subawards containing federal funds are normally awarded to subrecipients at the start of each fiscal biennium.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate controls over and did not comply with requirements to perform risk assessments for subrecipients of the Formula Grants for Rural Areas program.

We randomly selected and reviewed eight of the 27 subrecipients awarded funding during the audit period to verify the Department performed a risk assessment to determine the appropriate level of monitoring for each subrecipient. We found the Department did not perform a risk assessment for two subrecipients (25 percent). We also reviewed the Department's tracking spreadsheet and found it did not include nine subrecipients (33 percent) that received funding during the audit period, including the two previously identified. All nine of these subrecipients received their subawards after the Department's normal process of subawarding at the start of the fiscal biennium had already occurred.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not ensure the Department met the federal requirement to perform risk evaluations for subrecipients. It also did not have a process in place for performing risk assessments for subrecipients when executing subawards after the start of the fiscal biennium.

Effect of Condition

By not performing risk assessments, the Department is less likely to detect subrecipients' noncompliance with federal regulations and the grant's terms and conditions. Further, without consistently performing risk assessments for all subrecipients, the Department cannot ensure it using the proper criteria to determine the appropriate level of monitoring required for each subrecipient.

Recommendations

We recommend the Department:

- Ensure it performs and documents the required risk assessments, which would allow management to evaluate the results and demonstrate compliance with federal requirements
- Modify its risk assessment process to ensure it performs risk assessments for every subrecipient regardless of when the subaward is granted

Department's Response

The Washington State Department of Transportation (WSDOT) appreciates the State Auditor's Office audit of the Formula Grants for Rural Areas and COVID-19 Formula Grants for Rural Areas. WSDOT is committed to ensuring our programs comply with federal regulations. WSDOT concurs with the finding and plans to implement the recommendations. Specifically, our Public Transportation Division will ensure that it performs risk assessments for all subrecipients receiving federal subawards regardless of when WSDOT executes the related contract. As of February 2023, the Public Transportation Division is currently updating its risk assessment process that it plans to implement in Spring 2023.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 332, Requirements for pass-through entities, describes the requirement to evaluate each subrecipient's risk of noncompliance with federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring.

Title 2 CFR Part 200, *Frequently Asked Questions,* states in part:

> Are pass-through entities required to assess the risk of non-compliance for each applicant prior to making a subaward?
>
> Section 200.332(b) requires risk assessments of subrecipients. While there is no requirement for pass-through entities to perform these assessments before making subawards, pass-through entities are encouraged to conduct the risk assessments prior to making subawards. Doing so before making the subaward helps determine the appropriate monitoring tools pass-through entities should use for their subrecipients. Pass-through entities may use their own judgment regarding the most appropriate timing for the assessments. Regardless of the timing chosen, the pass-through entity should document its procedures for assessing risk.

The Washington State Department of Transportation *Consolidated Grant Guidebook (M130 (March 2022 version)),* Chapter 1 – Requirements and guidelines for all projects, states in part:

> Program compliance and project reporting
>
> > Risk assessments
> >
> > > Every two years and in accordance with 2 CFR 200.332(b)(1-4), WSDOT conducts risk assessments to evaluate each grantee's risk of noncompliance with the grant requirements. We use the risk assessment results to determine how much technical assistance and oversight may be necessary to help organizations comply with grant requirements.

State of Washington
July 1, 2021 through June 30, 2022

2022-013 The Department of Corrections improperly charged $37,392 to the Coronavirus Relief Fund.

Assistance Listing Number and Title:	21.019 COVID-19 Coronavirus Relief Fund
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$37,392

Background

In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which authorized the spending of $2.2 trillion in federal funds to respond to the COVID-19 pandemic.

The CARES Act established the Coronavirus Relief Fund (CRF), which authorized $150 billion in federal financial assistance for state, territorial, tribal, and certain eligible local governments. Through the CARES Act, Washington was awarded about $2.95 billion of CRF money to help fund the state's response to the COVID-19 pandemic. Of this amount, the Office of financial Management allocated approximately $2.2 billion to state agencies for various programs. In fiscal year 2022, state agencies spent approximately $345 million in CRF funds.

The CARES Act requires recipients to only use CRF payments to cover:

- Necessary expenditures incurred due to the public health emergency (COVID-19)
- Costs that were not accounted for in the government's most recently approved budget as of March 27, 2020
- Costs that were incurred during the period that begins March 1, 2020, and ends December 31, 2021

In fiscal year 2022, the Department of Corrections spent $240 million in CRF funds. The Department used the funds to cover payroll costs for employees who were substantially dedicated to responding to the COVID-19 public health emergency.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department improperly charged $37,392 to the CRF.

We found the Department had adequate internal controls to ensure it materially complied with activities allowed or unallowed and allowable costs/cost principles requirements. We used a statistical sampling method and randomly selected and examined 59 monthly payments out of a total population of 29,459. In addition to the 59 payments, we judgmentally picked two individually significant items. We examined the supporting documentation for each monthly payment and found one instance where an employee's payroll overpayment totaling $37,392 was identified and referred to collections by the Department, but was inadvertently charged to the CRF.

Federal regulations require the auditor to issue a finding when the known or estimated questioned costs identified in a single audit exceed $25,000. We are issuing this finding because, as stated in the Effect of Condition and Questioned Costs section of this finding, the actual questioned costs exceed that threshold.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department followed procedures for approving payroll costs. However, multiple reviews did not prevent the overpayment made to an employee from being charged to the CRF.

Effect of Condition and Questioned Costs

The Department improperly charged the CRF for payroll costs totaling $37,392.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Department's Response

The Department of Corrections (DOC) would like to thank the State Auditor's Office (SAO) for the audit of the Coronavirus Relief Fund (CRF) grant. The Department agrees that questioned costs were charged to the grant due to an employee's overpayment. While the SAO has complimented our internal controls and processes for being able to track each line item in the CRF, we also know that internal controls can always be improved. The Department has additional allowable costs that were not charged to the grant which should compensate for the questioned costs identified and intends to discuss this change with the funder. The Department appreciated the patience of the SAO in obtaining supporting documentation and having clarifying conversations during the audit.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

State of Washington
July 1, 2021 through June 30, 2022

2022-014 The Department of Social and Health Services improperly charged $390 to the Coronavirus Relief Fund.

Assistance Listing Number and Title:	21.019 COVID-19 Coronavirus Relief Fund
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$390

Background

In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which authorized the spending of $2.2 trillion in federal funds to respond to the COVID-19 pandemic.

The CARES Act established the Coronavirus Relief Fund (CRF), which authorized $150 billion in federal financial assistance for state, territorial, tribal, and certain eligible local governments. Through the CARES Act, Washington was awarded about $2.95 billion of CRF money to help fund the state's response to the COVID-19 pandemic. Of this amount, the Office of Financial Management allocated about $2.2 billion to state agencies for various programs. In fiscal year 2022, state agencies spent about $345 million in CRF funds.

The CARES Act requires recipients to only use CRF payments to cover:

- Necessary expenditures incurred due to the public health emergency (COVID-19)
- Costs that were not accounted for in the government's most recently approved budget as of March 27, 2020
- Costs that were incurred during the period that begins March 1, 2020, and ends December 31, 2021

In fiscal year 2022, the Department of Social and Health Services spent $40 million in CRF funds. The Department used the funds to cover payroll costs for employees who were substantially dedicated to responding to the COVID-19 public health emergency.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department improperly charged $390 to the CRF.

We found the Department had adequate internal controls to ensure it materially complied with activities allowed or unallowed and allowable costs/cost principles requirements. We used a statistical sampling method to randomly select and examine 83 monthly payments out of a total population of 9,415. We reviewed the supporting documentation for each monthly payment and found:

- One overpayment for four hours overtime and overtime shift totaling $208.
- One payment where there was no supporting documentation for an employee's shift differential pay of $7.50.
- One overpayment for call-back pay totaling $174.23.

Federal regulations require the auditor to issue a finding when the known or estimated questioned costs identified in a single audit exceed $25,000. We are issuing this finding because, as stated in the Effect of Condition and Questioned Costs section of this finding, the estimated questioned costs exceed that threshold.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department followed procedures for approving payroll costs. However, multiple reviews did not prevent the unsupported shift differential pay and the two overpayments from being charged to the CRF.

Effect of Condition and Questioned Costs

The Department improperly charged the CRF for payroll costs totaling $390. Based on the unallowable payments, we estimate the likely questioned costs for this grant to be $45,266.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program

requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflect this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs" as required by 2 CFR § 200.516(3).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendation

We recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Department's Response

The Department concurs with the audit finding.

If the grantor contacts the Department regarding the questioned costs, the Department will discuss the way we used the funds and will take additional action if appropriate.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

State of Washington
July 1, 2021 through June 30, 2022

2022-015 The Office of Financial Management did not have adequate internal controls over and did not comply with reporting requirements for the Coronavirus Relief Fund.

Assistance Listing Number and Title:	21.019 COVID-19 Coronavirus Relief Fund
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

In March 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which authorized the spending of $2.2 trillion in federal funds to respond to the COVID-19 pandemic.

The CARES Act established the Coronavirus Relief Fund (CRF), which authorized $150 billion in federal financial assistance for state, territorial, tribal, and certain eligible local governments. Through the CARES Act, Washington was awarded about $2.95 billion of CRF money to help fund the state's response to the COVID-19 pandemic. The Office of Financial Management (Office) is the prime recipient and allocated $2.2 billion to state agencies for various programs. In fiscal year 2022, the state spent about $345 million in CRF funds, with the Department of Social and Health Services (DSHS) and the Department of Corrections (DOC) accounting for more than $280 million (81 percent) of these expenditures.

The Office was required to submit quarterly Financial Progress Reports (FPR) that contained COVID-19-related costs incurred during the covered period of March 1, 2020, to December 31, 2021. During fiscal year 2022, the FPRs were due no later than 10 days after each calendar quarter. The FPR submissions should be supported by the data in the state's accounting system.

The federal grantor specified there were four key line items on FPRs that contained critical information:

1) The total amount of CRF payments received from the U.S. Department of the Treasury.
2) The amount of funds received that were expended or obligated for each project or activity.
3) A detailed list of all projects or activities for which funds were expended or obligated.
4) Detailed information on any loans issued, contracts and grants awarded, transfers made to other government entities, and direct payments made by the prime recipient that are greater than $50,000. For amounts less than $50,000, the prime recipient must report in the aggregate for these expenditure categories. For direct payments to people, the prime recipient must report in the aggregate regardless of the amount.

The Office was responsible for compiling this information from state agencies that spent CRF funds during the reporting period.

Federal regulations require the Office to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding reporting requirements, retaining source data, and monitoring the effectiveness of established controls.

In the prior audit, we reported the Office did not have adequate internal controls over and did not comply with reporting requirements for the CRF. The prior finding number was 2021-014.

Description of Condition

The Office did not have adequate internal controls over and did not comply with reporting requirements for the CRF.

During the audit period, the Office submitted four FPRs. It also submitted a fifth FPR shortly after the end of the audit period, which reported on activity during the audit period. At the end of each quarter, Office staff sent an Excel template to state agencies to report CRF expenditures for key line items for the reporting period. The agencies completed and sent the template back to the Office along with detailed expenditure reports from their accounting systems to support the information they provided in the template. Office staff reviewed and consolidated it into one state-level template to complete the FPR submission.

We examined all five FPRs the Office submitted. Our examination focused on DSHS and DOC expenditures because they accounted for more than 81 percent of CRF expenditures. To examine the accuracy of the FPRs, we reviewed the agency and state-level templates and accounting records provided by the Office. We found that the templates and accounting records did not adequately support and align with information the Office reported on the FPRs. We also found that when the amounts reported on the FPR differed from the state-level templates or accounting records, the Office could not provide documentation supporting the change. Finally, we could not determine that staff responsible for certifying the FPRs reviewed the supporting documentation, but a review should have identified differences between the source data and submitted reports.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

During the audit period, management transferred responsibility for reporting from the fiscal and operations division to the statewide accounting division. However, during this process, management did not ensure that all records necessary to support the reports submitted by the fiscal and operations division were retained and reviewed for completeness. In addition, the employee responsible for preparing these first two reports left the Office, and management did not ensure that complete supporting documentation was retained.

Effect of Condition

Because the Office did not establish adequate internal controls to ensure staff retained the proper supporting documentation after submitting the reports, we cannot conclude whether the FPRs were accurate and complete.

Since the Office could not provide complete supporting documentation for some reports, we contacted DSHS and DOC for supporting documentation and additional information. To determine whether the FPRs submitted were accurate and complete, we compared the Office's consolidated templates and FPRs to expenditure reports and the information provided by DSHS and DOC.

During our review of DSHS projects, we identified the following discrepancies:

Reporting Cycle & Expenditure Type	DSHS Reported Amount	DSHS Accounting Record Amount	DSHS Variance	Details
Cycle 6 – ***Contracts >= $50,000***	$10,220,300	$10,345,300	($125,000)	Underreported
Cycle 7 – ***Contracts >= $50,000***	$120,000	$195,000	($75,000)	Underreported
Cycle 7 – ***Transfers >= $50,000***	($402,616,439)	($403,364,801)	$748,362	Overreported
Cycle 8 – ***Transfers >= $50,000***	$0	$7,382,000	($7,382,000)	Underreported

During our review of DOC expenditures, we identified discrepancies totaling $246,550,000 in the final reporting cycle (Cycle 10). We determined that $240,000,000 in expenditures reported as aggregate payments to individuals was reported twice, once in Cycle 7 and again in Cycle 10. In addition, $6,550,000 of Coronavirus State and Local Fiscal Recovery Funds were incorrectly included in the report as CRF expenditures.

Recommendations

We recommend the Office:

- Improve internal controls to ensure reported amounts, including corrections or adjustments made during submission, are properly tracked and documented for subsequent reporting cycles
- Ensure management reviews source data when certifying the report to ensure amounts reported reconcile to supporting documentation
- Retain all necessary documentation to support amounts reported to the federal grantor
- Consult with the federal grantor to determine if a revision and resubmission of the final FPR is required

Office's Response

The Office had controls in place for the Coronavirus Relief Fund (CRF) reporting requirements to ensure reported amounts, including corrections or adjustments made during the reporting period, were properly tracked and documented for subsequent reporting cycles. The Office performed continual monitoring of CRF expenditures to ensure the total grant expenditures reported were complete and accurate.

During the audit period, the Fiscal & Operations staff were responsible for uploading and certifying cycle 6 and 7 reports. Agencies were required to provide data on a report template designed to collect and compile statewide information. Since CRF reporting deadlines did not align with the state's accounting fiscal month cut-off, agencies reported expenditure data up to the end of the last calendar month included in the reporting period instead of waiting until after the close of fiscal month. Staff entered agencies' data into the federal reporting system manually, while dealing with various challenges caused by system issues. During the process, staff communicated with agencies for questions and clarifications via emails or phone calls to ensure reporting was complete and accurate. With staff turnover, some of the email exchanges and telephone conversations could not be provided for audit purposes. Due to the cumulative reporting nature of CRF, it was our understanding that any corrections could be made in the subsequent reporting cycle.

The Statewide Accounting staff, who took over the responsibility for reviewing and certifying cycle 8-10 reports, performed a review of each report prior to submission which was documented via emails. The review ensured amounts submitted on the reports reconciled to supporting documentation provided by agencies at the time the reports were prepared.

In accordance with the CRF reporting guidance issued by Department of Treasury, specifically the FAQ's published in March 2021 (OIG-CA-20-028R), the Office made necessary adjustments to reports to accurately reflect all expenditures in the appropriate categories. For the final cycle

10 report, the Office ensured the amounts on the CRF report were supported by the underlying accounting records and performed a complete reconciliation of expenditures to the totals reported for each expenditure category. All revisions and resubmissions of the final report was completed in cycle 10. No additional revisions are required as this time.

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Office of Management and Budget, 2 CFR Part 200, Appendix XI, *2022 Compliance Supplement*, for Assistance Listing 21.019 Coronavirus Relief Fund, states in part:

L. Reporting

3. Special Reporting

a. Each prime recipient of the Fund shall provide a quarterly Financial Progress Report that contains COVID-19 related costs incurred during the covered period (the period beginning on March 1, 2020; and ending on December 31, 2021) to Treasury OIG. Each prime recipient shall report this quarterly information mentioned above into the GrantSolutions portal. The prime recipient's quarterly Financial Progress Report submissions should be supported by the data in the prime recipient's accounting system.

Key Line Items – The following line items from the reporting contain critical information:

(1) The total amount of payments from the Fund received from Treasury.

(2) The amount of funds received that were expended or obligated for each project or activity.

(3) A detailed list of all projects or activities for which funds were expended or obligated, including:

   a. The name of the project or activity

   b. A description of the project or activity

(4) Detailed information on any loans issued; contracts and grants awarded; transfers made to other government entities; and direct payments made by the prime recipient that are greater than $50,000. For amounts less than $50,000, the prime recipient must report in the aggregate for these expenditure categories. For direct payments to individuals, aggregate reporting is required to be reported regardless of amount.

Beginning September 21, 2020, prime recipients were required to submit via the GrantSolutions portal the first detailed quarterly Financial Progress Report, which cover the period March 1 through June 30, 2020, (with exception to the September 21 first quarter deadline and the October 13 second quarter reporting deadlines for those prime recipients using GrantSolutions' upload feature, which was available December 1, 2020). Thereafter, quarterly reporting will be due no later than ten days after each calendar quarter. If the tenth calendar day falls on a weekend or a federal holiday, the due date will be the next working day. Reporting shall end with either the calendar quarter after the COVID-19-related costs and expenditures have been liquidated and paid or the calendar quarter ending September 30, 2022, whichever comes first. The prime recipient's quarterly Financial Progress Report submission should be supported by the data in the prime recipient's accounting system.

State of Washington
July 1, 2021 through June 30, 2022

2022-016 The Department of Commerce did not have adequate internal controls over and did not comply with requirements to ensure payments to subrecipients of the Emergency Rental Assistance program were allowable and properly supported.

Assistance Listing Number and Title:	21.023 COVID-19 Emergency Rental Assistance Program
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	N/A
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Period of Performance
Known Questioned Cost Amount:	$255,642,551

Background

Congress passed two acts authorizing federal funds for the Emergency Rental Assistance (ERA) program to respond to the COVID-19 pandemic. The Consolidated Appropriations Act, 2021, enacted on December 27, 2020, provided $25 billion for ERA. These funds are known as ERA1. The American Rescue Plan Act of 2021, enacted on March 11, 2021, provided $21.55 billion in additional funding for ERA. These funds are known as ERA2. The funds are provided directly to states, U.S. territories, local governments and, in the case of ERA1, Indian tribes, to assist eligible households through existing or newly created rental assistance programs.

The Department of Commerce administers the ERA program in Washington. The Department subawarded federal funds to subrecipients to provide financial assistance to households, landlords and utility providers. In fiscal year 2022, the Department spent about $450 million in ERA1 and ERA2 funds. During the audit period, the Department allocated program funds to 38 ERA1 subrecipients and 12 ERA2 subrecipients. Grant recipients may use ERA1 and ERA2 funds for administrative expenses, housing stability services, financial assistance, and other affordable rental housing and eviction prevention purposes.

Most of the expenditures the Department spent were for financial assistance to eligible households, which included payment of rent, rental arrears, utilities and home energy costs, utilities and home energy costs arrears, housing stability services and other expenses related to housing. Under the ERA1 program, award funds used for "other expenses" must be related to housing and "incurred due, directly or indirectly, to the COVID-19 outbreak." The amount for prospective rent cannot exceed three months under a single household application. Financial assistance arrears may only cover household expenses accrued on or after March 13, 2020, up to a maximum 15 months for ERA1 and a maximum of 18 months under ERA1 and ERA2 combined.

There is no maximum dollar amount for the cumulative financial assistance that may be provided on behalf of an eligible household beyond the requirement that the amounts paid be based on documentation of household income, leases and equivalent forms.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure payments for the ERA program were allowable and properly supported.

During the audit period, the Department only required high-level supporting documentation when approving subrecipient payments. Since detailed source documentation was not required at the time of the reimbursement payment, the Department implemented a fiscal review process for the ERA1 and ERA2 subrecipients.

We reviewed the three fiscal reviews completed in the audit period and determined they were sufficient for ensuring payments to these subrecipients were allowable and adequately supported. However, we determined the Department did not complete fiscal reviews for 35 of the 38 ERA1 subrecipients (92 percent) and all 12 ERA2 subrecipients (100 percent) during the audit period.

We used a statistical sampling method to randomly select and review 55 out of 369 payments. Additionally, we judgmentally reviewed one individually significant payment that exceeded $23 million. In total, we examined more than $258 million in provider payments as part of the audit.

Of the 56 payments examined, we identified 54 payments (96 percent), including the individually significant payment, that did not have adequate documentation and for which the subrecipient did not receive a fiscal review to ensure the payment(s) was for allowable activities, met cost principles, and occurred within the award's period of performance.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not ensure that proper internal controls were in place to oversee the ERA program. Department staff approved payments to subrecipients without adequate supporting documentation, and management relied on annual fiscal monitoring reviews to ensure subrecipients had proper support for reimbursement payments. However, management said that due to limited staffing and resources, they were only able to conduct monitoring for three subrecipients during the audit period.

Effect of Condition and Questioned Costs

We determined the Department did not receive adequate supporting documentation before paying subrecipients and did not perform fiscal reviews to ensure that expenditures were for allowable activities. As a result, we identified $255,642,551 in known federal questioned costs and $437,002,382 in likely federal questioned costs.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Without establishing adequate internal controls, the Department cannot reasonably ensure it is using federal funds for allowable purposes and spending occurs within the allowed period of performance.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Implement additional monitoring procedures to ensure adequate review of each subrecipient's use of the federal subaward
- Improve internal controls to ensure subrecipients provide adequate supporting documentation when requesting reimbursement

- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

The Coronavirus pandemic created an unprecedented crisis of imminent evictions for an estimated 200,000 households who would face homelessness. Prompt program implementation was critical to reducing evictions as homelessness was shown to increase the spread of COVID-19 leading to death. Every week of delay would increase the number of people at risk of dying.

During fiscal years 2021 through 2023, the department created the following programs with federal funding:

- *Eviction Rent Assistance Program (ERAP) 1.0 and 2.0, with Coronavirus State Fiscal Recovery Funds allocated by the Washington State Legislature.*
- *Treasury Rent Assistance Program (T-RAP) 1.0 and 2.0, with funds awarded to the Department by the United States Department of Treasury.*

The Department endeavored to quickly deploy these programs either concurrently or on overlapping timelines, as the federal government doubled down on passing legislation to provide much needed assistance to the states.

At the time the Department received the first ERAP funds for rental assistance, the Department had current contracts with grantees for the same activity and for whom monitoring plans had been completed. The vast majority of our grantees are local government entities, with whom the Department has a long history of contracting and partnering on delivering services. Local governments have controls in place and a proven track record of administering housing assistance funds, so the Department has an inherent trust and confidence in their administrative and fiscal control functions, including the detailed review of expenditures.

When the Department received the first emergency rental assistance funds (August 2020) the funding for the program was set to expire just four months after the federal award, requiring the Department to lift bureaucratic barriers and issue funds quickly. It was not until late December 2020 that Congress extended the end date and we were informed we could continue to fund the program into 2021. The Department had started a fiscal review process for ERAP 1 and ERAP 2 programs following those awards. Upon receiving the results of the fiscal year 2021 emergency rental assistance audit, it was determined the fiscal review must be completed for all program reimbursements, even if the detail review of expenditures was completed at our subrecipient level. The initial fiscal monitoring was based on previously conducted risk assessments, so not all payees received a fiscal monitoring. The State Auditor's Office identified this deficiency during fiscal year 2021. Following that, at the end of fiscal year 2022, the department began to review supporting backup documentation for all expenditures. Unfortunately this process had not been

implemented in full to meet the second audit requirements for fiscal year 2022. The Department continues to complete reviews of supporting documentation for fiscal year 2023 expenditures and we strive to meet all other program requirements. We will continue to submit monthly and quarterly data and reconciliation reports to the United States Department of Treasury and work with the Washington State Auditor's Office in response to any current or future audits.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 403, Factors affecting allowability of costs, describes the general criteria in order for a cost to be allowable under federal awards, including being adequately documented.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

State of Washington
July 1, 2021 through June 30, 2022

2022-017 The Department of Commerce did not have adequate internal controls over and did not comply with reporting requirements for the Emergency Rental Assistance program.

Assistance Listing Number and Title:	21.023 COVID-19 Emergency Rental Assistance Program
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting Special Tests and Provisions: ERA Funds Reallocation
Known Questioned Cost Amount:	None

Background

Congress passed two acts authorizing federal funds for the Emergency Rental Assistance (ERA) program to respond to the COVID-19 pandemic. The Consolidated Appropriations Act, 2021, enacted on December 27, 2020, provided $25 billion for ERA. These funds are known as ERA1. The American Rescue Plan Act of 2021, enacted on March 11, 2021, provided $21.55 billion in additional funding for ERA. These funds are known as ERA2. The funds are provided directly to states, U.S. territories, local governments and, in the case of ERA1, Indian tribes, to assist eligible households through existing or newly created rental assistance programs.

The Department of Commerce administers the ERA program in Washington. The Department subawarded federal funds to subrecipients to provide financial assistance to households, landlords and utility providers. In fiscal year 2022, the Department spent about $450 million in ERA1 and ERA2 funds. During the audit period, the Department allocated program funds to 38 ERA1 subrecipients and 12 ERA2 subrecipients. Grant recipients may use ERA1 and ERA2 funds for administrative expenses, housing stability services, financial assistance, and other affordable rental housing and eviction prevention purposes.

The Department is required to submit monthly and quarterly reports for ERA1 and ERA2. For monthly reports, the Department reports the total number of participating households that received ERA assistance and the total amount of ERA funds expended by the Department to or for participating households. For quarterly reports, the Department reports the cumulative amount obligated and expended. Additionally, before the federal government issued the full reporting requirements for the program, the Department submitted interim reports for the first quarter after each award opened. The Department collects data from each subrecipient and manually aggregates it together to determine the reported amounts.

The U.S. Department of the Treasury uses these reports to make reallocation determinations to ensure ERA funds remain available to grantees in accordance with jurisdictional needs and demonstrated capacity to deliver assistance while the ERA appropriations remain available.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with reporting requirements for the ERA program.

During the audit period, Department program staff asserted that all reports were reviewed and approved by appropriate staff before submission to Treasury. However, program staff did not document their review or approval, so we were unable to determine if the proper reviews occurred.

For the monthly reports, we used a nonstatistical sampling method to randomly select and examine eight out of 24 reports. We identified one report (13 percent) that did not contain data for two subrecipients, resulting in an underreporting of 262 households and $1,720,736 in rental assistance.

For the quarterly reports, we used a nonstatistical sampling method to randomly select and examine five out of 12 interim and quarterly reports. We identified two interim quarterly reports (40 percent) where the reported amounts were supported only by subrecipients' reported amounts with no detailed support. As a result, we could not verify that $55,139,970 in expenditures and obligations were accurate and complete. Furthermore, in reviewing the accuracy of the aggregated subrecipient data, one of these interim reports was overreported by $811,010.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department did not require management to document their reviews of reports and supporting documentation prior to submission. If reviews of the reports were performed, they were inadequate for detecting the identified errors.

Additionally, for the interim quarterly reports, the Department did not require subrecipients to provide detailed data to support expenditure and obligation amounts submitted on the data-collection forms.

Effect of Condition

By not retaining adequate supporting documentation for the reports, management was unable to demonstrate that the amounts the Department reported were complete and accurate. As a result, Treasury may not be able to make accurate reallocation determinations.

Without establishing adequate internal controls, the Department cannot reasonably ensure that the expenditure and obligation amounts reported to Treasury are complete and accurate.

Recommendations

We recommend the Department:

- Ensure that management perform and document an adequate review of the supporting documentation before submitting reports to the Department of the Treasury
- Ensure that data collected from subrecipients contains detailed information to support the amounts included in required reports

Department's Response

The Coronavirus pandemic created an unprecedented crisis of imminent evictions for an estimated 200,000 households who would face homelessness. During fiscal years 2021 through 2023, the Department managed the Treasury Rent Assistance Programs 1.0 and 2.0: ERA funds.

The program included multiple funding allocations to fund the programs. The Department endeavored to quickly deploy these programs either concurrently or on overlapping timelines, as the federal government doubled down on passing legislation to provide much needed assistance to the states.

At the time the Department received the Treasury Rent Assistance funds directly from the Department of Treasury (Treasury), the program was unaware of the 2 CFR 200 compliance requirements. The only program specific information provided for reporting was the basic outline of requirements from the statute authorizing the use of ERA funds.

The Department's Treasury Rent Assistance Program (T-RAP 1.0 and 2.0) launched in March of 2021. Reporting guidance specifically for Treasury Rent assistance programs was not released until June 30, 2021. While it was helpful to have more guidance on reporting, the guidance provided was confusing and difficult to understand. Accessing Treasury staff to provide additional guidance and answer questions was a challenge. Local governments also had a difficult time comprehending the guidance and were unable to get technical assistance from Treasury, which led the National Council of State Housing Agencies (NCSHA) to convene regular meetings with local government peers administering emergency rental assistance funds. The NCSHA assisted in understanding the guidance and advocated to Treasury to provide clear language and technical assistance on the guidance they issued.

As the Department's program ramped up over the summer of 2021, Treasury updated the reporting requirements adding a significant amount of new data elements and expenditure reporting. Between June 2021 and March of 2023, Treasury updated reporting guidance eight times. With each update and new requirements added, Department staff had to reconfigure their data collection methods to ensure they were able to collect the newly required information from subrecipients, and ultimately able to properly report it.

The Department quickly realized that additional support was needed in order to ensure compliance with reporting requirements. The Department contracted with a vendor skilled in performing data analytics, FORWARD (formerly known as LiveStories), to help aggregate the data required in the monthly and quarterly reports. FORWARD began helping the Department with their reporting duties starting in January 2022.

Program management acknowledges reporting approvals were not separately documented for signature of review and approvals. The Department's Internal Control Officer has provided recommendations for the program to implement to ensure all reporting reviews and approvals are documented. The Department is currently evaluating how to implement the review and approval controls. We also acknowledge the under reporting deficiency which occurred on one of our monthly reports and the interim report. The Treasury reporting system did not allow the Department the ability to modify or change existing reports. The Department had no way of updating the reported information, the only method the program had to update reporting was to verify the final fiscal year figures were updated and reported accurately.

The Department constantly strives to ensure we obtain detailed supporting documentation from subrecipients which support all amounts included in all Treasury required reports.

The Department thanks SAO for this opportunity to provide a response to the deficiencies reported.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Section 501 of the Consolidated Appropriations Act, 2021

(d) Reallocation of unused funds.
Beginning on September 30, 2021, the Secretary shall recapture excess funds, as determined by the Secretary, not obligated by a grantee for the purposes described under subsection (c) and the Secretary shall reallocate and repay such amounts to eligible grantees who, at the time of such reallocation, have obligated at least 65 percent of the amount originally allocated and paid to such grantee under subsection (b)(1), only for the allowable uses described under subsection (c). The amount of any such reallocation shall be determined based on demonstrated need within a grantee's jurisdiction, as determined by the Secretary.

Section 3201 of the American Recue Plan Act of 2021

(e) Reallocation of funds.

(1) In General. Beginning March 31, 2022, the Secretary shall reallocate funds allocated to eligible grantees in accordance with subsection (b) but not yet paid in accordance with subsection (c)(2) according to a procedure established by the Secretary.

State of Washington
July 1, 2021 through June 30, 2022

2022-018 The Office of Financial Management did not have adequate internal controls over and did not comply with requirements to ensure Coronavirus State and Local Fiscal Recovery Funds were used only for allowable activities.

Assistance Listing Number and Title:	21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles Period of Performance
Known Questioned Cost Amount:	$300,000,000

Background

The Coronavirus State and Local Fiscal Recovery Fund (SLFRF) provides direct payments to states to respond to the COVID-19 pandemic or its negative economic effects. Washington has received approximately $4.4 billion of SLFRF money from the U.S. Department of the Treasury (Department).

Federal law stipulates that states may use SLFRF funds to:

- Support public health expenditures, including COVID-19 prevention and mitigation efforts
- Address negative economic impacts caused by the public health emergency
- Replace lost public sector revenue
- Provide premium pay for essential workers
- Invest in water, sewer, and broadband infrastructure

States may only use funds to cover costs incurred during the period of performance, which began on March 3, 2021, and ends on December 31, 2024.

Under the Department's final rule, SLFRF recipients could use funds to replace lost public sector revenue to provide government services. Recipients could elect a one-time standard allowance of $10 million to spend on the provision of government services during the grant's period of performance. Alternatively, SLFRF recipients could calculate lost revenue based on a formula established by the Department to determine the amount of SLFRF funds that can be used for the provision of government services. Washington chose to calculate its lost revenue rather than used the standard allowance.

The calculated amount of revenue loss determines the limit of SLFRF funds that can be used to provide government services by a recipient. For reporting purposes on the Schedule of Expenditures of Federal Awards (SEFA), the aggregate expenditures for all eligible use categories must be reported, not the result of the revenue loss calculation or the standard allowance.

Washington received the first half ($2.2 billion) of its total $4.4 billion SLFRF allocation in May 2021. When received, the funds were accounted for in the state's Coronavirus State Fiscal Recovery Fund (Fund 706). Washington State Substitute Senate Bill 5165, section 408, included distributions totaling $600 million from Fund 706 into various state transportation-related accounts. According to the Office, the purpose of these distributions was to compensate for revenue losses in state fiscal years 2020 and 2021 relative to revenues collected in state fiscal year 2019 and to be used to maintain government services. The Office attributed $300 million of this as SLFRF expenditures for transportation related accounts on the State's fiscal year 2022 SEFA.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Office did not have adequate internal controls and did not comply with requirements related to the SLFRF revenue loss provision.

While SLFRF funds are allowed to replace lost public sector revenues, the State was required to identify actual expenditures that were provided for government services. At the time of audit, the State had not identified such expenditures. Rather, the state asserted that all expenditures in the Transportation accounts receiving the SLFRF funds were appropriated for government services and, therefore, there was no doubt as to the allowability of the use of funds.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Office does not believe federal requirements and the Department's final rule required the State to separately identify actual expenditures that equal the amount of SLFRF expenditures claimed. It is the Office's position that all expenditures in the Transportation related accounts were for government services and, therefore, the state had sufficient expenditures to meet the grant requirement.

During the audit, the Office contacted the Department to obtain guidance on the matter. The Office cited the Department's FAQ Question 13.15, which states in part, "recipients should not deviate from their established practices and policies regarding the incurrence of costs, and that they should expend and account for the funds in accordance with laws and procedures for expending and accounting for the recipient's own funds." A Department representative acknowledged this FAQ and said the Department does not have additional specific requirements about how recipients should internally track their use of SLFRF funds used for revenue replacement.

Effect of Condition and Questioned Costs

Without a population of actual expenditures to audit, we could not design tests to verify costs charged to the grant were only for allowable activities, met cost principles, and were incurred during the grant's period of performance. In our judgment, without identifying the specific expenditures charged to the SLFRF, the Office did not comply with federal requirements.

Therefore, we are questioning $300 million in costs that were not supported by specifically identified expenditures for government services. We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its federal expenditures.

Recommendations

We recommend the Office:

- Identify the actual government service expenditures that are the basis for the $300 million in SLFRF expenditures recorded on the State's fiscal year 2022 SEFA
- Review the supporting documentation for the expenditures to ensure they meet compliance requirements for the SLFRF and are adequately documented, while also documenting the details of this review
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Office's Response

The Office does not concur with the audit finding.

The state of Washington created a separate fund to track the Coronavirus State and Local Fiscal Recovery Fund (SLFRF) expenditures. The state, through legislation, approved the transfer from the SLFRF account to various state transportation accounts. Each transportation account that received SLFRF funds was established in statute and is for a specific "government service" purpose. Therefore, all payments from those accounts would be considered an actual government service expenditure. The U.S. Department of Treasury FAQ 3.2 states that "Government services generally include any service traditionally provided by a government, unless Treasury has stated otherwise." We reaffirm that all expenditures from the transportation accounts that received the SLFRF funds were used to maintain government services.

The State Administrative and Accounting Manual requires all state agencies to establish internal controls over payments for goods and services, including ensuring payments are lawful and for proper purposes, reviewing payments to ensure they are supported, as well as documenting the review of all payments. State agencies continued to follow their established internal controls to ensure expenditures from the transportation accounts were proper and allowable. Additionally, the Office followed consistent policies and practices regarding the incurrence of costs in the transportation accounts for both non-SLFRF and SLFRF funds, which complied with federal guidance.

We disagree that the total amount of lost revenue transferred to the transportation accounts should be considered questioned costs because the auditors were unable to design tests for compliance. The following table lists the accounts and the amounts received from SLFRF during fiscal year 2022. We know all expenditures in these accounts are for government services, and therefore are allowable costs for the program.

	Account	***Authority***	***Amount transferred from Account 706 (CSLFRF)***
1	*Account 039 - Aeronautics Account*	*RCW 82.42.090*	*$ 388,500.00*
2	*Account 081 - State Patrol Highway Account*	*RCW 46.68.030*	*$ 6,179,000.00*
3	*Account 082 - Motorcycle Safety Education Account*	*RCW 46.68.065*	*$ 9,000.00*
4	*Fund 099 - Puget Sound Capital Construction Account*	*RCW 47.60.505*	*$ 1,446,000.00*
5	*Account 09H - Transportation Partnership Account*	*RCW 46.68.290*	*$ 19,773,500.00*
6	*Account 102 - Rural Arterial Trust Account*	*RCW 36.79.020*	*$ 1,546,000.00*
7	*Account 106 - Highway Safety Account*	*RCW 46.68.060*	*$ 4,109,500.00*

8	*Account 108 - Motor Vehicle Account*	*RCW 46.68.070*	*$ 49,708,000.00*
9	*Fund 109 - Puget Sound Ferry Operations Account*	*RCW 47.60.530*	*$ 42,983,000.00*
10	*Fund 16J - State Route Number 520 Corridor Account*	*RCW 47.56.875*	*$ 29,783,500.00*
11	*Account 17P - SR520 Civil Penalties Account*	*RCW 47.56.876*	*$ 2,721,000.00*
12	*Account 144 - Transportation Improvement Account*	*RCW 47.26.084*	*$ 7,922,000.00*
13	*Account 186 - County Arterial Preservation Acct*	*RCW 46.68.090*	*$ 969,500.00*
14	*Account 20H - Connecting Washington Account*	*RCW 46.68.395*	*$ 33,831,500.00*
15	*Account 215 - Special Category C Account*	*RCW 46.68.090*	*$ 1,987,500.00*
16	*Account 218 - Multimodal Transportation Account*	*RCW 47.66.070*	*$ 57,805,500.00*
17	*Account 511 - Tacoma Narrows Toll Bridge Account*	*RCW 47.56.165*	*$ 7,853,500.00*
18	*Account 550 - Transportation 2003 Account*	*RCW 46.68.280*	*$ 14,340,500.00*
19	*Account 595 - I-405 and SR-167 Express Toll Lanes Acct*	*RCW 47.56.884*	*$ 16,446,500.00*
20	*Account 780 - School Zone Safety Account*	*RCW 46.61.440*	*$ 196,500.00*
			$ 300,000,000.00

We requested that the auditors perform testing of the entire population of expenditures in the transportation accounts for compliance. Questioned costs, if any, could have been identified through relevant audit procedures.

During multiple trainings offered by the U.S. Treasury, there has been communication that the grantor will be working with grant recipients through ongoing desk audits to ensure no questioned costs are required to be repaid. The Office will work with the legislature to ensure SLFRF funds can be tracked separately from other funds.

Auditor's Remarks

We believe that the federal requirement is that SLFRF recipients must separately identify actual expenditures that equal the amount of SLFRF expenditures stated on the Schedule of Expenditures of Federal Awards. Furthermore, that is the practice used by the State for all other federal programs. We appreciate that the Office will make efforts to work with the Legislature to ensure future SLFRF funds can be tracked separately from other funds.

We reaffirm our finding and will follow-up on the Office's corrective actions in the next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 302, Financial management, states in part:

> The financial management system of each non-Federal entity must provide for the following (see also 200.334, 200.335, 200.336, and 200.337)
>
> (1) Identification, in its accounts, of all Federal awards received and expended and the Federal programs under which they were received. Federal program and Federal award identification must include, as applicable, the Assistance Listings title and number, federal award identification number and year, name of the Federal agency, and name of the pass-through entity, if any.
>
> (3) Records that identify adequately the source of the application of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, financial obligations, unobligated balances, assets, expenditures, income and interest and be supported by source documentation.

Title CFR Part 200, Uniform Guidance, section 403, Factors affecting allowability of costs, states in part:

> Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards:
>
> (g) Be adequately documented.

Title 2 CFR Part 200, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 516, Audit findings, establishes reporting requirements for audit findings.

State of Washington
July 1, 2021 through June 30, 2022

2022-019 The Department of Commerce did not have adequate internal controls over and did not comply with requirements for monitoring subrecipients to ensure payments were allowable, properly supported, and met period of performance requirements for the Coronavirus State and Local Fiscal Recovery Funds.

Assistance Listing Number and Title:	21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	SLFRP0002
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles Period of Performance Subrecipient Monitoring
Known Questioned Cost Amount:	$28,886,606

Background

The Coronavirus State and Local Fiscal Recovery Funds (SLFRF), as part of the American Rescue Plan Act of 2021, delivered $350 billion to state, local, and tribal governments to support the response to and recovery from the COVID-19 public health emergency. Washington received $4.4 billion of SLFRF money from the U.S. Department of the Treasury, which the state's Office of Financial Management allocated to state agencies for various programs. In fiscal year 2022, state agencies spent more than $1.4 billion in SLFRF funds, $132 million of which was spent by the Department of Commerce.

The Department used SLFRF funds to administer and provide economic assistance to households at risk of eviction and homelessness primarily through the Eviction Rental Assistance Program (ERAP 2.0), in addition to transportation, tourism, and other pandemic-recovery projects. During fiscal year 2022, the Department expended about $111 million on reimbursements and advance

payments to local governments and nonprofit organizations as subrecipients. These subrecipients were responsible for making direct payments of rent and utilities for eligible low-income households with overdue rent payments dating as far back as March 2020.

Pass-through entities are required to monitor the activities of subrecipients to ensure they are properly using federal funds for allowable activities and expenditures.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements for monitoring subrecipients to ensure payments were allowable, properly supported, and met period of performance requirements for the SLFRF program.

During the audit period, the Department only required summary level supporting documentation when approving subrecipient payments. Since detailed source documentation was not required at the time of reimbursement, the Department implemented a fiscal review process for ERAP 2.0 subrecipients.

We determined that the Department did not perform fiscal reviews or any program reviews for 20 of its 32 subrecipients (63 percent) during the audit period.

We used a statistical sampling method to randomly select and review seven out of 12 subrecipients for which the Department completed monitoring during the audit period. We determined four of the seven fiscal reviews completed were insufficient for ensuring payments to these subrecipients were allowable and adequately supported, primarily because the support reviewed lacked enough detail to ensure the activities were allowable and within the period of performance.

We also examined program monitoring documentation completed for these same seven subrecipients. The Department selected only one household from each subrecipient for eligibility verification. We determined these reviews did not provide reasonable assurance that payments to the subrecipients were made only on behalf of eligible households.

We also used a statistical sampling method to randomly select and review 56 out of 627 payments. Additionally, we judgmentally selected and reviewed one individually significant payment of $6 million. In total, we examined 57 provider payments totaling $48.5 million. Of the 57 payments examined, we identified 37 (65 percent), including the individually significant payment, that did not have adequate documentation to ensure the payment was for allowable activities, met cost principles, and occurred within the award's period of performance.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

The issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not ensure that proper internal controls were in place to oversee ERAP 2.0 and the use of SLFRF funds. Department staff approved payments to subrecipients without reviewing adequate supporting documentation, and management relied on annual program and fiscal monitoring to ensure subrecipients had proper support and only served eligible households. However, management said that due to limited staffing and resources, they were only able to monitor 12 subrecipients during the audit period, wherein staff elected to review just one household payment for each subrecipient for appropriateness.

Furthermore, the program did not have written policies and procedures in place documenting the programmatic and fiscal monitoring requirements for staff to follow. Therefore, management could not ensure that reviews were thorough and consistent, included a valid sample of subrecipient records, and required detailed source documentation, including accounting support.

Effect of Condition and Questioned Costs

We determined the Department did not review adequate supporting documentation before paying subrecipients, and it did not perform adequate fiscal reviews to ensure that expenditures were for allowable activities. As a result, we identified $28,886,606 in known federal questioned costs and $71,007,353 in likely federal questioned costs.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflect this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

Without establishing adequate internal controls and reviewing detailed supporting documentation from subrecipients, the Department cannot reasonably ensure it is using federal funds for allowable purposes and that spending occurs within the allowed period of performance.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Implement written policies and monitoring procedures to ensure adequate review of each subrecipient's use of federal funds
- Improve internal controls to ensure subrecipients provide adequate supporting documentation when requesting reimbursement
- Ensure it has sufficient staffing and resources to monitor each subrecipient, as required under Uniform Guidance
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

The Coronavirus pandemic created an unprecedented crisis of imminent evictions for an estimated 200,000 households who would face homelessness. Prompt program implementation was critical to reducing evictions as homelessness was shown to increase the spread of COVID-19 leading to death. In fiscal year 202, Commerce created the Eviction Rent Assistance Programs 1.0 and 2.0: Coronavirus State Fiscal Recovery Funds allocated by the Washington State legislature to fund the program.

All of the rental assistance programs included multiple funding allocations. To provide much needed assistance to the state, the Department quickly deployed the programs either concurrently or on overlapping timelines. The vast majority of our grantees are local government entities with whom the Department has a long history of contracting and partnering with to deliver services. Federal requirements dictate local governments ensure their internal controls meet standards to comply with all compliance requirements. The Department used that expectation to rely on their administrative and fiscal control functions to ensure compliance.

The Department received the first emergency rental assistance funds in August 2020 and the funding was set to expire four months after the award issuance. The Department moved quickly to relieve barriers to issue funding. In December 2020 Congress extended the end date to continue the funding for this program into 2021.

As a result of the fiscal year 2021 audit, it was determined the fiscal review must be completed for all program reimbursements, even if the detail review of expenditures was completed at our subrecipient level. The initial fiscal monitoring was based on previously conducted risk assessments, so not all payees received a fiscal monitoring. As a result of the deficiencies reported in the fiscal year 2021 audit, the program deployed new subrecipient monitoring risk assessment processes, and now completes a new assessment for each award at the time of the award.

Once the deficiency was identified, the Department began to review supporting backup documentation for all expenditures. The current finding also focused on specific sets of expenditures which were not reviewed in detail. As a result, the Department is currently evaluating the best approach to obtain and review supporting documentation at a detail level to ensure compliance with all requirements. The Department continues to complete reviews of supporting documentation for fiscal year 2023 expenditures and we strive to meet all other program requirements.

We thank the State Auditor's Office for identifying areas we could improve to meet all compliance requirements for federal funding.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 332, Requirements for pass-through entities, establishes the requirements for all pass-through entities.

Title 2 CFR Part 200, Uniform Guidance, section 403, Factors affecting allowability of costs, describes the general criteria in order for a cost to be allowable under federal awards, including being adequately documented.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

State of Washington
July 1, 2021 through June 30, 2022

2022-020 The Office of Financial Management did not have adequate internal controls over and did not comply with reporting requirements for the Coronavirus State and Local Fiscal Recovery Funds.

Assistance Listing Number and Title:	21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	None
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Coronavirus State and Local Fiscal Recovery Funds (SLFRF), as part of the American Rescue Plan Act of 2021, delivered $350 billion to state, local, and tribal governments to support the response to and recovery from the COVID-19 public health emergency. The program also provides resources to fight the pandemic, address economic impacts, maintain vital public services, and build a strong, resilient, and equitable recovery.

Washington received about $4.4 billion of SLFRF money from the U.S. Department of the Treasury (Treasury), which the state's Office of Financial Management allocated to state agencies for various programs. In fiscal year 2022, the State spent more than $1.1 billion in federal program funds.

Under the SLFRF program, recipients are required to submit Project and Expenditure Reports during the covered period which began March 3, 2021 and ends December 31, 2024. Treasury identified the following key line items that contain critical information:

1. Obligations and Expenditures
    - Current period obligation
    - Cumulative obligation

    - Current period expenditure
    - Cumulative expenditure
2. Subawards
3. Detailed information on any loans issued; contracts and grants awarded; transfers made to other government entities; and direct payments made by the recipient that are greater than $50,000. For amounts less than $50,000, the recipient must report in the aggregate for these same categories of loans issued; contracts and grants awarded; transfers made to other government entities; and direct payments made by the recipient.

Recipients must submit the reports online using the Treasury Portal. Users had the option of manually entering data or providing information through a bulk upload using a Treasury template. The Office was responsible for compiling information from state agencies and submitting the reports no later than the last day of the month following the end of each reporting period.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant reporting requirements, retaining source data, and monitoring the effectiveness of established controls.

Description of Condition

The Office did not have adequate internal controls over and did not comply with reporting requirements for the SLFRF.

During the audit period, the Office submitted three Project and Expenditure Reports:

- Report No. 1 (covering activity from March 3, 2021 to December 31, 2021)
- Report No. 2 (covering activity from January 1, 2022 to March 31, 2022)
- Report No. 3 (covering activity from April 1, 2022 to June 30, 2022)

At the end of each reporting period, Office staff sent an Excel template to state agencies to report SLFRF expenditures. The agencies completed and returned the template along with supporting accounting records. Office staff reviewed and consolidated each agency template into one statewide template to prepare and submit the reports online via the Treasury Portal.

We examined all three reports and the Office's supporting documentation related to each. We found that each report was incomplete and inaccurate when compared to the supporting documentation and information submitted in the Treasury Portal.

We consider these internal control deficiencies to be a material weakness that led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

During the audit period, the Office transitioned responsibility from its fiscal and operations division to the statewide accounting division. This change improved the Office's reporting process but did not ensure adequate documentation was retained. Multiple staff submitted reports during the audit period, causing a lack of familiarity with information submitted in previous reporting cycles. For Report No. 1, management did not ensure adequate separation of duties.

Treasury's new reporting system was implemented and updated during the audit period, and included safeguards intended to prevent the submission of incomplete information. However, the Office said these safeguards created system errors that caused it to have to manually input information for the report to be accepted.

Office management also did not ensure manual entries and adjustments to draft uploads were documented and retained. Additionally, management did not adequately review and reconcile the information submitted in the Treasury Portal to ensure it was completely and accurately captured in the reports.

Effect of Condition

We examined each of the obligation and expenditure key line items and focused our review on agencies with project expenditures that were material to the overall report. We identified three instances of inaccurate or incomplete reporting, which include the following:

Report	Agency (Project ID)	Reported Amount	Expected Amount	Variance	Details
Report No. 1	Health Care Authority (Project No. 5)	$31,000,000	$30,985,791	$14,209	Overreported
Report No. 1	Commerce (Project No. 11)	$37,419,820	$31,116,860	$6,302,960	Overreported
Report No. 3	Commerce (Project No. 11)	$37,033,965	$36,805,037	$228,928	Overreported

We also examined detailed expenditure information in each report, including subaward amounts, subaward IDs, subaward types, subrecipient names, and expenditure amounts. We identified 241 instances where required fields were left blank, or the information reported was inaccurate.

Additionally, we examined the Office's bulk upload templates and found 494 subawards and expenditures uploaded to the Treasury Portal that were omitted from the reports. These omissions included 124 subawards and expenditures for amounts totaling $102,952,311 that were included in Report No. 1, but subsequently omitted from the expenditures and subaward sections of Report

Nos. 2 and 3 without a discernible cause. Because the Office did not maintain adequate documentation of manually entered expenditures, we could not determine whether the information entered was accurate.

During the covered period for fiscal years 2021 and 2022, cumulative SLFRF expenditures totaled $818,297,395 in the reports and $1,230,743,420 in the state's Schedule of Expenditures of Federal Awards (SEFA). We found the total expenditures in Report No. 3 did not account for $412,446,025 (33.5 percent) of expenditures that were reported on the SEFA for the same time period.

By not establishing adequate internal controls, the Office cannot ensure that information reported to the federal grantor is complete and accurate.

Recommendations

We recommend the Office:

- Establish internal controls to ensure information is completely and accurately uploaded to the federal reporting system, supported by accounting records, and reviewed and reconciled prior to submission and certification of the report
- Provide training to increase staff familiarity with the federal reporting system
- Provide resources for staff to improve report preparation so that it complies with federal reporting guidance and system requirements
- Refer to Treasury's Project and Expenditure Report User Guide for instructions on correcting the data.

Office's Response

The Office has continued to improve internal controls for the Coronavirus State and Local Fiscal Recovery Fund (CSLFRF) reporting requirements to ensure reported amounts, including corrections or adjustments made during the reporting period, were properly tracked and documented for the subsequent reporting cycles. The Office created a separate fund to track CSLFRF expenditures and performed continual monitoring to ensure the total grant expenditures reported were complete and accurate.

The Office was proactive in strengthening controls and processes in CSLFRF reporting. Once the complexities of the federal reporting guidelines became apparent, an additional staff member was hired and dedicated to preparing and submitting the quarterly reports. Staff are familiar with Treasury's Project and Expenditure (P&E) Report User Guide but had to deal with challenges due to guidance being issued late, changed multiple times, and containing complicated reporting requirements. The federal reporting system also does not allow the prior report to be edited after the reporting deadline. Per Treasury's P&E Report User Guide, FAQ 1.11, any changes or revisions need to be reflected in the next quarterly report.

The audit procedures did not take into consideration irregularities found in the Treasury reporting system. The auditors reviewed a pdf. version of the report located on the Treasury website to conduct audit testing. However, the information on that report did not tie to the actual information in the reporting portal. Additionally, the CSLFRF reporting deadlines did not align with the state's accounting fiscal month and fiscal year cut-off dates. Agencies had to report expenditure data up to the end of the last calendar month included in the reporting period, but all expenditure activities could not be captured due to the short timeframe between fiscal month close and the report due date. Also, for this reason, the report for the quarter ending June 30, 2022 (due July 31st) did not tie to the FY22 Schedule of Expenditure of Federal Awards.

The Office continues to improve the quarterly reporting template and assist state agencies during the reporting process to ensure compliance with federal reporting guidance and system requirements. The Office will continue to perform reconciliations of reported expenditures to ensure expenditures are accurately reflected in the appropriate projects and categories. Internal controls also include adequate reviews to ensure reported expenditures are accurate and adequately supported by accounting records before the information is uploaded to the federal reporting system. Internal procedures have been developed to formally document the reporting process.

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Office of Management and Budget, 2 CFR Part 200, Appendix XI, *2022 Compliance Supplement*, for Assistance Listing 21.027 Coronavirus State and Local Fiscal Recovery Funds, states in part:

L. Reporting

b. Special Reporting

a. There are three types of reporting requirements for the CSLFRF program:

   i. Project and Expenditure Report: Report on financial data, projects funded, expenditures, and contracts and subawards over $50,000, and other information. Project and Expenditure Reports are due on a regular recurring basis after the Interim Reports. The reporting frequency and deadlines vary by type of recipient and total allocation amount.

b. *Key Line Items* – The following line items contain critical information for the Project and Expenditure Report:

   i. Obligations and Expenditures

      - Current period obligation
      - Cumulative obligation
      - Current period expenditure
      - Cumulative expenditure

   ii. Subawards

   iii. Detailed information on any loans issued; contracts and grants awarded; transfers made to other government entities; and direct payments made by the recipient that are greater than $50,000. For amounts less than $50,000, the recipient must report in the aggregate for these same categories of loans issued; contracts and grants awarded; transfers made to other government entities; and direct payments made by the recipient.

Please see Treasury's Compliance and Reporting Guidance at (https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds/recipient-compliance-and-reporting-responsibilities) for more information.

State of Washington
July 1, 2021 through June 30, 2022

2022-021 The Department of Commerce did not have adequate internal controls over and did not comply with requirements to perform risk assessments for subrecipients of the Coronavirus State and Local Fiscal Recovery Funds.

Assistance Listing Number and Title:	21.027 COVID-19 Coronavirus State and Local Fiscal Recovery Funds
Federal Grantor Name:	U.S. Department of the Treasury
Federal Award/Contract Number:	SLFRP0002
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Coronavirus State and Local Fiscal Recovery Funds (SLFRF), as part of the America Rescue Plan Act of 2021, delivered $350 billion to state, local, and tribal governments to support the response to and recovery from the COVID-19 public health emergency. Washington received $4.4 billion of SLFRF money from the U.S. Department of the Treasury, which the state's Office of Financial Management allocated to state agencies for various programs. In fiscal year 2022, state agencies spent about $1.15 billion in SLFRF funds, $132 million of which was spent by the Department of Commerce.

The Department used SLFRF funds to administer and provide economic assistance to households at risk of eviction and homelessness primarily through the Eviction Rental Assistance Program (ERAP 2.0), in addition to transportation, tourism, and other pandemic-recovery projects. During fiscal year 2022, the Department expended about $109 million on payments to local governments and nonprofit organizations as subrecipients. These subrecipients were responsible for making direct payments of rent and utilities for eligible low-income households with overdue rent payments dating as far back as March 2020.

Pass-through entities are required to monitor the activities of subrecipients to ensure they are properly using federal funds for allowable activities and expenditures. To determine the

appropriate level of monitoring, federal regulations require the Department to evaluate each subrecipient's risk of noncompliance with federal statutes and regulations and the terms and conditions of the subaward.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to perform risk assessments for SLFRF subrecipients.

During the audit period, the Department awarded about $360 million in SLFRF funds to 37 subrecipients. The Department's Office of Family and Adult Homelessness, which oversees multiple housing assistance programs, delegated responsibility to individual programs to complete risk assessments of various federal and state awards and grants. All risk assessments, including ERAP 2.0, were to be completed in January 2022 for active subrecipients. Management relies on the results of these risk assessments to prioritize program and fiscal monitoring of higher-risk subrecipients to ensure expenditures are allowable and rent and utility payments are made only to eligible households.

We examined 12 of the 37 subrecipients awarded funding during the audit period to verify if the Department performed a risk assessment to determine the appropriate level of monitoring for each one. We found the Department did not perform a risk assessment for three subrecipients (25 percent). All three subrecipients received their ERAP 2.0 subawards after the Department conducted risk assessments for the subrecipients' other programs, and management did not ensure the required risk assessments were performed.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department's subrecipient monitoring controls and processes were not well-defined or monitored for effectiveness. In addition, because the Department scheduled risk assessments to be performed annually rather than at the time of the award, management did not monitor to ensure subawards executed throughout the year were properly identified and that subrecipients receiving federal funds after January 2022 would undergo a risk assessment. Management also did not implement a formal tracking process to ensure risk assessments were reviewed for appropriateness and adequately documented.

Effect of Condition

Without performing risk assessments of subrecipients that received SLFRF funding, which the federal government has classified as a program of higher risk, the Department cannot determine the appropriate amount of monitoring required for each subrecipient. Not performing new risk assessments also makes the Department less likely to detect subrecipients' noncompliance with federal regulations and the subaward's terms and conditions.

Recommendations

We recommend the Department:

- Improve its internal controls to ensure it performs risk assessments for all subawards issued to subrecipients
- Ensure it performs and documents the required risk assessments sufficiently for management to evaluate the results and demonstrate compliance with federal requirements
- Update its risk assessment procedures to ensure factors related to potential noncompliance with ERAP requirements are incorporated into the overall risk assessment result

Department's Response

The Department received a similar finding in the fiscal year 2021 Single Audit and has since implemented corrective action to ensure risk assessments for each program subrecipient is completed, even if a risk assessment for the same subrecipient was completed for a prior award.

The program had two separate program awards from the United States Department of Treasury (Treasury) which funded the same program. The Department funded the same subrecipients with each award, therefore, we felt it was a duplication of efforts to create separate risk assessments for each of the awards.

Specifically, we did not perform new risk assessments for the three Eviction Rent Assistance Program contracts (funded with Treasury Coronavirus State and Local Fiscal Recovery Funds) because we had already completed them for the Treasury Rent Assistance Program contracts (funded with Treasury Emergency Rental Assistance funds).

Moving forward, we will complete a separate risk assessment for each award even if it is for the same program and sub recipient.

We thank the State Auditor's Office for providing this guidance so the Department can comply with all subrecipient monitoring requirements.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 332, Requirements for pass-through entities, establishes the requirements for all pass-through entities.

Title 2 CFR Part 200, Uniform Guidance, section 516, Audit findings, establishes reporting requirements for audit findings.

State of Washington
July 1, 2021 through June 30, 2022

2022-022 Washington State University did not ensure that returns of Title IV funds were accurate for the Student Financial Assistance programs.

Assistance Listing Number and Title:	84.007 Federal Supplemental Educational Opportunity Grant 84.033 Federal Work-Study Program 84.038 Federal Perkins Loan Program 84.063 Federal Pell Grant Program 84.268 Federal Direct Student Loans 84.379 Teacher Education Assistance for College and Higher Education Grants
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	Various
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Return of Title IV Funds
Known Questioned Cost Amount:	$2,582

Background

As amended, Title IV of the Higher Education Act authorizes programs that provide financial assistance to students to pursue postsecondary education at eligible institutions of higher education. When students who receive Title IV grant or loan assistance withdraw from an institution during a payment period or period of enrollment, the institution must determine the amount of Title IV aid the students have earned as of their withdrawal date.

Schools calculate this by determining the percentage of program funds the students have earned and applying that percentage to the total amount of assistance that was or could have been disbursed to students for the payment period or period of enrollment as of their withdrawal date.

If the total amount of Title IV assistance earned by students is less than the amount that was disbursed to them as of their withdrawal date, the institution is required to return the difference to

the U.S. Department of Education (Department), and it cannot make any additional disbursements to students for the payment period or period of enrollment.

In fiscal year 2022, Washington State University disbursed more than $205 million in Title IV funds to students.

Description of Condition

The University did not ensure that returns of Title IV funds were accurate for the Student Financial Assistance programs.

We found the University had adequate internal controls over the return of Title IV funds, and it materially complied with the federal requirements. However, we identified questioned costs as the result of returns that were incorrectly calculated.

We used a statistical sampling method to randomly select and examine 57 out of a total population of 873 students for which the University was required to calculate a return of Title IV funds. We found two students for whom the University incorrectly calculated the amount required to be returned to the Department. Specifically:

- One student had $489 returned to the Department. When recalculating the amount required to return, we found the University should have returned $2,801, resulting in a difference of $2,312.
- The second student had $2,590 returned to the Department. When recalculating the amount required to return, we found the University should have returned $2,860, resulting in a difference of $270.

Federal regulations require the auditor to issue a finding when the known or estimated questioned costs identified in a single audit exceed $25,000. We are issuing this finding because, as stated in the Effect of Condition and Questioned Costs section of this finding, the estimated questioned costs exceed that threshold.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The University returned incorrect amounts because it did not verify that the students were eligible for all funds within their student accounts before calculating amounts and returning the Title IV funds to the Department. Staff responsible for calculating the amounts to return did not verify that loans that were never disbursed were excluded from the University's calculation of unearned aid.

Effect of Condition and Questioned Costs

We identified $2,582 in known federal questioned costs and $39,550 in likely federal questioned costs. We consider the $2,582 difference for the two students to be questioned costs because they had unearned financial aid still owed to the Department. At the time of the audit, the University had not processed a corrected return of funds for the two students.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflect this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the University:

- Verify student eligibility for all disbursed Title IV funds before calculating the amount of unearned aid required to be returned for students who have withdrawn from school
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

University's Response

Washington State University takes very seriously its responsibilities to ensure compliance with federal requirements.

The University appreciates the auditor acknowledgement that the University's internal controls over the Return of Title IV funds are adequate. The two (out of 57) records with noted exception were isolated and should not be a reflection on the whole of the program or the University's management of federal funds. These exceptions were identified by management when the records were pulled for auditor testing. Management had not made correction yet only because the audit was still in progress. Upon finding the isolated issues, management performed a review of all 873 students that fell in the audit population, performing calculations of each record to determine if there were any other errors. No errors that needed to be submitted to the Department of Education, other than the two in the test population, were noted.

The University is working with the sponsor to ensure return of the known questioned costs can be properly facilitated.

Internal processes have been further strengthened to provide for independent quality checks. A report was developed to identify and isolate anomalies, like returning more funds than were actually disbursed. The return to Title IV requirements are very complex and internal controls over compliance are regularly reviewed to ensure improvement and continued adherence to the requirements.

The University thanks the State Auditor for bringing this issue to the University's attention.

Auditor's Remarks

We thank the University for its cooperation and assistance throughout the audit. We will review the status of the University's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 34 CFR Part 668, *Student Financial Assistance General Provisions*, Section 668.14 Program participation agreement, states in part:

(b) By entering into a program participation agreement, an institution agrees that –

(24) It will comply with the requirements of §668.22;

Title 34 CFR Part 668, *Student Financial Assistance General Provisions*, Section 668.22 Treatment of title IV funds when a student withdraws, states in part:

(a) General.

(1) When a recipient of title IV grant or loan assistance withdraws from an institution during a payment period or period of enrollment in which the recipient began attendance, the institution must determine the amount of title IV grant or loan assistance that the student earned as of the student's withdrawal date in accordance with paragraph e) of this section.

(4) If the total amount of title IV grant or loan assistance, or both, that the student earned as calculated under paragraph (e)(1) of this section is less than the amount of title IV grant or loan assistance that was disbursed to the student or on behalf of the student in the case of a PLUS loan, as of the date of the institution's determination that the student withdrew–

(i) The difference between these amounts must be returned to the title IV programs in accordance with paragraphs (g) and (h) of this section in the order specified in paragraph (i) of this section; and

(ii) No additional disbursements may be made to the student for the payment period or period of enrollment.

(5) If the total amount of title IV grant or loan assistance, or both, that the student earned as calculated under paragraph (e)(1) of this section is greater than the total amount of title IV grant or loan assistance, or both, that was disbursed to the student or on behalf of the student in the case of a PLUS loan, as of the date of the institution's determination that the student withdrew, the difference between these amounts must be treated as a post-withdrawal disbursement in accordance with paragraph (a)(6) of this section and §668.164(i).

(e) Calculation of the amount of title IV assistance earned by the student –

(1) General. The amount of title IV grant or loan assistance that is earned by the student is calculated by–

(i) Determining the percentage of title IV grant or loan assistance that has been earned by the student, as described in paragraph (e)(2) of this section; and

(ii) Applying this percentage to the total amount of title IV grant or loan assistance that was disbursed (and that could have been disbursed, as defined in paragraph (l)(1) of this section) to the student, or on the student's behalf, for the payment period of period of enrollment as of the student's withdrawal date.

(2) Percentage earned. The percentage of title IV grant or loan assistance that has been earned by the student is–

(iii) Equal to the percentage of the payment period or period of enrollment that the student completed (as determined in accordance with paragraph (f) of this section) as of the student's withdrawal date, if this date occurs on or before—

(A) Completion of 60 percent of the payment period or period of enrollment for a program that is measured in credit hours; or

(B) Sixty percent of the clock hours scheduled to be completed for the payment period or period of enrollment for a program that is measured in clock hours; or

(iv) 100 percent, if the student's withdrawal date occurs after—

(A) Completion of 60 percent of the payment period or period of enrollment for a program that is measured in credit hours; or

(B) Sixty percent of the clock hours scheduled to be completed for the payment period or period of enrollment for a program measured in clock hours.

(3) Percentage unearned. The percentage of title IV grant or loan assistance that has not been earned by the student is calculated by determining the complement of the percentage of title IV grant or loan assistance earned by the student as described in paragraph (e)(2) of this section.

(4) Total amount of unearned title IV assistance to be returned. The unearned amount of title IV assistance to be returned is calculated by subtracting the amount of title IV assistance earned by the student as calculated under paragraph (e)(1) of this section from the amount of title IV aid that was disbursed to the student as of the date of the institution's determination that the student withdrew.

(g) Return of unearned aid, responsibility of the institution.

(1) The institution must return, in the order specified in paragraph (i) of this section, the lesser of—

(i) The total amount of unearned title IV assistance to be returned as calculated under paragraph (e)(4) of this section; or

(ii) An amount equal to the total institutional charges incurred by the student for the payment period or period of enrollment multiplied by the percentage of title IV grant or loan assistance that has not been earned by the student, as described in paragraph (e)(3) of this section.

State of Washington
July 1, 2021 through June 30, 2022

2022-023 The Office of Superintendent of Public Instruction did not have adequate internal controls over and did not comply with federal requirements to ensure Local Education Agencies implemented testing security measures.

Assistance Listing Number and Title:	84.010 Title I Grants to Local Educational Agencies (Title I, Part A of the Every Student Succeeds Act)
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	S101A190047–19A; S010A200047; S010A210047–21A
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Assessment System Security
Known Questioned Cost Amount:	None

Background

The Title I Grants to Local Educational Agencies (Title I, Part A) provides financial assistance to help improve the teaching and learning of children who are at risk of not meeting challenging academic standards and who reside in areas with high concentrations of children from low-income families.

The Every Student Succeeds Act (ESSA) requires states to perform annual statewide assessments in reading, language arts and mathematics to all students in grades three through eight. The ESSA also requires states to administer assessments in reading, language arts and mathematics once in high school, as well as in science at least once in reach of the grades three through five, six through nine, and 10 through 12.

The Office of Superintendent of Public Instruction administers the Title I, Part A program in Washington. The Office, in consultation with the Local Education Agencies (LEAs), establishes and maintains an assessment system that is valid, reliable and consistent with professional and

technical standards. In its assessment system, the Office has policies and procedures to maintain test security and ensure that LEAs implement them.

LEAs are required to complete a District Administration and Security Report (DASR) for each test administered. This report must be submitted to the Office no later than 10 business days after the test has been administered and the testing window has closed for the LEA.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Office did not have adequate internal controls and did not comply with federal requirements to ensure LEAs implemented testing security measures. The prior finding numbers were 2020-026 and 2021-021.

Description of Condition

The Office did not have adequate internal controls and did not comply with federal requirements to ensure LEAs implemented testing security measures.

Through manuals, training modules, tools, templates and other documents, the Office provides guidance to LEAs on how they must manage and administer assessments in compliance with the law. The Office also requires LEAs submit a DASR at the end of each testing cycle to ensure they have implemented testing security measures.

During the audit period, the Office did not address known instances of LEAs not submitting DASRs within 10 days after the testing window closed. The Office implemented new monitoring protocols in the spring of 2021. The new protocols included identifying a list of all LEAs that administered each state assessment and checking to ensure that DASRs were received for all assessments administered.

During the audit, we randomly selected 58 assessments out of 1,216 tests administered by LEAs. The Office did not receive 33 DASRs (57 percent) within 10 business days of the testing window ending. The Office pursued these unsubmitted reports from the LEAs and received 25 of the late DASRs. At the time of our testing, the Office still had not received eight DASRs (14 percent). These unsubmitted DASRs are known instances of LEA noncompliance that the Office did not correct.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

While the Office developed and implemented new monitoring protocols to track DASR submissions, they did not address instances of LEA noncompliance. The Office routinely followed up with LEAs through various forms of communication, but continued to not receive the DASRs in a timely manner.

Effect of Condition

By not properly monitoring LEAs, the Office cannot ensure that the school districts are following testing security policies and procedures.

Recommendation

We recommend the Office address LEAs' test security noncompliance to ensure they have implemented testing security measures.

Office's Response

The Office will continue to communicate with LEAs, as it has documented to the SAO. In addition, the Office will begin direct communication with every LEA once per week for four weeks leading up to the end of the test administration window and then once per week for three weeks after the end of the test administration window. This communication will remind each LEA to provide DASR reports for all tests administered in the spring.

Once the Office receives the annual final list in August of all tests administered by each LEA, it will be able to narrow its focus and send out weekly reminders to LEAs beginning in mid-August.

If the Office has not received completed DASRs by mid-September, a management decision has been established for non-compliance. This management decision is a letter that will be sent to each district Superintendent from the Office's Assistant Superintendent of Assessment and Student information, informing them of their assessment office's non-compliance.

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 20 U.S. Code §6311 – State plans, states in part:

(b) Challenging academic standards and academic assessments

(2) ACADEMIC ASSESSMENTS.—

(A) IN GENERAL.—Each State plan shall demonstrate that the State educational agency, in consultation with local educational agencies, has implemented a set of high-quality student academic assessments in mathematics, reading or language arts, and science. The State retains the right to implement such assessments in any other subject chosen by the State.

(B) REQUIREMENTS — The assessments under subparagraph (A) shall—

(i) except as provided in subparagraph (D), be—

(I) the same academic assessments used to measure the achievement of all public elementary school and secondary school students in the State; and

(II) administered to all public elementary school and secondary school students in the State;

(ii) be aligned with the challenging State academic standards, and provide coherent and timely information about student attainment of such standards and whether the student is performing at the student's grade level;

(iii) be used for purposes for which such assessments are valid and reliable, consistent with relevant, nationally recognized professional and technical testing standards, objectively measure academic achievement, knowledge, and skills, and be tests that do not evaluate or assess personal or family beliefs and attitudes, or publicly disclose personally identifiable information;

(iv) be of adequate technical quality for each purpose required under this Act and consistent with the requirements of this section, the evidence of which shall be made public, including on the website of the State educational agency;

(v)(I) in the case of mathematics and reading or language arts, be administered—

(aa) in each of grades 3 through 8; and

(bb) at least once in grades 9 through 12;

(II) in the case of science, be administered not less than one time during—

(aa) grades 3 through 5;

(bb) grades 6 through 9; and

(cc) grades 10 through 12; and

(III) in the case of any other subject chosen by the State, be administered at the discretion of the State;

(vi) involve multiple up-to-date measures of student academic achievement, including measures that assess higher-order thinking skills and understanding which may include measures of student academic growth and may be partially delivered in the form of portfolios, projects, or extended performance tasks;

(vii) provide for—

(I) the participation in such assessments of all students;

(II)the appropriate accommodations, such as interoperability with, and ability to use, assistive technology, for children with disabilities (as defined in section 602(3) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(3))), including students with the most significant cognitive disabilities, and students with a disability who are provided accommodations under an Act other than the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), necessary to measure the academic achievement of such children relative to the challenging State academic standards or alternate academic achievement standards described in paragraph (1)(E); and

(III) the inclusion of English learners, who shall be assessed in a valid and reliable manner and provided appropriate accommodations on assessments

> administered to such students under this paragraph, including, to the extent practicable, assessments in the language and form most likely to yield accurate data on what such students know and can do in academic content areas, until such students have achieved English language proficiency, as determined under subparagraph (G);

The Professional Standards and Security, Incident, and Reporting Guidelines (PIRG) established by the Office states in part:

> After testing, it is the LEA's responsibility to complete a District Administration and Security Report for each test administration. This report has check boxes of responsibilities. Include an explanation of boxes checked "no" and notation of any missing or damaged materials. As required, submit the report to OSPI through ARMS no later than five business days after completion of each test administration.

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-024 The Charter School Commission did not have adequate internal controls over and did not comply with requirements to ensure charter schools with relationships to charter management organizations were monitored for conflicts of interest.

Assistance Listing Number and Title:	84.010 Title I Grants to Local Educational Agencies (Title I, Part A of the Every Student Succeeds Act)
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	S101A190047-19Al; S010A200047; S010A210047-21A
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Oversight and Monitoring Responsibilities with Respect to Charter Schools with Relationships with Charter Management Organizations
Known Questioned Cost Amount:	None

Background

The Title I Grants to Local Educational Agencies (Title I, Part A) provides financial assistance to help improve the teaching and learning of children who are at risk of not meeting challenging academic standards and who reside in areas with high concentrations of children from low-income families.

The Washington State Charter School Commission is the main authorizer of charter public schools in Washington. The Commission provides monitoring and oversight of charter schools, holding them accountable for administering education and use of funds. The Commission was formed following the passage of Initiative 1240 by state voters in 2012, which established the charter public school system in Washington.

The Commission is responsible for overseeing and monitoring charter schools that have relationships with charter management organizations (CMOs) to ensure they comply with federal regulations and the terms and conditions of the subaward. There are two CMOs in Washington. Each CMO is comprised of three different charter schools and one charter board that oversees all charter schools collectively.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Commission did not have adequate internal controls over and did not comply with requirements to ensure charter schools with relationships to CMOs were monitored for conflicts of interest.

The Commission provides guidance and oversight to charter schools in the state through the use of contracts, reporting requirements and charter board meeting review. Each board member of a charter school must submit an F-1 Personal Financial Affairs Disclosure form to the Public Disclosure Commission (PDC). During the audit period, the Commission did not review the F-1 forms that had been submitted to the PDC by charter board members for either of the charter management organizations.

While the Commission informs charter schools of the requirement to submit F-1 forms to the PDC, and routinely attends board meetings of charter schools with CMOs to make note of conflicts of interest, they did not review each board member’s F-1 forms to determine whether conflicts of interest existed.

We consider this internal control deficiency to be a material weakness which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Commission was unaware of the federal requirement to monitor charter schools for conflicts of interest and financial risks.

Effect of Condition and Questioned Costs

Without reviewing the financial disclosures of board members, the Commission cannot ensure it is aware of, and can address, any conflicts for a charter school with a relationship with a CMO in a timely manner.

Recommendation

We recommend the Commission review financial disclosures of charter board members to ensure that conflicts of interest can be monitored.

Commission's Response

Thank you for giving the Commission the opportunity to respond to the proposed finding relating to the April 2022 Federal Compliance Supplement regarding Federal Title I funds. The Commission looks forward to implementing the changes recommended by the Auditor in order to strengthen and improve oversight of charter public schools. The Commission will reach out to OSPI regarding future information sharing regarding the federal funds that OSPI administers, and matters that may require additional action by the Commission. However, the Commission disagrees with the Auditor's position that a finding is warranted for the 2021-2022 audit year for the reasons below.

Under the Charter School Act (CSA), state and federal funds are received and distributed by OSPI to charter public schools, not the Commission. RCW 28A.710.220. OSPI is also required to "adopt rules necessary for the distribution of funding required by this section and to comply with federal reporting requirements. RCW 28A.710.280. This is consistent with state law establishing OSPI as the state agency authorized to accept and administer federal education funds for Washington State. RCW 28A.300.070. See, for example: Title I, Part A Fiscal Requirements and Guidance | OSPI (www.k12.wa.us). The Commission has no authority over or role in managing federal funds.

In the April 2022 Federal Compliance Supplement, the guidance makes a distinction between a charter public school that is an LEA under a covered program or a charter public school that is within an LEA under a covered program. Compliance Supplement 2022, 4-84.000-25. Also see, 4-84.000-28 ("Auditors should also note that, depending upon state law, a public charter school may be its own LEA or a school that is part of a traditional LEA."). The distinction impacts which entity is subject to the obligations, as does the entity that is responsible for allocating funds:

> ***If a state considers a charter school to be an LEA under a covered program, this requirement applies to the SEA or other state agency responsible for allocating funds under that program—*** *either by formula or through a competition—to LEAs. If a state considers a charter school to be a public school within an LEA under a covered program, this requirement applies to the LEA.* ***The requirements in this Supplement address an SEA's responsibilities with respect to eligible charter school LEAs****. An LEA that is responsible for providing funds under a covered program to eligible charter schools must comply with these requirements on the same basis as an SEA.*
>
> *Compliance Supplement 2022, 4-84.000-25 (emphasis added).*

Under the CSA, a charter school is an LEA for purposes of federal law (but not state law). RCW 28A.710.020(4) states that a charter public school:

> ***Functions as a local education agency under applicable federal laws and regulations and is responsible for meeting the requirements of local education agencies and public schools under those federal laws and regulations,*** *including but not limited to compliance with the individuals with disabilities education improvement act (20 U.S.C. Sec. 1401 et seq.), the federal educational rights and privacy act (20 U.S.C. Sec. 1232g), the McKinney-Vento homeless assistance act of 1987 (42 U.S.C. Sec. 11431 et seq.), and the elementary and secondary education act (20 U.S.C. Sec.6301 et seq.).*

RCW 28A.710.020(4) (emphasis added). Based on the fact that charter public schools in Washington are LEAS for purposes of federal law, the requirements as written apply to the SEA responsible for allocating funds which would be OSPI. Because of the status of charter public school as an LEA for purposes of federal law, the "Compliance Requirements" obligations fall to the SEA under the guidance, when the distinction between a charter school as an LEA under federal law (as in Washington) vs. a charter public school within an LEA are considered:

> ***Compliance Requirements*** *As grantees, SEAs/LEAs are responsible for overseeing and monitoring subrecipients, including charter schools with relationships with Charter Management Organizations (CMOs). . . .*
>
> *Compliance Supplement 2022, 4-84.000-28 (strikethrough added). Also see, 4-84.000-25, above.*

In addition, the CSA specifically addresses where charter public school boards are required to file their financial disclosure statements:

> *(2) Members of a charter school board must file personal financial affairs statements* ***with the public disclosure commission.***
>
> *RCW 28A.710.290(2) (emphasis added).*

The Commission is ready to implement the additional oversight requirements identified by the Auditor. However, the Commission believes that based on the analysis above, a finding against the Commission is not warranted. The April 2022 Federal Compliance Supplement, along with Washington law, indicate that the compliance obligations under these federal programs do not apply to the Commission given the status of charter public schools as LEAs for purposes of federal law, and OSPI's authority over the receipt and distribution of federal funds. Moving forward, the Commission will add the review of the financial disclosure statements of school board members to its oversight process.

Auditor's Remarks

The Commission asserts it does not have the responsibility to monitor the charter schools for this requirement and instead it is the responsibility of the SEA, which is OSPI. Our work in this area started with inquiry with OSPI, but we were directed to the Commission and reviewed RCW 28A.710.070 which states, in part:

> (1) The Washington state charter school commission is established as an independent state agency whose mission is to authorize high quality charter public schools throughout the state, especially schools that are designed to expand opportunities for at-risk students, and to ensure the highest standards of accountability and oversight for these schools.

It is our opinion that the RCW established the Commission as an independent state agency whose scope of responsibility includes this requirement.

The Commission also states that they have no authority or role in the management of federal funds. We agree with this assertion. However, this special test and provision does not require the Commission to administer Title I funds, but rather oversee the risk posed by charter schools with relationships to CMOs, pertaining specifically to conflict of interest, segregation of duties, and related party transactions.

While the CSA specifically addresses where charter public school boards are required to file their financial disclosure statements, this special test and provision requires that the Commission, as the agency responsible for administering these requirements, review financial disclosures of charter board members to ensure that conflicts of interest can be monitored.

We reaffirm our finding and will follow up on the status of the Commission's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 34 CFR Part 75, Subpart E – Conflict of Interest, 525 Conflict of Interest: Participation in a Project states:

> (a) A grantee may not permit a person to participate in an administrative decision regarding a project if:
>
> (1) The decision is likely to benefit that person or a member of his or her immediate family; and
>
> (2) The person
>
> (i) Is a public official; or
>
> (ii) Has a family or business relationship with the grantee.

(b) A grantee may not permit any person participating in the project to use his or her position for a purpose that is – or gives the appearance of being – motivated by a desire for a private financial gain for that person or others.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-025 The Office of Superintendent of Public Instruction did not have adequate controls over and did not comply with requirements to ensure it met the earmarking requirements for the Special Education program.

Assistance Listing Number and Title:	84.027 Special Education Grants to States (IDEA, Part B) 84.027 COVID-19 Special Education Grants to States (IDEA, Part B) 84.173 Special Education-Preschool Grants (IDEA Preschool) 84.173 COVID-19 Special Education-Preschool Grants (IDEA Preschool)
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	H027A190074 - 19A; H027A200074 - 20A; H027A210074 - 21A; H027X210074; H173A190074; H173A200074; H173A210074; H173X210074
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Earmarking
Known Questioned Cost Amount:	$188,873

Background

The Individuals with Disabilities Education Act's (IDEA) Special Education Grants to States program (IDEA, Part B) provides grants to states, and through them to local educational agencies (LEAs), to help provide special education and related services to eligible children with disabilities. IDEA's Special Education Preschool Grants program (IDEA Preschool), also known as the "619 program," provides grants to states, and through them to LEAs, to assist with providing special education and related services to children with disabilities ages 3 through 5 and, at a state's discretion, to 2-year-old children with disabilities who will turn 3 during the school year.

The Office of Superintendent of Public Instruction administers the Special Education program in Washington and serves about 143,000 eligible students. The program provides specially designed instruction that addresses students' unique needs. The Office offers the program at no cost to parents, and it includes the related services students need to access their educational program. The Office spent about $264 million in federal IDEA grant funds during fiscal year 2022, and passed about $260 million of that funding through to LEAs and educational service districts (ESDs).

IDEA, Part B identifies the amount of funds the Office must distribute to its LEAs on a formula basis, as well as the amount it can set aside for administration and other state-level activities. The Office was awarded $8,375,301 for the fiscal year 2020 IDEA Preschool Grant. From this award, $2,205,322 was earmarked to be spent on state-level activities. This state-level activity is split between administrative costs of up to $441,064 and other state-level activities for the remaining amount.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Office did not have adequate internal controls over and did not comply with requirements to ensure it met the earmarking requirements for the program.

During the audit period, the Office did not accurately track expenditures for administration and other state-level activities. For the life of the grant, the Office spent $156,773 on administrative costs, which allowed for a maximum of $2,048,548 to be spent on other state-level activities. The Office spent $2,237,421 on other state-level activities, which exceeded the maximum by $188,873. As a result, we are questioning the $188,873 as unallowable state-level costs.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The recommended earmarks were established, but the Office did not address identified variances in the spending plan for them. This was due in part to the program having changes in management that led to inconsistencies in tracking expenditures of the earmarked funds.

Effect of Condition and Questioned Costs

Without adequate internal controls, the Office cannot ensure that it meets the grant's earmarking requirements. By not complying with the grant's earmarking requirements, the Office improperly spent $188,873 on activities that exceeded the allowable earmarked amount.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Office:

- Improve internal controls to ensure it does not exceed the maximum allowable amounts that are earmarked for administration and other state-level activities
- Consult with the federal grantor to discuss whether the questioned costs identified in the audit should be repaid

Office's Response

When special education fiscal leadership transitioned in 2021, the incoming director identified necessary changes in agency procedures for closing out the fiscal year for special education. Since that time, the following internal controls have been fully implemented to ensure spending plans do not exceed the maximum allowable amounts earmarked for administration and other state-level activities:

1. *At the beginning of the fiscal year, the Director of Operations/Budget Analysis meet to review the criteria for spending plans.*
2. *Copies of GAN and Grants to States Summary Table and Preschool Grants to States Summary Table are shared with the Budget Analysis.*
3. *Director of Operations/Budget Analysis meet to review the GAN and Grants to States Summary Table and Preschool Grants to States Summary Table.*
4. *Director of Operations/Budget Analysis meet to review spending plan and update the maximum allowable amounts earmarked for administration and other state-level activities in the spending plan.*
5. *Maximum allowable amounts earmarked for administration and other state-level activities are reviewed throughout the fiscal year.*
6. *Director of Operations/Budget Analysis meet weekly to review spending plan.*
7. *Spending Plan updated as requests are received.*
8. *Monthly expenditure reports are produced and during weekly meetings, Director of Operations/Budget Analysis review expenditures.*

These internal controls have contributed to increased communication and partnership between the Director of Operations/Budget Analysis. With implementing these consistent controls, we can ensure that maximum allowable amounts that are earmarked for administration and other state-level activities will meet compliance.

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 34 CFR Part 300*, Assistance to States for the Education of Children with Disabilities,* states in part:

Section 300.812 Reservation for State activities, states:

(a) Each State may reserve not more than the amount described in paragraph (b) of this section for administration and other State-level activities in accordance with §§ 300.813 and 300.814.

(b) For each fiscal year, the Secretary determined and reports to the SEA an amount that is 25% of the amount the State received under section 619 of the Act for fiscal year 1997 cumulatively adjusted by the secretary for each succeeding fiscal year by the lesser of –

(1) The percentage increase, if any, from the preceding fiscal year in the State's allocation under section 619 of the Act; or

(2) The rate of inflation, as measured by the percentage increase, if any, from the preceding fiscal year in the Consumer Price Index for All Urban Consumers, published by the Bureau of Labor Statistics to the Department of Labor.

Section 300.813 State administration, states:

(a) For the purpose of administering section 619 of the Act (including the coordination of activities under Part B with the Act with, and providing technical assistance to, other programs that provide services to children with disabilities), a State may use not more than 20 percent of the maximum amount the State may reserve under § 300.812 for any fiscal year.

(b) Funds described in paragraph (a) of this section may also be used for the administration of Part C of the Act.

Section 300.814 Other State-level activities.

Each State must use any funds the State reserves under § 300.812 and does not use for administration under § 300.813 –

(a) For support services (including establishing and implementing the mediation process required by section 615€ of the Act), which may benefit children with disabilities younger than three or older than five as long as those services also benefit children with disabilities aged three through five;

(b) For direct services for children eligible for services under section 619 of the Act;

(c) For activities at the State and local levels to meet the performance goals established by the State under section 612(a)(15) of the Act;

(d) To supplement other funds used to develop and implement a statewide coordinated services system designed to improve results for children and families, including children with disabilities and their families, but not more than one percent of the amount received under section 619 of the Act for a fiscal year;

(e) To provide early intervention services (which must include an educational component that promotes school readiness and incorporates preliteracy, language, and numeracy skills) in accordance with Part C of the Act to children with disabilities who are eligible for services under section 619 of the Act and who previously received services under Part C of the Act until such children enter, or are eligible under State law to enter, kindergarten; or

(f) At the State's discretion, to continue service coordination or case management for families who receive services under Part C of the Act, consistent with § 300.814(e).

State of Washington
July 1, 2021 through June 30, 2022

2022-026 The Office of Superintendent of Public Instruction did not have adequate internal controls to ensure it performed risk assessments for subrecipients of the Special Education program.

Assistance Listing Number and Title:	84.027 Special Education Grants to States (IDEA, Part B) 84.027 COVID-19 Special Education Grants to States (IDEA, Part B) 84.173 Special Education Preschool Grants (IDEA Preschool) 84.173 COVID-19 Special Education-Preschool Grants (IDEA Preschool)
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	H027A190074 - 19A; H027A200074 - 20A; H027A210074 - 21A; H027X210074; H173A190074; H173A200074; H173A210074; H173X210074
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Individuals with Disabilities Education Act's (IDEA) Special Education Grants to States program (IDEA, Part B) provides grants to states, and through them to local educational agencies (LEAs), to help provide special education and related services to eligible children with disabilities. IDEA's Special Education Preschool Grants program (IDEA Preschool), also known as the "619 program," provides grants to states, and through them to LEAs, to assist with providing special education and related services to children with disabilities ages 3 through 5 and, at a state's discretion, to 2-year-old children with disabilities who will turn 3 during the school year.

The Office of Superintendent of Public Instruction administers the Special Education program in Washington and serves about 143,000 eligible students. The program provides specifically designed instruction that addresses a student's unique needs. The Office offers the program at no cost to parents, and it includes the related services students need to access their educational program. The Office spent about $264 million in federal IDEA grant funds during fiscal year 2022, and it passed about $260 million of that funding through to LEAs and all nine educational service districts (ESDs).

Federal law requires the Office to evaluate each subrecipient's risk of noncompliance with federal statues, regulations, and the terms and conditions of the subaward for determining the appropriate amount and type of subrecipient monitoring.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Office did not have adequate internal controls over requirements to perform risk assessments for the program's subrecipients. The prior finding number was 2021-023.

Description of Condition

The Office did not have adequate internal controls to ensure it performed risk assessments for subrecipients of the Special Education program. As a result, the Office did not perform risk assessments for the nine ESDs that received program funding during the audit period.

We consider this internal control deficiency to be a significant deficiency.

Cause of Condition

In response to the prior year audit finding, the Office provided training to ESDs on how to submit monitoring documentation. It also updated the ESD contracts to reflect monitoring activities that would start during the 2022-2023 school year. Since the Office did not plan to start monitoring until the following school year, it did not perform risk assessments of any ESDs that received program funding during the audit period.

Effect of Condition

Without conducting risk assessments, management cannot ensure the Office performs the appropriate amount of monitoring to ensure subrecipients comply with program requirements. Further, without appropriate levels of subrecipient monitoring, the Office cannot have reasonable assurance that federal requirements are being met.

Recommendation

We recommend the Office establish and follow adequate internal controls to ensure it performs the required risk assessments, which would allow management to evaluate the results, monitor subrecipients appropriately, and demonstrate compliance with federal requirements.

Office's Response

Initial Implementation Actions Completed to Date:

In April 2022 OSPI Special Education revised and expanded the form package submitted by Educational Service Districts (ESDs), including the required end of year reporting. ESDs are required to respond to the following questions, but are not limited to:

a. *Contracts/Procurement: Did the ESD/subrecipient contract for services? List the planned contractors and the services provided. Describe the procurement process implemented by the ESD.*
b. *Time & Effort: Describe the ESD's process to ensure payroll charges are accurate, allowable, and properly allocated to federal programs, and how the ESD ensures time and effort is received from employees in a timely manner. Provide a Payroll Distribution Report from which OSPI will request supporting documents for selected employees.*
c. *Professional Development: Provide supporting evidence such as, agendas, sign-in sheets, electronic invitations, etc., related to professional development provided by the ESD using federal funds.*
d. *End of Year Expenditures: Upload an end of year expenditure report to verify allowable expenditures.*

Based on the results from monitoring activities, ESDs will be selected for additional monitoring and may be subject to an onsite visit if determined necessary.

The Fiscal Monitoring Procedures Handbook for Educational Service Districts has been finalized March 2023.

Timeline for Full Implementation:

- *February 1, 2024: Last day for ESDs to upload required documentation.*
- *February 2024: Finalize review of required documents. Issue Report to ESDs that identify any Actions Required or Actions Recommended.*
- *March 2024: Final reports issued no later than 60 calendar days after the ESD review.*

Auditor's Remarks

We thank the Office for its cooperation and assistance throughout the audit. We will review the status of the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, section 332, Requirements for pass-through entities, establishes the requirements for all pass-through entities.

State of Washington
July 1, 2021 through June 30, 2022

2022-027 The Office of Financial Management did not have adequate internal controls over and did not comply with federal level of effort requirements for the Education Stabilization Fund program.

Assistance Listing Numbers and Titles:	84.425D COVID-19 Elementary and Secondary School Emergency Relief Fund (ESSER) 84.425R COVID-19 Coronavirus Response and Relief Supplemental Appropriations Act, 2021 – Emergency Assistance to Non-Public Schools (CRRSA EANS) 84.425U COVID-19 American Rescue Plan – Elementary and Secondary School Emergency Relief (ARP ESSER) 84.425V COVID-19 American Rescue Plan – Emergency Assistance to Non-Public Schools (ARP EANS)
Federal Grantor Name:	U.S. Department of Education
Federal Award/Contract Number:	S425D210015; S425R210012; S425U210015; S425V210012
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Level of Effort
Known Questioned Cost Amount:	None

Background

The U.S. Department of Education distributed funding to multiple federal subprograms of the Education Stabilization Fund (ESF). Beginning in March 2020, Congress set aside the Elementary and Secondary School Emergency Relief (ESSER) Fund to address the effect that COVID-19 has had, and continues to have, on elementary and secondary schools across the nation. Several rounds of funding were distributed to states under the ESF program, each with the intent to support public and non-public schools. The U.S Department of Education awarded ESF grants to the Office of Financial Management (Office), which then dispersed funds to the Office of Superintendent of

Public Instruction for pass through to Local Education Agencies (LEAs). In fiscal year 2022, the state spent more than $1.15 billion in ESF federal funding.

The ESF program included a level of effort requirement to ensure states provided a minimum level of funding to LEAs based on prior years. Under the American Rescue Plan Act, ESF recipients were required to meet a proportional amount of their state's support for elementary and secondary education relative to their overall spending, averaged over fiscal years 2017, 2018 and 2019.

The Legislature included a proviso with ESF funding that instructed the Office to coordinate with the Office of Superintendent of Public Instruction and legislative fiscal staff from the House of Representatives Office of Program Research and Senate Committee Services on the data, quantification, and report required to seek from the U.S. Department of Education a waiver to the state's level of effort requirement.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Office did not have adequate internal controls over and did not comply with federal level of effort requirements for the ESF program.

The Office performed the calculations required to monitor the level of effort requirements for the ESF program, and determined that the fiscal year 2022 expenditures did not meet the level of effort requirement.

When compared to overall state spending, the average of state spending on elementary and secondary education for fiscal years 2017, 2018 and 2019 totaled 49.25 percent. The state was required to spend at least this percentage toward education in fiscal year 2022. However, the state only expended 46.85 percent of total state spending on education, meaning the level of effort requirement was not met by approximately 2.5 percent, or $725,311,449.

Once the Office determined the state did not meet the level of effort requirement, it submitted a waiver request to the U.S. Department of Education in accordance with the Legislature's proviso. However, the U.S. Department of Education did not approve waivers for any state during the audit period, and the Office's waiver request is still pending.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

In response to the effects of the COVID-19 pandemic, the Legislature approved a state budget that spent proportionally more on social supports like food, rent and medical services than in prior

years. Further, state revenues declined due to restrictions included in the Governor's pandemic-related emergency proclamations that were intended to slow the spread of COVID-19. These changes, as well as directives to achieve state spending reductions, resulted in not meeting the ESF program's level of effort requirement because the state budget allocated less funding to elementary and secondary education than the average of the previous three fiscal years.

Effect of Condition

By not establishing adequate internal controls, the Office cannot ensure the state is meeting the federal level of effort requirement for the ESF program. In addition, receiving a waiver from the U.S. Department of Education for this requirement is not guaranteed. By not complying with federal requirements, the Office risks having to repay federal funds or having future federal funds withheld.

Recommendations

We recommend the Office:

- Consult with the grantor to discuss the pending waiver request and the next steps it should take
- Consult with the appropriate state-level authority to ensure the state maintains the level of effort required to comply with federal law

Office's Response

The Office of Financial Management (OFM) does not concur with the finding and maintains that there are adequate internal controls in place to ensure compliance with federal requirements.

OFM performed the maintenance of effort (MOE) calculations in accordance with the guidance provided by U.S. Department of Education (ED). Based on appropriations and past funding, it was determined that the fiscal year 2022 expenditures did not meet the MOE requirement. OFM followed the federal guidance and direction from a legislative proviso in the enacted state budget (Chapter 334, Laws of 2021, Sec. 954) and submitted a waiver request on ED's MOE Waiver Request Form for FY22 and FY23. The submission date was before ED's stipulated deadline of December 31, 2021. ED's website confirmed an MOE waiver request was received from Washington State and the status of the request is currently listed as "under review." OFM followed all federal and state requirements with due diligence in requesting the waiver. The approval process rests with the federal grantor, and the waiver has not been disapproved.

In addition, OFM has been meeting with ED on a monthly basis since October 2022 and is already consulting with the grantor regarding the pending waiver request. OFM will also continue to work with the Legislature, which is the state-level authority for state appropriations.

Auditor's Remarks

While we understand the Office submitted a request to the U.S. Department of Education to waive the maintenance of effort requirement during the audit period, unless and until the waiver is approved, the State is noncompliant with federal law. The submission of a waiver request does not guarantee its approval. In addition, the reason the waiver was requested was the State did not have sufficient internal controls to ensure it complied with federal law prior to expending the federal award.

We reaffirm our finding, and we will follow up on the Office's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (CRSSA Act) Sec. 317.

> (a) At the time of award funds to carry out sections 312 or 313 of this title, a State shall provide assurances that such State will maintain support for elementary and secondary education (which shall include State funding to institutions of higher educations and state need-based financial aid, and shall not include support for capital projects or for research and development or tuition fees paid by students) in fiscal year 2022 at least at the proportional levels of such State's support for elementary and secondary educations and for higher education relative to such State's overall spending, averaged over fiscal years 2017, 2018, and 2019.
> (b) The Secretary may waive the requirement in subsection (a) for the purpose of relieving the fiscal burdens on State that have been experienced a precipitous decline in financial resources.

The American Rescue Plan Act, Section 2004. Maintenance of Effort and Maintenance of Equity, states in part:

(a) State Maintenance of Effort. –
   1. In general.–As a condition of receiving funds under sections 2001, a State shall maintain support for elementary and secondary education, and for higher education (which shall

include state funding to institutions of higher education and State need-based financial aid, and shall not include support for capital projects or for research and development or tuition and fees paid by students), in each of fiscal years 2022 and 2023 at least at the proportional levels of such state's support for elementary and secondary education and for higher education relative to such State's overall spending, averaged over fiscal years 2017, 2018 and 2019.

2. Waiver.—For the purpose of relieving fiscal burdens incurred by States in preventing, preparing for, and responding to the coronavirus, the Secretary of Education may waive any maintenance of effort requirements associated with the Education Stabilization Fund.

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-028 The University of Washington did not establish adequate internal controls to ensure payments to contractors and subrecipients for the Global AIDS program were allowable, properly supported and within the period of performance.

Assistance Listing Number and Title:	93.067 Global AIDS 93.067 COVID-19 Global AIDS
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	NU2GGH001430; NU2GGH001968; NU2GGH002038; NU2GGH002116; NU2GGH002242; NUGGH002360; NU2GGH002157; NU2GGH002298; NU2GGH002374
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Period of Performance
Known Questioned Cost Amount:	None

Background

The Global AIDS program is a federal initiative focused on treating and preventing the transmission of HIV/AIDS around the world. The program is authorized by Sections 307 and 317(k)(2) of the Public Health Service Act, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Acts of 2003 and 2008, and the U.S. President's Emergency Plan for AIDS Relief.

Since it was established in 2003, the federal government has invested more than $100 billion in the global HIV/AIDS response, providing testing and treatment for millions of people, preventing transmission among affected communities, and supporting numerous countries to achieve HIV

epidemic control. The program distributes funding through public and private sector partnerships to reach the populations most vulnerable to HIV/AIDS epidemics.

The University of Washington administers this grant for the state through its International Training and Education Center for Health (I-TECH). I-TECH is a center in the University's Department of Global Health operated by more than 2,000 staff in offices located in Africa, Asia, the Caribbean, Eastern Europe and the United States.

In fiscal year 2022, the University spent more than $66 million in federal program funds, about $44 million of which it passed through to subrecipients.

To achieve the performance goals of the program, the Seattle headquarters of I-TECH (Seattle HQ) provides funding to subrecipients and contractors. Invoices submitted by contractors directly to Seattle HQ are reviewed and approved for payment by budget managers who have delegated authority from the Principal Investigator. Invoices submitted by subrecipients are reviewed and approved for payment by a Principal Investigator. Principal Investigators are also responsible for monitoring the subrecipient's technical progress and performance.

Seattle HQ also provides funding to country offices operating within the University's global network. The country offices incur costs associated with furnishing supplies and equipment to address the HIV/AIDS epidemic, as well as staffing resources and acquiring goods and services from contractors to carry out the objectives of the program. Payments made by country offices are approved by Country Directors and Country Representatives as delegated by the University. Under the University's policies, country offices are reimbursed for locally incurred expenses at least monthly. An invoice, accompanied by a schedule of expenses incurred, is submitted and approved by the Country Director and then by the Director of Finance at Seattle HQ, prior to payment. Country offices also responsible for obtaining and retaining supporting documentation for costs incurred and paid on each project.

Monthly, Budget Managers review and approve a Budget Activity Report (BAR) that details the expenses charged to the project for the previous month to ensure accurate posting of already approved expenses. This review is also to determine whether the work performed during the billing period reconciles to costs claimed within the contractor's invoice so that payment may be authorized.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The University did not have adequate internal controls to ensure payments to contractors and subrecipients of the Global AIDS program were allowable properly supported and within the period of performance.

Payments to country offices

We used a statistical sampling method to randomly select and examine 58 out of 1,644 transactions for country offices.

Of the 58 payments examined, we identified one payment (1.7 percent) that was not approved by the Country Director and the corresponding Budget Activity Report was not approved by the Director of Finance.

Payments to contractors

We used a statistical sampling method to randomly select and review 58 out of 3,040 payments to contractors. We found:

- Invoices for three payments (5 percent) were not approved by a Budget Manager
- Monthly Budget Activity Reports were not approved for 12 payments (20 percent)

Subrecipient reimbursements

We used a statistical sampling method to randomly select and review 55 out of 438 payments to subrecipients. We found the assigned Budget Manager did not review and approve the monthly Budget Activity Reports for 52 payments (94 percent).

We consider these internal control deficiencies to be a material weakness.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Program management did not require supporting documentation for each payment to be forwarded to and reviewed by headquarters personnel prior to payment authorization. Management also did not monitor the submission of invoices and Budget Activity Reports to ensure they were approved by the responsible Budget Manager, as required.

Effect of Condition

Without establishing adequate internal controls, the University cannot reasonably ensure it is using federal funds for allowable purposes and that expenditures of federal funds are supported by adequate documentation.

Recommendations

We recommend the University:

- Improve its internal controls to ensure invoices are properly approved by Principal Investigators, as required
- Improve its internal controls to ensure Budget Mangers review and approve monthly Budget Activity Reports before authorizing payments for projects incurring reimbursement requests
- Ensure it retains supporting documentation sufficient to show costs incurred and paid by the program are allowable, and to demonstrate the required managerial reviews have occurred prior to issuing payment

University's Response

In response to the findings for the Global Aids Program, we would like to clarify the following:

General Clarification: The draft finding inaccurately represents the role of BARS approvals as part of the internal controls to ensure payments to country offices, contractors and subrecipients are allowable, properly supported and within the period of performance. This is not the role of the BARS review process. Compliance, Budget Manager and PI reviews are the controls that ensure allowability of payments and BARS approvals are after-the-fact validations of accurate posting of already approved expenditures. We provided edits to the Background section to reflect our process. We request in light of this that the description of condition, cause of condition and recommendation sections of this finding be updated accordingly.

Payments to country offices

I-TECH country offices are not contractors; the offices are an extension of the University of Washington. Your review identified one of fifty-eight samples (1.7%) did not meet the approval requirements set forth in I-TECH's standard operating procedure. Based on the error percentage, we disagree with this finding.

Payments to contractors

Payments to contractors have multiple approvals. Upon receipt, individual invoices are approved by the program/budget manager either by signature or email. Invoices are then sent to the I-TECH Accounts Payable Administrator for input to the University's procurement system, ARIBA, which requires compliance approval from the Accounts Payable Supervisor or other manager, as well as funding approval from the budget manager prior to payment. Approvals of Budget Activity Reports (BARS) are not approval of individual payments to contractors, they are reviews of the monthly expenses posted to the budget and the program manager's concurrence that the expenses are as expected.

The exceptions noted were payments made to country offices instead of contractors. The support for approvals were provided to the State Auditors on April 26, 2023, prior to the completion of

fieldwork. We therefore disagree with this finding. We also request that the finding be adjusted to omit the 20% of missing BARS approvals as this is not related to the contractor payments.

Subrecipient reimbursements

Each subrecipient invoice is reviewed for reasonableness, allowability and allocability by the contracts manager and approved by both budget managers and principal investigators prior to being processed for payment in ARIBA. PI approvals were provided and verified for each subrecipient selection with no omissions noted by the auditors. Approvals of Budget Activity Reports (BARS) are not approval of individual payments to subrecipients, they are after-the-fact reviews of the monthly expenses posted to the budget, intended as documentation of the program manager's concurrence that the expenses are posted as expected.

We acknowledge the instances detailed in the finding where we were unable to produce related BARS approvals for 52 of the transactions; however, we request that the finding be adjusted as these BARS approvals are not related to subrecipient invoice review and approvals.

Our record keeping process for BARS approvals was to save the emails in a folder within our Finance Team mailbox. We learned during this review that emails beyond a certain date are deleted but maintained in the MS360 file. We've searched for the missing BARS approvals but have not yet been able to locate them. We have since begun saving the approvals to our server to ensure we have access to the data going forward.

Auditor's Remarks

The University's I-TECH Global Operations Manual stipulates that BARs will be generated, reviewed and approved monthly by the Budget Manager and management team. This information was provided to our Office as part of the University's overall design of internal controls over payments to contractors, subrecipients and country offices.

The University responded to our Office on April 20, 2023 adding that "BAR review is the University's key post payment control designed to ensure charges are accurately processed, coded and allowable on the budget charged." We interpret this response to indicate the BAR review process is a monitoring control, and the University asserted on multiple occasions this is a key internal control, which is why we tested it. On January 5, our Office notified University management in writing that the BAR review process would be tested as a key control over the cost principles and period of performance requirements for Global AIDS expenditures. We received no additional inquiry or concerns from University management regarding this internal control until the draft finding was issued on April 14.

We provided the University with a final written summary of our fieldwork in this area on April 6, 2023, after fieldwork had concluded. On April 7, the Finance Director responded to our Office in writing confirming they had no further questions or concerns regarding our testing results. It was

not until after the University received this finding that additional documentation supporting expenditures tested during the audit were ultimately given to our Office.

The basis for this audit finding is the key internal control failure rate of BAR approvals that exceeds our established materiality threshold of five percent, and constitutes a material weakness in internal control, which under the Uniform Guidance is required to be reported as an audit finding in accordance with 2 CFR 200.516 – *Audit findings*.

We reaffirm our finding and will follow up on the University's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

The University of Washington's Policies, Procedures and Guidance (UW Research), *GIM 02 – Acceptance of Sponsored Program Awards and Fiscal Compliance on Sponsored Program Accounts (Budget Numbers)*, states in part:

> Responsibilities
>
> **Principal Investigator**
>
> - Supervises expenditure of sponsored program funds and approves sub-recipient invoices (see GIM 8) to assure:
>   - That funds are used only for purposes that directly relate to and benefit the activity supported in the award.
>   - That expenditures are consistent with all special terms, conditions, or limitations that apply to expenditures under the particular grant or contract.
>   - That expenditures do not exceed the total funds authorized for a given period under the grant or contract.

GIM 07 – Sponsored Program Subaward Administration, states in part:

> **Principal Investigator**
>
> - Review and approve subaward invoices.

GIM 08 – Subrecipient Monitoring, states in part:

> Roles & Responsibilities
>
> **PI / Department Responsibilities**
>
> Project level monitoring of subrecipient including:
>
> - Reviews that expenses are necessary, reasonable, and allocable to the work completed and are aligned with technical progress.
> - Approve invoices for payment.
>
> **Subrecipient Monitoring – Project Level**
>
> Subrecipient invoices are reviewed and approved in accordance with the requirements of GIM 2 in the manner and frequency stated in the subaward.

The University of Washington *I-TECH Global Operations Manual* (GRef 2.3), Section 2, Finance, Accounting Policy and Procedure Requirements, states in part:

> In addition to the Fiscal Guidelines set forth in the I-TECH Field Operations Manual, these country specific policies are implemented at I-TECH.
>
> 10. Budget Management and Reporting
>
> f. Reports that show the variance between the budget plan and the activity for each region and activity code will be generated, reviewed and approved by the budget managers and the Management Team each month.

State of Washington
July 1, 2021 through June 30, 2022

2022-029 The University of Washington did not have adequate internal controls over and did not comply with requirements to ensure it filed reports required by the Federal Funding Accountability and Transparency Act.

Assistance Listing Number and Title:	93.067 Global AIDS 93.067 COVID-19 Global AIDS
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	NU2GGH001430; NU2GGH001968; NU2GGH002038; NU2GGH002116; NU2GGH002242; NUGGH002360; NU2GGH002157; NU2GGH002298; NU2GGH002374
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Global AIDS program is a federal initiative focused on treating and preventing the transmission of HIV/AIDS around the world. The program is authorized by Sections 307 and 317(k)(2) of the Public Health Service Act, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Acts of 2003 and 2008, and the U.S. President's Emergency Plan for AIDS Relief.

Since it was established in 2003, the federal government has invested more than $100 billion in the global HIV/AIDS response, providing testing and treatment for millions of people, preventing transmission among affected communities, and supporting numerous countries to achieve HIV epidemic control. The program distributes funding through public and private sector partnerships to reach the populations most vulnerable to HIV/AIDS epidemics.

The University of Washington administers this grant for the state through its International Training and Education Center for Health (I-TECH). I-TECH is a center in the University's Department of Global Health operated by more than 2,000 staff in offices located in Africa, Asia, the Caribbean, Eastern Europe and the United States.

In fiscal year 2022, the University spent more than $66 million in federal program funds, about $46.4 million of which it awarded to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Act), the Department is required to collect and report information on each subaward of federal funds more than $30,000. The University must report subawards by the end of the month following the month in which it made the subaward or subaward amendment. The intent of the Act is to empower citizens with the ability to hold the federal government accountable for spending decisions and, as a result, reduce wasteful government spending.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The University did not have adequate internal controls over and did not comply with requirements to ensure it filed reports required by the Act.

During the audit period, the University was required to report 18 subawards totaling about $46 million of program funds that it awarded to 10 subrecipients. The University generates subawards and subaward modifications using information from its Sponsored Projects Administration and Electronic Research Compliance (SPAERC) system.

We randomly selected seven of the 18 subawards required to be reported during the audit period. We found the University failed to report one subaward (14 percent) totaling $113,353 in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS).

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

The issue was not reported as a finding in the prior audit.

Cause of Condition

The University uses SPAERC to identify and monitor active subawards and subaward modifications for the Global AIDS program. However, OSP does not currently use SPAERC data to generate external reports to identify subawards and subaward modifications that require

reporting in FSRS. During the audit period, staff responsible for submitting the required reports manually searched the system for related transactions to report during the audit period.

In addition, management did not review FSRS submissions and compare the information to SPAERC to ensure all required information was reported.

Effect of Condition

Failing to submit the required reports diminishes the federal government's ability to ensure accountability and transparency of federal spending. The terms and conditions of the federal award allow the grantor to penalize the University for noncompliance by suspending or terminating the federal award or withholding future awards.

Recommendations

We recommend the University:

- Establish effective internal controls to ensure reports are submitted, as required
- Ensure management monitors reporting of this information to ensure future reports are submitted completely and accurately

Department's Response

The University acknowledges that we neglected to submit one FFATA report related to one Global AIDS program subaward modification during the audit period. We have since submitted that report.

The University believes that we already have solid and effective controls in place related to FFATA reporting. We have reviewed all subaward actions (new subawards and modifications) for the Global AIDS program during the audit period and have verified that no additional reports were missed.

Please note that per federal regulations, UW submits FFATA reports as required for all financial actions under 1st tier subawards once the threshold has first been met for a particular subaward. This generally results in multiple FFATA reports for a single subaward, with each monetary subaward action (new subawards and modifications) under direct federal funding requiring reporting once the threshold has been met. This results in a large volume of FFATA reports each month. Reporting for the Global AIDS project is handled along with all other FFATA reporting for subawards under the University's federal awards.

We acknowledge that our current processes can be improved through better use of the data in SPAERC. Upon receipt of the final FY2022 audit report (scheduled for June 2023) the University will design a report to assist in the identification and review of FFATA-reportable actions. Due to the timing, implementation of this report will not occur until FY2024.

Auditor's Remarks

We thank the University for its cooperation and assistance throughout the audit. We will review the status of the University's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 170, *Reporting Subaward and Executive Compensation Information*, states in part:

> Appendix A to Part 170 – Award Term
>
> I. Reporting Subawards and Executive Compensation
>
> a. Reporting of first-tier subawards.
>
> 1. *Applicability*. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that equals or exceeds $30,000 in Federal funds for a subaward to a non-Federal entity or Federal agency (see definitions in paragraph e. of this award term).
>
> 2. *Where and when to report*.
>
> i. The non-Federal entity or Federal agency must report each obligating action described in paragraph a.1. of this award term to https://www.fsrs.gov.
>
> ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)
>
> 3. *What to report*. You must report the information about each obligating action that the submission instructions posted at https://www.fsrs.gov specify.

State of Washington
July 1, 2021 through June 30, 2022

2022-030 The University of Washington did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Global AIDS program received required single or program-specific audits, and that it followed up on findings and issued management decisions.

Assistance Listing Number and Title:	93.067 Global AIDS 93.067 COVID-19 Global AIDS
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	NU2GGH001430; NU2GGH001968; NU2GGH002038; NU2GGH002116; NU2GGH002242; NUGGH002360; NU2GGH002157; NU2GGH002298; NU2GGH002374
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Global AIDS program is a federal initiative focused on treating and preventing the transmission of HIV/AIDS around the world. The program is authorized by Sections 307 and 317(k)(2) of the Public Health Service Act, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Acts of 2003 and 2008, and the U.S. President's Emergency Plan for AIDS Relief.

Since it was established in 2003, the federal government has invested more than $100 billion in the global HIV/AIDS response, providing testing and treatment for millions of people, preventing transmission among affected communities, and supporting numerous countries to achieve HIV epidemic control. The program distributes funding through public and private sector partnerships to reach the populations most vulnerable to HIV/AIDS epidemics.

The University of Washington administers this grant for the state through its International Training and Education Center for Health (I-TECH). I-TECH is a center in the University's Department of Global Health operated by more than 2,000 staff in offices located in Africa, Asia, the Caribbean, Eastern Europe and the United States.

In fiscal year 2022, the University spent more than $66 million in federal program funds, about $44 million of which it passed through to subrecipients.

Federal regulations require the University to monitor its subrecipients' activities. This includes verifying that its subrecipients that spend $750,000 or more in federal awards during a fiscal year obtain a single or program-specific audit. For the Global AIDS program, the Centers for Disease Control and Prevention requires foreign subrecipients to submit their audits directly to the federal government and pass-through entity within 30 days after receiving the auditor's report or nine months after the end of the subrecipient's audit period, whichever is earlier.

Additionally, for the awards it passes onto its subrecipients, the University must follow up and ensure the subrecipients take timely and appropriate corrective action on all deficiencies identified through audits. When a subrecipient receives an audit finding for a University-funded program, federal law requires the University to issue a management decision to the subrecipient within six months of the audit report's acceptance by the federal government. The management decision must clearly state whether the audit finding is sustained, the reason for the decision, and the actions the subrecipient is expected to take, such as repaying unallowable costs or making financial adjustments. These requirements help ensure subrecipients use federal program funds for authorized purposes and within the provisions of contracts or grant agreements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The University did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Global AIDS program received required single or program-specific audits, and that it appropriately followed up on findings and issued management decisions.

We found the University did not have adequate internal controls in place to verify whether:

- Subrecipients received required audits, if necessary, and appropriate remedies were taken if audits were not filed
- Management decisions were required to be issued for subrecipients who required a single or program-specific audit

We used a nonstatistical sampling method to randomly select and examine seven out of a total population of 21 subrecipients. We found the University did not adequately monitor one subrecipient (14 percent) to ensure it received a required single or program-specific audit.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Staff in the University's Office of Sponsored Programs (OSP) used a spreadsheet to track subrecipient certifications and responses, and reviewed annual certifications from the subrecipient to monitor its audit status. However, OSP did not correctly interpret the subrecipient's response and, therefore, did not require it to provide documentation of a single or program-specific audit.

Additionally, management did not review the subrecipient's federal assistance expenditures to detect that it required an audit and, therefore, also failed to adequately follow up to ensure any reported findings were resolved with appropriate corrective action, if required.

Effect of Condition

Without establishing adequate internal controls, the University cannot ensure all subrecipients that required a single or program-specific audit received one. Furthermore, the University cannot ensure it is following up on subrecipient audit findings and communicating required management decisions to subrecipients. By failing to ensure subrecipients establish corrective actions and management monitors them for effectiveness where required, the University cannot determine whether subrecipients have sufficiently corrected issues identified in audit findings.

Recommendations

We recommend the University:

- Follow policies and procedures to ensure subrecipients receive required single or program-specific audits
- Establish and follow effective internal controls to ensure it reviews audit reports for its subrecipients and issues written management decisions, as required
- Ensure subrecipients develop and perform acceptable corrective actions to adequately address all audit recommendations
- Follow up with the subrecipient to ensure the required audit reports are received and reviewed to determine if the subrecipient is required to take corrective action to address audit recommendations
- Issue a written management decision for all applicable audit findings, if necessary

University's Response

The University of Washington has established internal controls to carry out a risk assessment per Uniform Guidance, 2 CFR § 200.332, Requirements for pass-through entities, and our UW Grants Information Memorandum (GIM) 8. This involves using various factors to assess risk. Part of our process to obtain the information needed from each subrecipient is through a certification process. The certification was obtained from the subrecipient, along with additional documentation from the subrecipient, such as an audited financial statement. We made a risk assessment using our standard risk criteria. We did misinterpret the response provided from the subrecipient regarding whether it expended $750,000 or more in federal awards during a fiscal year in order to obtain a single or program-specific audit from this subrecipient. While this was not obtained and reviewed, a risk assessment using our standard criteria was performed with the subrecipient rated as a medium risk, and subject to monitoring throughout the project, per GIM 8. The monitoring at the program level occurred during the period in question.

We will be improving our required communications with subrecipients to have clear questions and responses regarding whether the subrecipient expended $750,000 or more in federal awards during the fiscal year in order to obtain a single or program-specific audit, follow up with the subrecipient to ensure the required audit reports are received and reviewed to determine if the subrecipient is required to take corrective action to address audit recommendations, and issue a written management decision for all applicable audit findings, if necessary.

Auditor's Remarks

We thank the University for its cooperation and assistance during the audit.

Whether the University performed a risk assessment for the subrecipient is not being questioned. The University did not adequately monitor the subrecipient to ensure it detected whether the subrecipient was required to receive a single audit, or program-specific audit in accordance with 2 CFR §200.332(f). There is no other mechanism for the Federal government to monitor subrecipients of the University and, because a single audit of the subrecipient was not performed, neither the federal grantor nor the University had reasonable assurance of the subrecipient's compliance with federal award requirements.

We reaffirm our finding and will follow up on the status of the University's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, establishes the following applicable requirements:

Section 200.332 Requirements for pass-through entities, states in part:

All pass-through entities must:

(d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. Pass-through entity monitoring of the subrecipient must include:

(2) Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award provided to the subrecipient from the pass-through entity detected through audits, on-site reviews, and written confirmation from the subrecipient, highlighting the status of actions planned or taken to address Single Audit findings related to the particular subaward.

(3) Issuing a management decision for applicable audit findings pertaining only to the Federal award provided to the subrecipient from the pass-through entity as required by § 200.521.

(4) The pass-through entity is responsible for resolving audit findings specifically related to the subaward and not responsible for resolving crosscutting findings. If a subrecipient has a current Single Audit report posted in the Federal Audit Clearinghouse and has not otherwise been excluded from receipt of Federal funding (e.g., has been debarred or suspended), the pass-through entity may rely on the subrecipient's cognizant audit agency or cognizant oversight agency to perform audit follow-up and make management decisions related to cross-cutting findings in accordance with section § 200.513(a)(3)(vii). Such reliance does not eliminate the responsibility of the pass-through entity to issue subawards that conform to agency and award-specific requirements, to manage

risk through ongoing subaward monitoring, and to monitor the status of the findings that are specifically related to the subaward.

(f) Verify that every subrecipient is audited as required by Subpart F of this part when it is expected that the subrecipient's Federal awards expended during the respective fiscal year equaled or exceeded the threshold set for the in §200.501 Audit requirements.

Section 200.339 Remedies for noncompliance, states:

If a non-Federal entity fails to comply with the U.S. Constitution, Federal statutes, regulations or the terms and conditions of a Federal award, the Federal awarding agency or pass-through entity may impose additional conditions, as described in § 200.208. If the Federal awarding agency or pass-through entity determines that noncompliance cannot be remedied by imposing additional conditions, the Federal awarding agency or pass-through entity may take one or more of the following actions, as appropriate in the circumstances:

(a) Temporarily withhold cash payments pending correction of the deficiency by the non-Federal entity or more severe enforcement action by the Federal awarding agency or pass-through entity.

(b) Disallow (that is, deny both use of funds and any applicable matching credit for) all or part of the cost of the activity or action not in compliance.

(c) Wholly or partly suspend or terminate the Federal award.

(d) Initiate suspension or debarment proceedings as authorized under 2 CFR part 180 and Federal awarding agency regulations (or in the case of a pass-through entity, recommend such a proceeding be initiated by a Federal awarding agency).

(e) Withhold further Federal awards for the project or program.

(f) Take other remedies that may be legally available.

Section 200.501 Audit requirements, states in part:

(a) Audit required. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

(b) Single audit. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single audit conducted in accordance with § 200.514 except when it elects to have a program-specific audit conducted in accordance with paragraph (c) of this section.

Section 200.521 Management decision, states in part:

(a) General. The management decision must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. If the auditee has not completed corrective action, a timetable for follow-up should be given. Prior to issuing the management decision, the Federal agency or pass-through entity may request additional information or documentation from the auditee, including a request for auditor assurance related to the documentation, as a way of mitigating disallowed costs. The management decision should describe any appeal process available to the auditee. While not required, the Federal agency or pass-through entity may also issue a management decision on findings relating to the financial statements which are required to be reported in accordance with GAGAS.

(c) Pass-through entity. As provided in § 200.332(d), the pass-through entity must be responsible for issuing a management decision for audit findings that relate to Federal awards it makes to subrecipients.

(d) Time requirements. The Federal awarding agency or pass-through entity responsible for issuing a management decision must do so within six months of acceptance of the audit report by the FAC. The auditee must initiate and proceed with corrective action as rapidly as possible and corrective action should begin no later than upon receipt of the audit report.

(e) Reference numbers. Management decisions must include the reference numbers the auditor assigned to each audit finding in accordance with § 200.516(c).

The University of Washington's Policies, Procedures and Guidance (UW Research), *GIM 8 – Subrecipient Monitoring*, states in part:

Background

Additionally, per the Federal Uniform Guidance, UW must evaluate each subrecipients' risk of noncompliance with federal regulations, include specific terms and conditions in the subaward as necessary, and monitor the activities of the subrecipient through various mechanisms. These mechanisms include: Training and technical assistance to subrecipients, on-site reviews, review of audit results, increased reporting requirements and enforcement action, if necessary.

University Policy

UW reviews each subrecipient entity according to an entity level comprehensive risk assessment prior to the issuance of a subaward. This risk assessment includes an entity level review of their fiscal systems, past audit activity, and if required, financial statements of the entity as well as the project specific activity proposed and that the required

compliance approvals are obtained. When necessary, UW imposes limitations and requirements on the subrecipient through subaward terms and conditions per Federal Uniform Guidance, Section 200.521, prior to the issuance or renewal of a subaward.

UW's subrecipient monitoring requirements are comprised, at a minimum, of the following:

- Completion of the UW's entity level comprehensive risk assessment (Certs & Reps, Annual Audit Certification)

Subrecipient Monitoring – Entity Level

Entity level monitoring consists of a combination of the following:

- Initial Subrecipient Certification Form completion and assurance by subrecipient's authorized official
- Annual audit assurance through an annual audit certification form
- Maintenance of a subrecipient profile list, which includes information on the entity's past audit information and certifications
- Risk assessment carried out at each annual renewal of a subaward

State of Washington
July 1, 2021 through June 30, 2022

2022-031 The Department of Health did not have adequate internal controls over and did not comply with requirements to ensure payments to providers were allowable, met cost principles, and were within the period of performance for the Immunization Cooperative Agreements program.

Assistance Listing Number and Title:	93.268 Immunization Cooperative Agreements 93.268 COVID-19 Immunization Cooperative Agreements
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	5 NH23IP922619-03-00; 6 NH23IP922619-03-01; 6 NH23IP922619-03-02; 6 NH23IP922619-02-01; 6 NH23IP922619-02-02; 6 NH23IP922619-02-03; 6 NH23IP922619-02-04; 6 NH23IP922619-02-06
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Period of Performance
Known Questioned Cost Amount:	$4,287,159

Background

The Department of Health administers the Immunization Cooperative Agreements program, which aims to reduce and ultimately eliminate vaccine-preventable diseases by increasing and maintaining high immunization coverage. Emphasis is placed on populations at highest risk for underimmunization and disease, including children eligible under the Vaccines for Children program. In fiscal year 2022, the Department spent more than $44.2 million in federal program funds, about $14.2 million of which it disbursed to subrecipients. The Department also received more than $94.5 million in non-cash assistance from the federal grantor in the form of vaccines.

To help carry out the program's objectives, the Department issues consolidated contracts to Local Health Jurisdictions that are classified as subrecipients. A consolidated contract is for one subrecipient that combines funding for multiple federal programs.

Subrecipients are awarded federal funds on a reimbursement basis only. The Department assigns each subrecipient a risk level based on standardized criteria, and it maintains a matrix that specifies the documentation that subrecipients at each risk level are required to submit with every reimbursement. There are varying requirements among low, moderate and high-risk subrecipients for each of the following expense categories:

- Salaries and benefits
- Equipment ($5,000 or more)
- Materials, supplies, and other
- Travel (in-state and out-of-state)
- Contracts and sub-subrecipients
- Administrative/indirect costs

The Department's Fiscal Monitoring Unit (FMU) also conducts fiscal reviews of each subrecipient to review source documentation to ensure payments are for allowable activities and within the period of performance.

During the audit period, subrecipients submitted invoices to the Department's accounting unit where staff, on a weekly basis, compiled a list of all consolidated contract invoices into one email. The emails were sent to Department program staff requesting review to ensure the payment was allowable and within the period of performance. The emails consisted of 30 to 50 invoice requests with hundreds of pages of supporting documentation. Each invoice listed in the email would be considered approved if program staff did not respond. To address concerns about an invoice, program staff were required to email the accounting unit within 10 business days to withhold payment until the items in question were resolved.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure payments to providers were allowable, met cost principles, and were within the program's period of performance.

Department program staff used the documentation matrix when reviewing subrecipient payments to ensure they were for allowable activities, met cost principles, were within the period of performance, and included required supporting documentation. However, program staff did not document their review or approval, so we were unable to determine if the proper reviews occurred.

During the audit period, the FMU conducted a fiscal monitoring review for four subrecipients that received program funds. We reviewed the fiscal monitoring activity for all four subrecipients and determined none of the four reviews included a detailed transaction review of program payments to ensure they had adequate supporting documentation.

We used a statistical sampling method to randomly select and review 55 out of 432 provider payments. Additionally, we judgmentally reviewed two individually significant payments that exceeded $1.2 million each. In total, we examined more than $9.3 million in provider payments as part of the audit. Of the 57 payments examined, we identified 27 payments that did not have the required supporting documentation for the subrecipients' assigned risk level. This included one of the individually significant payments.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department's established procedures allowed for paying providers without ensuring program staff reviewed and determined the payment was allowable, within the grant's period of performance, and adequately supported. Furthermore, program management did not ensure staff followed the existing review procedures.

In addition, management had not established guidance for how many transactions a fiscal reviewer needed to review to source documentation in order to have assurance the program funds were spent in accordance with grant requirements. Management also did not ensure transactions selected for review by the FMU represented all subawards issued to the subrecipient.

Effect of Condition and Questioned Costs

Without establishing adequate internal controls, the Department cannot reasonably ensure it is using federal funds for allowable purposes. By not ensuring subrecipients submitted required supporting documentation, staff could not adequately verify the reimbursement claims, and the Department could not ensure its subrecipients complied with the subaward's terms and conditions.

The 27 payments for which the Department did not have required supporting documentation from subrecipients totaled $4,287,159 in known questioned costs. Based on these results, we estimate that the total amount of likely improper payments using federal funds to be $5,503,611.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However,

the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3). To ensure a representative sample, we stratified the population by dollar amount.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Improve internal controls to ensure that it obtains adequate supporting documentation from subrecipients before reimbursing them
- Improve internal controls to ensure program staff review and approve expenditures to verify they are for allowable activities and within the period of performance prior to payment
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

We appreciate the State Auditor's Office (SAO) audit of the Immunization Cooperative Agreement. The Department is committed to ensuring our programs comply with federal regulations and understand that it is SAO's point of view that we did not have adequate controls over provider payments to ensure allowability in meeting cost principles and meeting period of performance.

The Department partially agrees with SAO's findings. The Department does agree and has already taken steps to improve internal controls over ensuring payments to providers contain support in line with our A-19 matrix and risk assessed of our subrecipients. Immunization staff who review invoices have been provided additional training and tracking sheets have been developed which enables staff to record details from backup documentation reviews. This ensures the proper level of review is completed and aligns with the agency's A-19 documentation matrix. We will also be addressing the control weakness identified with the consolidated contract payment process and documenting our review and approval by program staff to ensure allowability and that funds were spent within the period of performance.

It should be noted that the current process over provider payments at the Department of Health has been in place for well over a decade and has been through several annual audits by the State Auditor's Office and separate federal reviews by our federal funders without issue. The defined process of consolidated contract payments was in response to issues arising with timely payment of funds to our local government partners. The consolidated contracts are an essential tool in providing such funding on a large scale. This process balances many needs in tracking payments, providing documentation to the programs for review as well as allowing for timely distribution of

funding to the local health jurisdictions (LHJs) for state and federal programs in order to serve the residents of the State of Washington. It also simplifies the invoicing and payment process as well as reconciliation between DOH and the LHJs.

We would also note that for the exceptions identified with the Fiscal Monitoring Unit (FMU) visits, for all four reviews the totality of costs charged to Immunizations during the scope of those reviews were for staffing costs. FMU test staffing as a centralized function to determine if appropriate internal controls are being utilized to ensure costs are reasonable, necessary, allowable, and allocable. During review of these agencies, FMU did not find any instances of unallowable salary costs for time keeping samples that were tested.

We would respectfully disagree with the number of exceptions and questioned costs identified. While the level of support did not meet our internal policies, which are held to a higher standard than federal requirements, the level of documentation received from the subrecipient accounting system gave us assurance that the transactions/costs questioned met federal cost principles for allowability and period of performance. This, along with the following additional overall internal monitoring and policy processes support our overall assurance of the allowability of payments:

- *Program staff maintain detailed budget information for each subrecipient by project area, and as A-19s are submitted, program and accounting staff update budget spreadsheets. When reviewing the support provided by the subrecipient, they ensure amounts submitted by project are reasonable and are in alignment with expectations for the budget period submitted.*
- *The immunization program refers to the federal Immunization Program Operations Manual (IPOM) to determine allowable costs, purchase, and procurement procedures. This information is available to all subrecipients.*
- *FMU provides technical assistance and training, not only to program staff, but to the subrecipients while onsite and at the request of the entities receiving funding.*
- *Program staff provide technical assistance, policies, and training to Immunization subrecipients related to both allowability and compliance as it relates to programmatic processes.*

As a compensating control, each subrecipient of federal funds receive a monitoring visit from our Fiscal Monitoring Unit (FMU) once every two years. During the course of these visits monitoring staff perform walk-throughs and assessments of the internal controls surrounding the A19 payment process. They select the most recent three A19's submitted for funding and review all charges to appropriate source documentation to ensure allowability using cost principles as a basis.

Auditor's Remarks

Department management has implemented procedures to ensure adequate documentation is reviewed to support reimbursement requests from subrecipients receiving federal funds. Our testing was based on these documentation requirements, but we do not agree that these requirements are higher than the Uniform Guidance requires. We found that payments were made without the required level of support to ensure they were allowable and met cost principles.

The Department asserts that the fiscal monitoring performed every two years compensates for the lack of adequate documentation. However, we found the fiscal monitoring transaction level review for payroll and vendor reimbursement requests did not include a review of any Immunization program payments and therefore gave no assurance that grant funds were spent on allowable activities and were adequately supported.

We reaffirm our finding, and we will follow up on the status of the Department's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 403, Factors affecting allowability of costs, describes the general criteria in order for a cost to be allowable under federal awards, including being adequately documented.

Washington State Department of Health A-19 Documentation Matrix

Approved by FMU 11/30/20

This is the backup documentation required based on the determined risk level. Please ensure the *detailed* GL expenditure report clearly aligns with the A19 form. **More supporting documentation may be requested by programs at any time due to programmatic requirements regardless of risk category.**

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
Salaries and Benefits	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked Note: Salaries and benefits must be broken out as separate line items.	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked Note: Salaries and benefits must be broken out as separate line items.	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked AND • Time Sheets for all staff direct charging to the award Note: Salaries and benefits must be broken out as separate line items.
Equipment **($5,000 or more)**	A-19 and a *detailed* GL expenditure report that provides vendor name and amount **Note:** Pre-approval documentation must be provided	A-19 and a *detailed* GL expenditure report that provides vendor name, amount AND • Item Description **Note**: Pre-approval documentation must be provided	A-19 and a *detailed* GL expenditure report that provides vendor name, amount, item description AND • Invoice • Supporting documentation reflecting authorizing official's approval.

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
Materials, Supplies, and Other	A-19 and a *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item **Note**: If the entity has a petty cash fund, they must supply 100% of the supporting documentation.	A-19 and a *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item AND Invoices for transactions over $1,000 **Note**: If the entity has a petty cash fund, they must supply 100% of the supporting documentation.	A-19 and *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item AND Invoices for transactions over $200. **Note**: If the entity has a petty cash fund, they must supply 100% of the supporting documentation
Travel	A-19 and a *detailed* GL expenditure report that provides: • Employee name **Note:** Pre-approval documentation from DOH for any **out of state** travel must be provided.	A-19 and a *detailed* GL expenditure report that provides: • Employee name AND • Travel expense form* • All itemized receipts * Travel expense form should include employee signature, supervisor approval and purpose.	A-19 and a *detailed* GL expenditure report that provides: • Employee name • Travel expense form* • All itemized receipts AND Pre-approval required for any flights and overnight stays. *Travel expense form should include employee signature, supervisor approval and purpose.

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
		Note: Pre-approval documentation from DOH for any **out of state** travel must be provided.	**Note:** Pre-approval documentation from DOH for **any out of state** travel must be provided.
Contracts and Sub-Subrecipients	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name AND • Invoices for individual transactions over $1,000.00	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name AND • Invoices for individual transactions over $200.00.

NOTE:

Indirect costs included on A19s **must** include verification of the following:

- Indirect plan is current and on file with DOH
- Indirect rate is being applied accurately to allowable expenditures
- If the indirect cost rate plan has expired, no indirect costs can be charged

State of Washington
July 1, 2021 through June 30, 2022

2022-032 The Department of Health did not have adequate internal controls to ensure it filed accurate and timely reports required by the Federal Funding Accountability and Transparency Act for the Immunization Cooperative Agreements program.

Assistance Listing Number and Title:	93.268 Immunization Cooperative Agreements 93.268, COVID-19 Immunization Cooperative Agreements
Federal Grantor Name:	Department of Health and Human Services
Federal Award/Contract Number:	5NH23IP922619-03-00; 6NH23IP922619-03-01; 6NH23IP922619-03-02; 6NH23IP922619-02-01; 6NH23IP922619-02-02; 6NH23IP922619-02-03; 6NH23IP922619-02-04; 6NH23IP922619-02-06
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Health administers the Immunization Cooperative Agreements program. The objective of the program is to reduce and ultimately eliminate vaccine-preventable diseases by increasing and maintaining high immunization coverage. Emphasis is placed on populations at highest risk for underimmunization and disease, including children eligible under the Vaccines for Children (VFC) program. In fiscal year 2022, the Department spent more $44.2 million in federal program funds, approximately $14.2 million of which it disbursed to subrecipients. The Department also received more than $94.5 million in non-cash assistance from the federal grantor in the form of vaccines.

Under the Federal Funding Accountability and Transparency Act (Act), the Department is required to collect and report information on each subaward of federal funds more than $25,000 in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS). For federal awards issued on or after November 12, 2020, the monetary threshold for reporting increased to $30,000. The Department must report subawards by the end of the month following the month in which it made the subaward (or subaward amendment). The intent of the Act is to

empower citizens with the ability to hold the federal government accountable for spending decisions and, as a result, reduce wasteful government spending.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls to ensure it filed accurate and timely reports required by the Act.

During the audit period, the Department reported approximately $45 million of program funds that it awarded to 65 subrecipients. The Department's process for filing FFATA reports started with a fiscal analyst maintaining a spreadsheet throughout the month with the subaward information required for reporting. The fiscal analyst prepared and submitted the report each following month, and then emailed management to notify them the report was submitted. However, neither Department staff or management reviewed the reports for accuracy and completeness.

We consider this internal control deficiency to be a material weakness.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department does not require a review of FFATA reports before or after submitting them. Department officials said the purpose of the monthly email from the fiscal analyst is to inform management when a report has been finalized and uploaded, and it is not a request for managerial review.

Effect of Condition

Without requiring a review of the reports, management cannot ensure the Department is submitting accurate, complete and timely reports. To test for compliance with the Act, we randomly selected 12 of the 65 subawards obligated during state fiscal year 2022. We found the following:

- Eleven (92 percent) of the 12 subawards incorrectly reported the subaward obligation date.
- One (8 percent) of the 12 subawards was not reported timely.

Failing to submit complete, accurate and timely reports diminishes the federal government's ability to ensure accountability and transparency of federal spending. The terms and conditions of the federal award allow the grantor to penalize the Department for noncompliance by suspending or terminating the federal award, or withholding future awards.

Recommendation

We recommend the Department establish and follow effective internal controls, including a review, to ensure FFATA reports are accurate and complete before submitting them.

Department's Response

We appreciate the State Auditor's Office audit of the immunization grant. DOH is committed to ensuring our programs comply with federal regulations. We understand that it is SAO's point of view that we are not in compliance with FFATA reporting requirements. We will review our processes and determine when a review is most effective to ensure accuracy and completeness of FFATA submissions. Management has already addressed the obligation dates to ensure we're reporting the execution date of the award or amendment.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 170, *Reporting Subaward and Executive Compensation Information,* states in part:

Appendix A to Part 170 – Award Term

I. Reporting Subawards and Executive Compensation

a. Reporting of first-tier subawards.

1. *Applicability*. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that equals or exceeds $30,000 in Federal funds for a subaward to a non-Federal entity or Federal agency (see definitions in paragraph e. of this award term).

2. *Where and when to report*.

i. The non-Federal entity or Federal agency must report each obligating action described in paragraph a.1. of this award term to https://www.fsrs.gov.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. *What to report*. You must report the information about each obligating action that the submission instructions posted at https://www.fsrs.gov specify.

State of Washington
July 1, 2021 through June 30, 2022

2022-033 The Department of Health did not have adequate internal controls over and did not comply with fiscal monitoring requirements to ensure subrecipients of the Epidemiology and Laboratory Capacity for Infectious Diseases program only used funds for allowable activities and met cost principles.

Assistance Listing Number and Title:	93.323 Epidemiology and Laboratory Capacity for Infectious Diseases 93.323 COVID-19 Epidemiology and Laboratory Capacity for Infectious Diseases
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award Number:	NU50CK000515-01-00; NU50CK000515-01-06; NU50CK000515-01-07; NU50CK000515-01-08; NU50CK000515-01-09; NU50CK000515-02-00; NU50CK000515-02-01; NU50CK000515-02-03; NU50CK000515-02-04; NU50CK000515-02-06; NU50CK000515-02-07; NU50CK000515-02-09; NU50CK000515-03-00; NU50CK000515-03-01; NU50CK000515-03-03
Pass-through Entity:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Subrecipient Monitoring
Known Questioned Cost Amount:	$1,644,873

Background

The Department of Health administers the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) program. The goal of the program is to support state, local, and territories' public health efforts to reduce morbidity and associated deaths caused by a wide range of infectious disease threats. ELC provides annual funding, strategic direction, and technical assistance to domestic jurisdictions for strengthening core capacities in epidemiology, laboratory, and health information systems activities. In addition to strengthening core infectious disease capacities nationwide, the program also supports several specific infectious disease programs and projects and provides special appropriations in response to infectious disease emergencies. The Department spent almost $330 million in federal grant funds in fiscal year 2022, about $103 million of which it disbursed to subrecipients.

To help carry out the program's objectives, the Department issues consolidated contracts to Local Health Jurisdictions that are classified as subrecipients. A consolidated contract is for one subrecipient that combines funding for multiple federal programs.

Subrecipients are awarded federal funds on a reimbursement basis only. The Department assigns each subrecipient a risk level based on standardized criteria, and it maintains a matrix that specifies the documentation that subrecipients at each risk level are required to submit with every reimbursement. There are varying requirements among low, moderate and high-risk subrecipients for each of the following expense categories:

- Salaries and benefits
- Equipment ($5,000 or more)
- Materials, supplies, and other
- Travel (in-state and out-of-state)
- Contracts and sub-subrecipients
- Administrative/indirect costs

The Department's Fiscal Monitoring Unit (FMU) also conducts fiscal reviews of each subrecipient every two years to review source documentation to ensure payments are for allowable activities. A fiscal reviewer completes a standardized template to document what federal programs and reimbursement payment samples are reviewed. The fiscal reviewer judgmentally determines how many samples to test.

During the audit period, subrecipients submitted invoices to the Department's accounting unit where staff, on a weekly basis, compiled a list of all consolidated contract invoices into one email. The emails were sent to Department program staff requesting review to ensure the payment was allowable. The emails consisted of 30 to 50 invoice requests with hundreds of pages of supporting documentation. Each invoice listed in the email would be considered approved if program staff did not respond. To address concerns about an invoice, program staff were required to email the

accounting unit within 10 business days to withhold payment until the items in question were resolved.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure payments to providers were allowable and met cost principles.

Department program staff were required to use the documentation matrix when reviewing subrecipient payments to ensure they were for allowable activities, met cost principles, and included required supporting documentation. However, program staff did not document their review or approval to the accounting unit that issues payment, so we were unable to determine if the proper reviews occurred.

We used a statistical sampling method to randomly select and review 57 out of 880 provider payments. Additionally, we judgmentally reviewed three individually significant payments that exceeded $5.5 million each. In total, we examined more than $75.4 million in provider payments as part of the audit. Of the 57 randomly selected payments examined, we identified four payments (7 percent) that did not have the required supporting documentation for the subrecipients' assigned risk level.

For fiscal monitoring, we used a nonstatistical sampling method to randomly select and examine five out of a total of eight subrecipients that received a review during the audit period. We found that none of the detailed transactions reviewed were noted as being for the ELC program.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department's established procedures allowed for paying providers without ensuring program staff reviewed and determined the payment was allowable and adequately supported. Furthermore, program management did not ensure staff followed the existing review procedures.

In addition, management had not established guidance for how many transactions a fiscal reviewer needed to review to source documentation in order to have assurance the program funds were spent in accordance with grant requirements. Management also decided that all pandemic-related programs would be documented as "COVID" on the detailed testing section of the standardized template. Therefore, it was not possible to determine if any ELC transactions were reviewed.

Effect of Condition and Questioned Costs

Without establishing adequate internal controls, the Department cannot reasonably ensure it is using federal funds for allowable purposes. By not ensuring subrecipients submitted required supporting documentation, staff could not adequately verify the reimbursement claims, and the Department could not ensure its subrecipients complied with the subaward's terms and conditions.

Allowing staff to select samples without adequate guidance from management does not provide the Department with reasonable assurance that subrecipients spent program funds in accordance with grant requirements and federal regulations. Additionally, because the reviewers do not document which specific pandemic-related federal program is being covered in the transaction-level testing, management cannot perform sufficient oversight to ensure the Department has met federal requirements.

The four payments for which the Department did not have required supporting documentation from subrecipients totaled $1,644,873 in known questioned costs. Based on these results, we estimate that the total amount of likely improper payments using federal funds to be $2,905,694.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflect this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3). To ensure a representative sample, we stratified the population by dollar amount (if applicable).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Improve internal controls to ensure that it obtains adequate supporting documentation from subrecipients before reimbursing them
- Improve internal controls to ensure program staff review and approve expenditures to verify they are for allowable activities prior to payment
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

We appreciate the State Auditor's Office (SAO) audit of the Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases program. The Department of Health (DOH) is committed to ensuring our programs comply with federal regulations and would like to thank SAO for their work over the activities allowed and subrecipient monitoring requirements on the audit.

The Department partially agrees with the finding.

DOH would like to note that during the timeframe of this audit the Department and ELC program was in full COVID pandemic response mode. DOH was the leading agency charged with implementing a statewide response to an unprecedented pandemic. During this audit period, DOH's ELC Grants, and fiscal teams managed 27 newly awarded ELC grants totaling close to one billion dollars, which included applications, planning, restructuring, and monitoring. There were many emergency declarations that were also in place as well, creating new processes that staff were not familiar with, which created an environment where many of the normal day-to-day operations were pushed to their limits as well as the staff performing them. The COVID pandemic has shown us where we may have gaps in our processes, and we are diligently working to not only fill those gaps but to be better prepared for the next emergency response.

The Department does agree and is taking steps to improve internal controls over ensuring payments to providers contain support in line with our A19 matrix and risk assessed of our subrecipients. ELC staff who review invoices will be provided additional training and tracking sheets have been developed which enables staff to record details from backup documentation reviews. This ensures the proper level of review is completed and aligns with the agency's A-19 documentation matrix. Moving forward we've updated our A19 matrix to be more in line with federal guidance and the identified risk levels.

The Department partially agrees with SAO's assessment of a material weakness in internal controls over Subrecipient Monitoring. DOH agrees that the detailed transactions reviewed identified as being for "COVID" should have been specified to the specific revenue source and will do so in future monitoring visits. However, the Department would disagree that this is a material weakness over the subrecipient monitoring process. While the specific revenue source was not identified in testing allowability, monitoring staff document key control systems such as payroll and disbursements when conducting a fiscal monitoring site visit. When testing, this ensures those controls are operating effectively and provide assurance that amounts reported for reimbursement are allowable and accurate. Thus, not all transactions for that period may be tested.

The Department respectfully disagrees with SAO's assessment of a material weakness in internal controls over the consolidated contract provider payment process to ensure allowability in meeting cost principles with our ELC program. When accounting staff send the A19 consolidated contract invoices to the applicable programs ELC program staff review invoice support for

allowability and period of performance and keep a spreadsheet with a breakdown of the total payment requested for ELC. If the payment has no issues or concerns, the total payment is logged in the spreadsheet and staff save the spreadsheet to denote no issues and evidence of review and that full payment can be made. If there is a question on allowable cost, period of performance, a need for additional backup documentation or an error, program ELC staff will update spreadsheet with the amounts in question and communicate with the Local Health Jurisdiction, document the correspondence, and contact the accounting consolidated contract payment desk to withhold the specific amount of payment until the issue is resolved. Once resolved staff update the spreadsheet to denote the issue has been resolved and email accounting to release the payment amount in question.

It should be noted that the current process over provider payments at the Department of Health has been in place for well over a decade and has been through several annual audits by the State Auditor's Office and separate federal reviews by our federal funders without issue. The defined process of consolidated contract payments was in response to issues arising with timely payment of funds to our local government partners. The consolidated contracts are an essential tool in providing such funding on a large scale. This process balances many needs in tracking payments, providing documentation to the programs for review as well as allowing for timely distribution of funding to the local health jurisdictions (LHJs) for state and federal programs in order to serve the residents of the State of Washington. It also simplifies the invoicing and payment process as well as reconciliation between DOH and the LHJs.

We would also respectfully disagree with the number of exceptions and questioned costs identified. While the level of support did not meet our internal policies, which are held to a higher standard than federal requirements, the level of documentation received from the subrecipient accounting system gave us assurance that the transactions/costs questioned met federal cost principles for allowability and period of performance. This, along with the following additional overall internal monitoring and policy processes support our overall assurance of the allowability of payments:

- *Detailed ELC budgets were originally submitted by the subrecipient, reviewed and approved by Program staff so that they can ensure costs will be reasonable and are in alignment with expectations for the budget period submitted over time. No payment is made to an entity without that approved budget.*
- *The ELC program has allowable cost guidance documents that are provided to the subrecipients initially, on their SOWs, and after any changes.*
- *The ELC program/contract managers meet with subrecipients routinely (monthly or bi-monthly) to monitor progress of the work, resources, capacity, and budget management are discussed as well.*
- *Program staff provide technical assistance and policies to subrecipients related to both allowability and compliance as it relates to programmatic processes.*

Auditor's Remarks

Department management has implemented procedures to ensure adequate documentation is reviewed to support reimbursement requests from subrecipients receiving federal funds. Our testing was based on these documentation requirements, but we do not agree that these requirements are higher than the Uniform Guidance requires. We found that payments were made without the required level of support to ensure they were allowable and met cost principles.

The Department asserts that the fiscal monitoring performed every two years compensates for the lack of adequate documentation. However, we found the fiscal monitoring transaction level review for payroll and vendor reimbursement requests did not specifically include a review of any ELC payments and therefore gave no assurance that grant funds were spent on allowable activities and were adequately supported.

We reaffirm our finding, and we will follow up on the status of the Department's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Washington State Department of Health A-19 Documentation Matrix

> Approved by FMU 11/30/20
>
> This is the backup documentation required based on the determined risk level. Please ensure the *detailed* GL expenditure report clearly aligns with the A19 form. **More supporting documentation may be requested by programs at any time due to programmatic requirements regardless of risk category.**

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
Salaries and Benefits	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked Note: Salaries and benefits must be broken out as separate line items.	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked Note: Salaries and benefits must be broken out as separate line items.	A-19 and a *detailed* GL expenditure report for all employees who are charged to the grant for the period with the following information: • Salaries & Wages • Employee name • Employee rates of pay • Hours worked AND • Time Sheets for all staff direct charging to the award Note: Salaries and benefits must be broken out as separate line items.
Materials, Supplies, and Other	A-19 and a *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item **Note**: If the entity has a petty cash fund, they must supply 100% of the supporting documentation.	A-19 and a *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item AND Invoices for transactions over $1,000 **Note**: If the entity has a petty cash fund,	A-19 and *detailed* GL expenditure report that provides: • Vendor Name • Item description • Cost of item AND Invoices for transactions over $200. **Note**: If the entity has a petty cash fund, they must supply 100% of the

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
		they must supply 100% of the supporting documentation.	supporting documentation
Travel	A-19 and a *detailed* GL expenditure report that provides: • Employee name **Note:** Pre-approval documentation from DOH for any **out of state** travel must be provided.	A-19 and a *detailed* GL expenditure report that provides: • Employee name AND • Travel expense form* • All itemized receipts * Travel expense form should include employee signature, supervisor approval and purpose. **Note:** Pre-approval documentation from DOH for any **out of state** travel must be provided.	A-19 and a *detailed* GL expenditure report that provides: • Employee name • Travel expense form* • All itemized receipts AND Pre-approval required for any flights and overnight stays. *Travel expense form should include employee signature, supervisor approval and purpose. **Note:** Pre-approval documentation from DOH for **any out of state** travel must be provided.

Expenditure Category	Low-Risk	Moderate-Risk	High-Risk
Contracts and Sub-Subrecipients	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name AND • Invoices for individual transactions over $1,000.00	A-19 and a *detailed* GL expenditure report that provides: • Contractor/ Subrecipient Name AND • Invoices for individual transactions over $200.00.

NOTE:

Indirect costs included on A19s **must** include verification of the following:

- Indirect plan is current and on file with DOH
- Indirect rate is being applied accurately to allowable expenditures
- If the indirect cost rate plan has expired, no indirect costs can be charged

State of Washington
July 1, 2021 through June 30, 2022

2022-034 The Department of Health did not have adequate internal controls over and did not comply with reporting requirements for the Epidemiology and Laboratory Capacity for Infectious Diseases program.

Assistance Listing Number and Title:	93.323 Epidemiology and Laboratory Capacity for Infectious Diseases 93.323 COVID-19 Epidemiology and Laboratory Capacity for Infectious Diseases
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	NU50CK000515-01-08; NU50CK000515-02-04; NU50CK000515-02-07
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Health administers the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) program. The goal of the program is to support state, local, and territories' public health efforts to reduce morbidity and associated deaths caused by a wide range of infectious disease threats. ELC provides annual funding, strategic direction, and technical assistance to domestic jurisdictions for strengthening core capacities in epidemiology, laboratory, and health information systems activities. In addition to strengthening core infectious disease capacities nationwide, the program also supports a myriad of specific infectious disease programs and projects and provides special appropriations in response to infectious disease emergencies. The Department spent almost $330 million in federal grant funds during fiscal year 2022.

During the audit period, the Department was required to submit reports for the ELC projects Enhancing Detection, Enhancing Detection Expansion, and Reopening Schools. These projects are required to submit various reports to the Centers for Disease Control and Prevention (CDC).

Fiscal Reporting

For all three projects, the Department submits monthly fiscal reports in REDCap, a web-based system used by the CDC to collect data. This report summarizes the total monthly expenses, including salaries, fringe benefits, equipment, travel, supplies, and contractual payments.

Testing Reporting

This report is utilized by the Reopening Schools project to collect data on the use of polymerase chain reaction, antigen, and over-the-counter COVID-19 tests at schools. The Department collects the information for each type of test and submits the data utilizing the CDC report template.

Case Investigation and Contact Tracing (CICT)

For the Enhancing Detection and Enhancing Detection Expansion projects, the Department is required to submit monthly reports covering various attributes related to the number of COVID-19 cases reported and investigated. When a COVID-19 case is identified in the Washington Disease Reporting System, it is entered into the Case Risk and Exposure Surveillance Tool (CREST). Epidemiologists at the Department follow contact tracing protocols and enter the results of their investigations into CREST. The data is then reported in REDCap.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with reporting requirements for the ELC program.

During the audit period, for all three reports, Department program staff asserted that all reports were reviewed and approved by appropriate staff before submission to the federal government. However, program staff did not document their review or approval, so we were unable to determine if the proper reviews occurred.

For the CICT reports, we used a non-statistical sampling method to randomly select and review five out of twelve monthly reports. We identified two months (40 percent) where the data reported in CREST did not match what was reported in REDCap. The variance between the CREST and REDCap reports ranged from 312 percent underreported to 98 percent overreported. For one month, 16 of the 19 (84 percent) fields were incorrect. For the second month, 14 of the 19 (74 percent) fields were incorrect. The Department identified the errors in March 2022, seven months after the first inaccurate report was submitted. At that time, the Department tried to have the report updated in REDCap, but the system would not allow the edits due to the length of time between the report filing date and the detection of the errors.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department did not require management to document their reviews of reports before or after submission. If reviews of the CICT reports were performed, they were not adequate to detect the identified errors.

Effect of Condition

By not establishing adequate internal controls to ensure reports are complete and accurate, the Department reported incorrect data to the CDC.

Recommendation

We recommend the Department establish and follow effective internal controls, including a documented review, to ensure reports are accurate and complete before submitting them to the federal grantor.

Department's Response

We appreciate the State Auditor's Office (SAO) audit of the Epidemiology and Laboratory Capacity (ELC) for Infectious Diseases program. The Department of Health (DOH) is committed to ensuring our programs comply with federal regulations and would like to thank SAO for their work over ELC reporting requirements on the audit.

The Department partially agrees with the finding given the following clarifications.

DOH would like to note that during the timeframe of this audit the Department and ELC program was in full COVID pandemic response mode. DOH was the leading agency charged with implementing a statewide response to an unprecedented pandemic. During this audit period, DOH's ELC Grants, and fiscal teams managed 27 newly awarded ELC grants totaling close to one billion dollars, which included applications, planning, restructuring, and monitoring. There were many emergency declarations that were also in place as well creating new processes that staff were not familiar with, which created an environment where many of the normal day-to-day operations were pushed to their limits as well as the staff performing them. The COVID pandemic has shown us where we may have gaps in our processes, and we are diligently working to not only fill those gaps but to be better prepared for the next emergency response.

DOH does agree that there needs to be evidence of review of the reports documented and saved in a central location. During the audit period there was turnover in key positions involved in the report review process. Documented reviews and approvals were conducted as evidenced in the signed attestations by applicable remaining staff involved, however we were unable to locate the approval emails from staff that had left the agency, thus we will ensure in the future that documentation is saved in a central location accessible by program leadership.

The Department also acknowledges that through effective internal controls a review process of submitted data ensures accurate reporting to the CDC. However, we disagree that evidence of such a review would have changed the SAO findings, as the data entry was correct at the time of submission.

The ELC program did, in fact, catch the errors that were originally submitted and notified the CDC within the reporting period (February 2022). Due to a technical issue, the federal REDCap information system would not allow ELC Grant program staff to directly update the months of July through October (2021). After discussion with our CDC partners initiated by DOH, program staff were advised to email the corrected data which was accepted by the CDC and the issue was resolved. DOH asserts internal controls were in place as stated in multiple attestations by program staff. However, the Department recognizes that controls in place need to detect errors more timely.

In closing DOH would like to thank SAO for their work in this area and the Department will continue to ensure we have adequate controls over reporting for our ELC program in the future.

Auditor's Remarks

The Department asserts that a more thorough review would not have detected that the two reports were inaccurate because the data was correct at the time of submission. While the amounts reported matched the supporting documentation used when filing the report, the data used was not complete. In our judgment, a thorough review by a knowledgeable person should have detected that incomplete data was being used to compile the report.

Additionally, while the Department emailed the CDC with the correct reporting information, the Department did not receive confirmation from the CDC stating the reports had been updated and at the time of testing the reports were still inaccurate in RedCap.

We reaffirm our finding and will follow up on the status of the Department's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-035 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers paid with Temporary Assistance for Needy Families funds were allowable and properly supported.

Assistance Listing Number and Title:	93.558 Temporary Assistance for Needy Families
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2101WATANF; 2201WATANF
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$67,699,429

Background

The Department of Social and Health Services (DSHS), Community Services Office, administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. To receive TANF benefits, participants must be engaged in activities listed in the Individual Responsibility Plan through the WorkFirst program, unless the TANF benefits are received only on behalf of a child. TANF grant funds are also used to pay clients' child care costs to meet one of the program's primary purposes of helping clients obtain employment.

Washington has established the Working Connections Child Care (WCCC) program to help eligible working families pay for child care. Both the Department of Children, Youth, and Families (Department) and DSHS administer the program. The Department is responsible for establishing policies and procedures for licensing child care providers and paying them for allowable child care

services. DSHS determines TANF client eligibility and reimburses the Department for child care payments under an agreement between the two agencies.

The Department uses its Social Service Payment System (SSPS) to process the payments it makes to child care providers. The system allocates payments to various funding sources, based on the eligibility of the client. These funding sources include multiple federal programs, multiple Child Care Development Fund (CCDF) federal grant awards, and state funding. The Department uploads the payment data into the state's accounting system at a summary level based on the various funding sources.

DSHS worked with the Department to setup coding in the Payment Allocating Model (PAM) system that looks at the client-level information and then assigns the correct TANF source of funds. Once source of funds is identified, that information is then sent to SSPS for allocation assignment. The Department prepares electronic reports for funds allocated to TANF funding sources and sends DSHS a monthly bill.

There is always a need to transfer the funding sources for some payments throughout the year to manage federal and state funds properly. Prior to state fiscal year 2021, the Department prepared supporting documentation for transfers that included details of what payments it was transferring. The purpose of documenting this detail was to maintain proper support for federal expenditures.

Some payments the Department makes for child care are funded by both the CCDF and TANF grants. While the two federal programs are separate, the requirements and policies in Washington for child care payments are consolidated under the WCCC program. Federal regulations require grant fund expenditures to be adequately supported to show that they have been used in accordance with program requirements.

In fiscal year 2022, DSHS incurred $67,699,429 in child care service-related expenditures.

Federal regulations require recipients to establish and follow internal controls that ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers paid with TANF funds were allowable and properly supported. The prior finding number was 2021-028.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers paid with TANF funds were allowable and properly supported.

In order to identify TANF-funded payments the Department made to child care providers, we requested a population of payments charged to TANF sources from SSPS. However, during the fiscal year 2021 audit, management informed us the Department had changed its grant management practices to process expenditure transfers at the grant level. This new process made the original expenditure coding in SSPS inaccurate and unreliable for testing. As a result, we could not trace the federal funds to a level of expenditure adequate to establish whether the Department spent TANF funds in accordance with federal and state regulations. As a result, we could not test the Department's payments to child care providers for compliance with activities allowed and cost principles.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department is required to maintain sufficient documentation for each payment it makes with federal dollars. Management decided to modify the Department's accounting practices in a way that now prevents it from meeting this requirement.

The Department implemented what management referred to as fund-level accounting. This consisted of making significant accounting adjustments between funding sources in its general ledger without identifying the underlying transactions from SSPS that supported the adjustments. This affected all populations of child care expenditures for every month of the fiscal year. Officials from the U.S. Department of Health and Human Services informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant.

Effect of Condition and Questioned Costs

By not complying with federal law regarding maintaining adequate supporting documentation for expenditures, the Department created a condition that made it impossible for our Office to audit the federal dollars it used for payments to child care providers. Because we could not test transaction-level detail, we also could not determine whether the issues we identified in prior audits had improved or worsened, including the Department's lack of adequate internal controls and significant rate of noncompliance for payments to child care providers.

Because the Department did not comply with federal requirements to allow for the tracing of grant expenditures to a payment level, we are questioning all $67,699,429 in federal program costs for child care payments that DSHS incurred during the audit period.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Design and implement internal controls to ensure transaction-level data is sufficient to comply with federal law and state rules
- Update service level agreements with DSHS to ensure payments are sufficient and properly supported
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

The Working Connections Child Care (WCCC) program was previously managed by the Department of Social and Health Services (DSHS) and the Department of Early Learning. Since the program transitioned in 2019, the Department has been making efforts to strengthen internal controls over payments to child care providers and other grant requirements.

The Department implemented grant-level management of all federal funds, including the TANF grant. The Department allocated the TANF grant to eligible clients and allowable activities in compliance with 45 CFR 98.67.

For the fiscal year 2021 program audit, the State Auditor's Office (SAO) issued a finding with $32 questioned costs for non-compliance with the CCDF eligibility requirement. No other findings, management letters, or exit items were reported in this compliance area or the cost allocation of funds based on eligibility for the CCDF or TANF grants. Given that eligibility or cost allocation has not been an area of concern, and transfers were processed between TANF and CCDF source of funds with the same eligibility criteria, the Department is assured that TANF funding was spent appropriately within federal regulations.

In the Cause of Condition, the SAO stated, "HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant." The Department does not agree with this interpretation of the meeting outcome. During this informal meeting, on February 23, 2022, the State Auditor's Office, Office of Financial Management, and the Department met with HHS and they stated they would not offer an opinion until they received the completed finding from the state.

As part of the audit resolution process, HHS Administration for Children and Families', which oversees the TANF and CCDF programs at the federal level, reviews all SAO findings and issues management decision letters. The letters will reflect the grantor's determination of whether an audit finding is sustained, the reasons for the decision, and the required actions by the auditee. When a management decision is issued for the fiscal year 2022 finding, the Department will work with HHS and follow the audit resolution process.

The Department is ©d to improving internal controls. The Department does not currently have the resources to develop and maintain the business process redesign, as well as the information technology initiatives necessary to meet the level of assurance recommended by SAO. In response to prior year's audit recommendations, the Department has submitted a budget request to the Legislature in the 2023-2025 biennial budget for additional resources to process adjustments to include transaction-level data.

Auditor's Remarks

The level of assurance needed to support grant expenditures is not established by our Office, but in Titles 2 and 45 of the U.S. Code of Federal Regulations and the State's grant award.

We appreciate the Department's commitment to resolving these matters and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments. Part 200.53 defines improper payments. Part 200.403 establishes factors affecting allowability of costs. Part 200.410 establishes requirements for the collection of unallowable costs.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-036 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with client eligibility requirements for child care services paid with the Child Care and Development Fund and Temporary Assistance for Needy Families funds.

Assistance Listing Number and Title:	93.558 Temporary Assistance for Needy Families 93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD; 2101WATANF; 2201WATANF
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Eligibility
Known Questioned Cost Amount:	Temporary Assistance for Needy Families - $5,689 Child Care and Development Fund - $5,078

Background

The Department of Children, Youth, and Families administers the federal Child Care and Development Fund (CCDF) grant to help eligible working families pay for child care. In fiscal year 2022, the Department spent $668.6 million in CCDF federal funding. The Department of Social and Health Services (DSHS) administers the Temporary Assistance for Needy Families (TANF) grant. To meet one of the program's primary purposes of helping clients obtain employment, TANF grant funds may be used to pay clients' child care costs. If a client obtains employment and is no longer eligible for the program, TANF funds may still be used to pay child care costs to help the client maintain employment.

In fiscal year 2022, the Department spent more than $260.5 million in CCDF and $67.7 million in TANF federal grant funds on child care subsidy payments to providers.

Some payments made for child care are paid for by both the CCDF and TANF grants. While the two federal programs are separate, the requirements and policies in Washington for child care payments are consolidated under the Working Connections Child Care program. As of July 1, 2019, the responsibility for making and documenting child care eligibility determinations under the CCDF and TANF grants was transferred from DSHS to the Department.

For a family to be eligible for child care assistance, state and federal rules require that at the time of application or reapplication, children must:

- Reside in Washington and be a citizen or legal resident of the United States;
- Be younger than 13 years, or if for verified special needs, be younger than 19 years;
- Reside with a parent(s) or guardian whose countable income does not exceed 200 percent of the federal poverty level at application or 220 percent at reapplication for July, August and September 2021 but in October 2021 changed to 60 percent of the state median income at application or 65 percent of the state median income at reapplication;
- Reside with a parent(s) or guardian who works or attends a job-training or education program, or needs to be receiving protective services.

State rules describe the information clients must provide to the Department to verify their eligibility. The information must be accurate, complete, consistent and from a reliable source. This information includes, but is not limited to, employer and hourly wage information, proof of an approved activity under TANF, and family household size and composition.

Once determined to be eligible for the program, a client is eligible for one year unless a change in income causes the client to exceed 85 percent of the state's median income. The Department requires that clients self-report such income changes. A written notice communicates the recipients' reporting requirement and the specific dollar threshold applicable to the household's annual income. Once the client's income exceeds this cutoff level, the Department terminates services.

The Department has access to systems that contain wage and household benefit and composition data for some, but not all, child care recipients. The Department uses this information in part to determine program eligibility, benefit level, including client copayment, and the amount of child care the family is eligible to receive. If an ineligible client receives assistance, the payment made to the child care provider is not allowable and the client must repay the ineligible amount.

The Department also uses household income to determine the amount families must contribute for their monthly copay to providers. Beginning July 1, 2021, monthly copayments were calculated using an updated schedule described in Washington Administrative Code 110-15-0075.

Federal regulations require the Department to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the past 10 audits, we reported findings related to eligibility for the Working Connections Child Care program. In these prior audits, we reported the Department did not have adequate internal controls over the eligibility process for child care subsidy recipients. These were reported as finding numbers 2021-035, 2020-039, 2019-032, 2018-030, 2017-026, 2016-023, 2015-026, 2014-026, 2013-017 and 2012-30.

Description of Condition

The Department did not have adequate internal controls over and did not comply with client eligibility requirements for CCDF and TANF.

During the audit period the Department determined 69,815 children were eligible for child care. We used a statistical sampling method to randomly select and examine 59 of these determinations. In four instances (6.8 percent), we found the Department made eligibility determinations improperly, did not obtain required documentation, incorrectly assessed copayment, or did not verify information before authorizing services. Specifically, we found:

- Two cases (3.4 percent) where the Department had incorrectly determined household composition and did not obtain sufficient data for all parents in the household to make an accurate eligibility determination.
- One case (1.7 percent) where the Department did not follow procedure for verifying employment, which led to an incorrect household income calculation.
- One case (1.7 percent) where the copay was incorrectly assessed, which resulted in an underpayment due to a system error.

Though the Department has established internal controls, they were insufficient for ensuring material compliance with client eligibility requirements.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Department staff made eligibility determinations without obtaining sufficient supporting documentation to ensure households were eligible to receive assistance. This deviated from the standard policies and procedures the Department has established, and management did not monitor sufficiently to ensure staff made proper eligibility determinations. Further, the incorrect copay calculation was due to system error.

Effect of Condition and Questioned Costs

By not implementing adequate internal controls, the Department is at higher risk of paying providers for child care services when clients are ineligible.

Of the four client eligibility determinations that had errors, three resulted in $10,767 of federal overpayments to providers. The Department used $5,078 in CCDF grant funds and $5,689 in TANF grant funds for these payments.

Because we used a statistical sampling method to randomly select the payments examined in the audit, we estimate the amount of likely improper payments to be $6,008,693 for the CCDF grant and $6,731,953 for the TANF grant.

Although we identified known and likely questioned costs, we do not have reasonable assurance that the payments in question are appropriately represented in the Department's accounting records because of the grant management practice issue reported in findings 2022-035 and 2022-041. Additionally, the payments in question are duplicative of the costs already questioned in the aforementioned provider payment findings.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department improve its internal controls over determining client eligibility to ensure it:

- Reviews eligibility determinations sufficiently to detect improper eligibility determinations
- Reviews sufficient support for clients' income and household composition information for accuracy

We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Department's Response

The Department appreciates, acknowledges, and supports SAO's mission, which is to hold state and local government accountable for the use of public resources. Further, we appreciate SAO's work with us over the past year to strengthen the auditing process.

Due to recent changes to CCSP directed by the Legislature, the Department anticipates continued reduction in eligibility determination errors. The Fair Start for Kids Act (FSKA) required the Department to make several changes that expanded eligibility during SFY 2022. The FSKA increased the State Median Income (SMI) threshold, allowing more two parent households to be eligible for child care subsidy. The FSKA also capped copayments to $115 for applicants and $215 for reapplicants, greatly reducing the copay amounts for typical two parent households. These changes are disincentives for fraud as struggling families receive needed benefits and are more likely to provide accurate and complete information. This is supported by the overall reduction in investigation requests submitted to the Office of Fraud and Accountability. In the federal fiscal year prior to the implementation of the FSKA, the Department submitted 1,405 requests for investigations. The year following FSKA implementation requests for investigations fell to 912. The Department continues to explore ways to remove the possibility for improper use of CCDF funds.

The Department agrees with the SAO that there is a need to review household composition at application and reapplication to improve reliability of eligibility decisions. The Department accesses data across available state systems to confirm information, including household composition provided by clients. Unfortunately, there is no household composition verification system, and information provided to other state agencies is often provided by client self-attestation. The Department continues to balance verification requirements with providing timely benefit decisions to support family access to high quality child care. Eighty-six percent of households receiving child care subsidies are headed by single parents. Supporting these families with child care is essential for their continued participation in work, education, and other social service programs.

The Department provides training for eligibility in the specific areas of household composition and income determination and improvements to training are ongoing. The Department recently made changes to the professional development and training process to improve staff skills and accuracy. Staff training is in a continuous improvement cycle and evolves with staff needs and

changes in rule. The Department will continue to improve processes and internal controls and create and deliver staff training based on current data trends and patterns.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Washington Administrative Code (WAC) 110-15-0015 – Determining family size, states in part:

(1) DCYF determines a consumer's family size as follows:

(a) For a single parent, including a minor parent living independently, DCYF counts the consumer and the consumer's children;

(b) For unmarried parents who have at least one mutual child, DCYF counts both parents and all of their children living in the household;

(c) Unmarried parents who have no mutual children are counted as separate WCCC households, the unmarried parents and their respective children living in the household;

(d) For married parents, DCYF counts both parents and all of their children living in the household;

(e) For parents who are undocumented aliens as defined in WAC 388-424-0001, DCYF counts the parents and children, documented and undocumented, and all other family rules in this section apply. Children needing care must meet citizenship requirements described in WAC 110-15-0005;

(f) For a legal guardian verified by a legal or court document, adult sibling or step-sibling, nephew, niece, aunt, uncle, grandparent, any of these relatives with the prefix "great," such as a "great-nephew," or an in loco parentis custodian who is not related to the child as described in WAC 110-15-0005, DCYF counts only the children and only the children's income is counted;

(g) For a parent who is out of the household because of employer requirements, such as training or military service, and expected to return to the household, DCYF counts the consumer, the absent parent, and the children;

(h) For a parent who is voluntarily out of the household for reasons other than requirements of the employer, such as unapproved schooling and visiting family members, and is expected to return to the household, DCYF counts the consumer, the absent parent, and the children. WAC 110-15-0020 and all other family and household rules in this section apply;

(i) For a parent who is out of the country and waiting for legal reentry into the United States, DCYF counts only the consumer and children residing in the United States and all other family and household rules in this section apply;

(j) An incarcerated parent is not part of the household count for determining income and eligibility. DCYF counts the remaining household members using all other family rules in this section; and

(k) For a parent incarcerated at a Washington state correctional facility whose child lives with them at the facility, DCYF counts the parent and child as their own household.

(U) When the household consists of the consumer's own child and another child identified in subsection (1)(f) of this section, the household may be combined into one household or kept as distinct households for the benefit of the consumer.

WAC 110-15-0065 – Calculation of income, states in part:

DSHS uses a consumer's countable income when determining income eligibility and copayment. A consumer's countable income is the sum of all income listed in WAC 110-15-0060 minus any child support paid out through a court order, division of child support administrative order, or tribal government order.

(1) To determine a consumer's income, DSHS either:

(a) Calculates an average monthly income by:

(i) Determining the number of months, weeks or pay periods it took the consumer's WCCC household to earn the income; and dividing the income by the same number of months, weeks or pay periods.

(ii) If the past wages are no longer reflective of the current income, DSHS may accept the employer's statement of current, anticipated wages for future income determination.

(b) When the consumer begins new employment and has less than three months of wages, DSHS uses the best available estimate of the consumer's WCCC household's current income:

(i) As verified by the consumer's employer; or

(ii) As provided by the consumer through a verbal or written statement documenting the new employment at the time of application, reapplication or change reporting, and wage verification within sixty days of DSHS request.

(2) If a consumer receives a lump sum payment (such as money from the sale of property or back child support payment) in the month of application or during the consumer's WCCC eligibility:

(a) DSHS calculates a monthly amount by dividing the lump sum payment by twelve;

(b) DSHS adds the monthly amount to the consumer's expected average monthly income:

(i) For the month it was received; and

(ii) For the remaining months of the current eligibility period; and

(U) ©To remain eligible for WCCC the consumer must meet WCCC income guidelines after the lump sum payment is applied.

WAC 110-15-0075 – Determining income eligibility and copayment amounts, states (effective prior to October 1, 2021):

(U) DCYF takes the following steps to determine a consumer's eligibility and copayment, whether care is provided under a WCCC voucher or contract:

(U) Determine the consumer's family size (under WAC 110-15-0015);

(U) Determine the consumer's countable income (under WAC 110-15-0065).

(U) DCYF calculates the consumer's copayment as follows:

If a consumer's income is:	**Then the consumer's copayment is:**
(a) At or below 82% of the federal poverty guidelines (FPG).	$15
(b) Above 82% of the FPG up to 137.5% of the FPG.	$65
© Above 137.5% of the FPG through 200% of the FPG.	The dollar amount equal to subtracting 137.5% of the FPG from countable income, multiplying by 50%, then adding $65, up to a maximum of $115.

(U) DCYF does not prorate the copayment when a consumer uses care for part of a month.

(U) The FPG is updated every year. The WCCC eligibility level is updated at the same time every year to remain current with the FPG.

WAC 110-15-0075 – Determining income eligibility and copayment amounts, states (effective beginning October 1, 2021):

(1) DCYF takes the following steps to determine consumers' eligibility and copayments, when care is provided under a WCCC voucher or contract:

(a) Determine their family size as described in WAC 110-15-0015; and

(b) Determine their countable income as described in WAC 110-15-0065.

(2) DCYF calculates consumers' copayments as follows:

If the household's income is:	**Then the household's maximum monthly copayment is:**
At or below 20 percent of the SMI	Waived
Above 20 percent and at or below 36 percent of the SMI	$65
Above 36 percent and at or below 50 percent of the SMI	$90
Above 50 percent and at or below 60 percent of the SMI	$115
At reapplication, above 60 percent and at or below 65 percent of the SMI	$215

(3) DCYF does not prorate copayments when consumers use care for only part of a month.

(4) For parents age 21 years or younger who attend high school or are working towards completing a high school equivalency certificate, copayments are not required.

2022-037 The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure staff properly considered the income information obtained from data matching when determining client eligibility and benefits for the Temporary Assistance for Needy Families program.

Assistance Listing Number and Title:	93.558 Temporary Assistance for Needy Families
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2101WATANF; 2201WATANF
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Eligibility Special Tests and Provisions: Income Eligibility Verification System
Known Questioned Cost Amount:	None

Background

The Department of Social and Health Services administers the Temporary Assistance for Needy Families (TANF) grant that provides temporary cash assistance for families in need. To receive TANF benefits, applicants must meet individual eligibility criteria and financial eligibility criteria according to the state's quantified income and resource criteria. The Department spent more than $372 million in federal grant funds during fiscal year 2022.

Federal regulations require the Department to participate in the Income Eligibility and Verification System (IEVS). The state is required to coordinate data exchanges with other formally assisted benefit programs, and request and use income and benefit information when making eligibility determinations. The Department uses the Automated Client Eligibility System (ACES) in

determining eligibility, issuing benefits, providing management support, and sharing data between agencies.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure staff properly considered the income information obtained from data matching when determining client eligibility and TANF benefits.

Department management asserted that part of the eligibility determination process included ACES alerting staff when there was a discrepancy between the information that was reported by applicants and the information that was obtained through the IEVS data matching. During our testing, we confirmed that this internal control was not in place. We determined ACES generated an alert when an applicant reported having no income, but the IEVS data match showed income. However, ACES did not return an error if the applicant reported any income other than zero, regardless of how large the discrepancy was with the IEVS data match.

We used a statistical sampling method to randomly select and examine 59 out of a total population of 134,107 clients who were determined eligible during state fiscal year 2022. We found seven instances (12 percent) where we could not determine if the Department properly considered income information when determining eligibility because it did not retain supporting documentation for the client's income.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Department relied on an automated alert system that management did not know was not in place and operating as intended.

The Department's policy required eligibility staff to review information from IEVS cross-matches and document results in the case file. However, the policy did not require eligibility staff to adequately document their review of IEVS data matching in detail or the basis of their conclusion in determining income eligibility.

Effect of Condition

Without sufficiently documenting clients' income, management cannot ensure whether staff are properly considering the information from IEVS data matching when determining client eligibility and the amount of TANF benefits they will receive.

Recommendation

We recommend the Department improve its internal controls to ensure staff properly consider and adequately document the income information from IEVS data matching when determining client eligibility and the amount of TANF benefits they will receive.

Department's Response

The Department does not concur with this audit finding.

The Department does not concur with the SAO's determination that DSHS did not have adequate internal controls over and did not comply with requirements to ensure staff properly considered the income information obtained from data matching when determining client eligibility and benefits for the Temporary Assistance for Needy Families (TANF) Program.

The audit objective was to determine if income information obtained through the various interfaces verifies the accuracy of the information in the case to determine financial eligibility. The key control for ACES is working as designed to sufficiently determine eligibility.

The SAO had preconceptions about when ACES alerts occur and how eligibility staff complete these alerts. The department clarified that:

"ACES generates an alert to be reviewed by Community Service Division (CSD) staff if there is an inconsistency within the information recorded in ACES and the income or benefit information that is obtained through the various interfaces to verify accuracy of the information and eligibility of the TANF program."

During the eligibility determination process at application intake, the eligibility worker:

1. *Interviews the client to determine income.*
2. *Compares client reported information against cross matches including IEVS per Code of Federal Regulations (CFR).*
3. *Resolves discrepancies for all new or previously unverified information received.*
4. *Uses the information to determine if the client income is below the maximum earned income limits for TANF per WAC 388-478-0035.*

The Department then verifies all circumstances as required in WAC 388-490-0005, which includes when discrepancies exist, and where the agency takes appropriate action if the information is questionable, confusing or outdated.

The Department uses templates to appropriately and comprehensively document the eligibility determination to ensure consistency, accuracy, and lean processes. Income documentation templates address:

- *Income received within 30 days of the application date,*
- *Any discrepancies found between the case record, online verification systems, what was used to project income and income type.*

The income template does not require documentation if there is no income reported, and no discrepancies were found in cross matches. Not requiring this eliminates steps for the worker therefore ensuring a lean process. This is the instance when the final narrative documentation template includes check boxes to select cross matches reviewed during application intake. The final narrative will always have a summary of the transaction that occurred.

Spider is a tool that combines several different data matches including IEVS. The eligibility workers created the referenced documentation in all seven cases using the final narrative template consistent with Department procedures. In all seven exception cases, documentation existed in the final narrative stating: "Reviewed the following system(s): Spider."

The Department did not use earned income templates in the seven exception cases because there was no income reported and no income found in IEVS and other cross matches, no discrepancies, and no changes within 30 days. This action is in alignment with department procedures.

Department procedures for "Standard Remarks and Narrative Documentation" requires documentation to verify circumstances and states:

1. **Use the Narrative for client interactions and case actions. Use Templates when applicable.*
    a. *Complete the appropriate template based on the case action, adding relevant information to ensure that there is an accurate, complete summary.*
6. *Include Remarks to reconcile any discrepancies, or important information not otherwise captured, including required questions left blank on the application or eligibility review form.*
7. *When documenting Earned or Unearned income:*
    d. *Address any discrepancies between information in the case record, online verification systems, and what was used to project income:*

If there was no discrepancy and no income indicated in IEVS, eligibility staff are not required to document anything as there is no discrepancy to address.

Once there is an open case, ACES generates alerts when an applicant is budgeted with zero income, and the IEVS data match shows income. To be clear, this would be new information because any such discrepancies existing in IEVS at the application intake would already be addressed at that time.

As SAO points out in this finding, alerts were not generated for all income fluctuations. The Department agrees, and asserts that the system is working as designed, and alerts are created when staff review is required. Creating alerts for unnecessary and unhelpful reviews arising from the scenarios outlined above would take staff time away from other required and mission-critical actions. Alerts are generated, as appropriate, when a review and potential action is required.

This is evidenced by the fact that the department accurately determined eligibility in 100% of all seven cases the SAO determined to be exceptions.

Auditor's Remarks

The 2022 OMB *Compliance Supplement* instructs auditors to "*Test a sample of TANF cases subject to IEVS to ascertain if the state properly considered the information obtained from the data matching in determining eligibility and the amount of TANF benefits*." We tested to determine if the Department sufficiently documented that staff properly considered the details of income verification when reviewing a client's application. While the Department may have followed internal procedures when not fully documenting its eligibility decisions, in our opinion, the documentation was not sufficient to demonstrate compliance with federal law.

We disagree with the Department's presumption that "*SAO had preconceptions about when ACES alerts occur and how eligibility staff complete these alerts."* This statement is inaccurate because the Department first provided our Office with information about the internal control in question on July 14, 2022, and later confirmed it during a meeting with staff on July 19, 2022. Department management said that when the IEVS system identifies a discrepancy, ACES will generate an alert notifying the case worker to review the information. On November 23, 2022, we notified the Department of the internal controls we planned to test, which included the key control asserted. We asked Department management on December 13, 2022, if this was the correct key control and if it was accurate. Department staff responded that it was, and we tested the control on January 18, 2023.

In its response to this finding, the Department asserts our Office had preconceptions about the following internal control:

> *"ACES generates an alert to be reviewed by Community Service Division (CSD) staff if there is an inconsistency within the information recorded in ACES and the income or benefit information that is obtained through the various interfaces to verify accuracy of the information and eligibility of the TANF program."*

This is the same internal control that we tested. It differs slightly in language, but it reiterates the Department's original assertion that an alert was generated if there was an inconsistency identified. We determined, and the Department confirmed, the alert was only generated when the system identified an inconsistency in the cases where an applicant claimed to have zero income and the other verifications reported an income other than zero. If the applicant claimed anything other than zero, the alert did not generate no matter how large or small the discrepancy was between the claimed income and the income identified through various interfaces. Staff who oversee the system confirmed on January 10, 2023, that this internal control was not functioning in the manner that Department management asserted. Once our Office informed program staff that the internal control was not working as intended, the Department made a new assertion that the system was working as designed and that we misunderstood the internal control conveyed to us many times by management over the course of the audit.

We reaffirm our finding, and we will follow up on the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 75, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards,* section 361, Retention requirements for records, states in part:

> Financial records, supporting documents, statistical records, and all other non-Federal entity records pertinent to a Federal award must be retained for a period of three years from the date of submission of the final expenditure report or, for Federal awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report, respectively, as reported to the HHS awarding agency or pass-through entity in the case of a subrecipient. HHS awarding agencies and pass-through entities must not impose any other record retention requirements upon non-Federal entities. The only exceptions are the following:

(a) If any litigation, claim, or audit is started before the expiration of the 3-year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken.

(b) When the non-Federal entity is notified in writing by the HHS awarding agency, cognizant agency for audit, oversight agency for audit, cognizant agency for indirect costs, or pass-through entity to extend the retention period.

(c) Records for real property and equipment acquired with Federal funds must be retained for 3 years after final disposition.

(d) When records are transferred to or maintained by the HHS awarding agency or pass-through entity, the 3-year retention requirement is not applicable to the non-Federal entity.

(e) Records for program income transactions after the period of performance. In some cases, recipients must report program income after the period of performance. Where there is such a requirement, the retention period for the records pertaining to the earning of the program income starts from the end of the non-Federal entity's fiscal year in which the program income is earned.

(f) Indirect cost rate proposals and cost allocations plans. This paragraph applies to the following types of documents and their supporting records: Indirect cost rate computations or proposals, cost allocation plans, and any similar accounting computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates).

    (1) ***If submitted for negotiation***. If the proposal, plan, or other computation is required to be submitted to the Federal Government (or to the pass-through entity) to form the basis for negotiation of the rate, then the 3-year retention period for its supporting records starts from the date of such submission.

    (2) ***If not submitted for negotiation***. If the proposal, plan, or other computation is not required to be submitted to the Federal Government (or to the pass-through entity) for negotiation purposes, then the 3-year retention period for the proposal, plan, or computation and its supporting records starts from the end of the fiscal year (or other accounting period) covered by the proposal, plan, or other computation.

State of Washington
July 1, 2021 through June 30, 2022

2022-038 The Department of Commerce did not have adequate internal controls over and did not comply with requirements to ensure it filed reports required by the Federal Funding Accountability and Transparency Act.

Assistance Listing Number and Title:	93.568 Low-Income Home Energy Assistance Program 93.568 COVID-19 Low-Income Home Energy Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2201WALIEA; 2101WALIEA; 2101WALWC5; 2101WALWC6
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Commerce administers the Low-Income Home Energy Assistance Program, which provides financial assistance to low-income households to meet their home energy needs. The Department makes subawards to community-based organizations to provide this assistance.

In fiscal year 2022, the Department spent more than $102 million in federal program funds, approximately $98 million of which it paid to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Act), the Department is required to collect and report information on each subaward of federal funds more than $25,000 in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS). For federal awards issued on or after November 12, 2020, the monetary threshold for reporting increased to $30,000. The Department must report subawards by the end of the month following the month in which it made the subaward (or subaward amendment). The intent of the Act is to

empower citizens with the ability to hold the federal government accountable for spending decisions and, as a result, reduce wasteful government spending.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate controls over and did not comply with this reporting requirement. The prior finding number was 2021-031.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure it filed reports required by the Act.

The Department has two units—energy assistance and weatherization—that administer the two different program funding activities. Each unit is responsible for complying with this reporting requirement. During the audit period, the Department was required to report 127 subawards (103 energy assistance and 24 weatherization) totaling approximately $123 million of program funds that it awarded to 26 subrecipients. We found the Department did not report 101 of these subawards in FSRS as required, including all 24 of the weatherization subawards, totaling $77.8 million.

We randomly selected eight of the 26 subawards reported during the audit period. We found the following:

- Eight (100 percent) subawards were submitted after the end of the month following the month in which the obligation was made.
- Eight (100 percent) did not have the correct obligation amount and date.
- One (12.5 percent) had an incorrect DUNS number.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The energy assistance unit began to report subawards during the audit period, but employees did not know how to correctly submit the reports. In addition, management did not ensure employees in the weatherization unit knew about the reporting requirements. The Department implemented a new reporting procedure in April 2022, but the units did not consistently follow it.

Effect of Condition

Failing to submit the required reports diminishes the federal government's ability to ensure accountability and transparency of federal spending. The terms and conditions of the federal award

allow the grantor to penalize the Department for noncompliance by suspending or terminating the federal award, or withholding future awards.

Recommendations

We recommend the Department:

- Establish effective internal controls to ensure reports are submitted as required
- Ensure the energy assistance and weatherization units follow the newly implemented reporting procedure
- Provide training for employees who oversee reporting and who verify the submission and accuracy of the reports
- Ensure management monitors reporting of this information to ensure future reports are submitted completely and timely

Department's Response

LIHEAP

The Department of Commerce received additional pandemic funding for the LIHEAP program beginning in FY20. As a result of the reporting finding issued for FY20, the LIHEAP program implemented recommended procedures to resolve deficiencies identified.

Regarding the correct submission of reports, LIHEAP employees misunderstood the requirements for entering FFATA and are in the process of correcting the misunderstanding and how the information will be reported to FFATA in the future. The Program Manager did not find any instructions in the FFATA guide that disallowed the process used for reporting. Only after SAO reviewed the FFATA reports did LIHEAP receive guidance on how to enter the FFATA reports separately for each award and the corresponding amendments.

Regarding the April 2022 implementation of the reporting procedure, the program consistently followed the procedures that were established which is why all LIHEAP FFATA reporting was not entered correctly. The Program Manager provided FFATA reporting for combined awards, not all awards and amendments were separated. This resulted in the numbers reported not matching the original awards. The Program Manager has updated the FFATA reporting procedure to provide only one award or amendment is reported for the 2023 program year funding.

Weatherization LIHEAP

History:

The Federal Funding Accountability and Transparency Act (FFATA) was signed on September 26, 2006. This legislation intends to empower every American to hold the government accountable

for spending decisions. The Commerce Low Income Weatherization team understands and values this work. In 2018, our team went through a staff transition process at both the position primarily responsible for completing FFATA reporting as well as the position supervising this position. Staff onboarding and transition processes did not adequately train new staff to maintain FFATA reporting requirements. Furthermore, internal contracting processes were not adequately in place to recognize the deficiency.

Solution to Finding:

The Low-income Weatherization team concurs with the finding and has researched FFATA reporting requirements to gain clear understanding of how to fulfill them moving forward. The Program Coordinator is primarily responsible for reporting in the online FFATA system has been trained on how to accurately register relevant sub-grantees in the system, as well as how to input required data within the mandated time period. This task will also be added to the Program Coordinator onboarding checklist to ensure this requirement will continue to be met by new staff after any future position transition. The FFATA reporting requirement has also been added to our internal federal contracting timeline which is referenced at monthly meetings by the relevant Program Supervisor, Program Manager, and Program Coordinator. At the time any future obligation memo is approved for a federal fund source with FFATA reporting requirements, staff will immediately initiate fulfilling this requirement within 30 days.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 170, *Reporting Subaward and Executive Compensation Information*, states in part:

Appendix A to Part 170 – Award Term

II. Reporting Subawards and Executive Compensation

b. Reporting of first-tier subawards.

4. *Applicability*. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that equals or exceeds $30,000 in Federal funds for a subaward to a non-Federal entity or Federal agency (see definitions in paragraph e. of this award term).

5. *Where and when to report*.

iii. The non-Federal entity or Federal agency must report each obligating action described in paragraph a.1. of this award term to https://www.fsrs.gov.

iv. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

6. *What to report*. You must report the information about each obligating action that the submission instructions posted at https://www.fsrs.gov specify.

State of Washington
July 1, 2021 through June 30, 2022

2022-039 The Department of Commerce did not have adequate internal controls over and did not comply with reporting requirements for the Low-Income Home Energy Assistance Program.

Assistance Listing Number and Title:	93.568 Low-Income Home Energy Assistance Program 93.568 COVID-19 Low-Income Home Energy Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2201WALIEA; 2101WALIEA; 2201WALIEI; 2101WALWC5; 2101WAE5C6; 2102WALWC6
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The U.S. Department of Health and Human Services, through the Office of Community Services at the Administration for Children and Families, administers the Low-Income Home Energy Assistance Program (LIHEAP). The agency distributes LIHEAP block grant funds by formula to states, the District of Columbia, and territories.

In Washington, the Department of Commerce (Department) administers LIHEAP, which provides financial assistance to low-income households to meet their home energy needs. The Department makes subawards to community-based organizations to provide this assistance.

The Department is required to collect and report program information annually. The LIHEAP Performance Data Form is used to report performance metrics, mostly related to home energy burden targeting and reduction, as well as the continuity of home energy service. The Annual Report on Households Assisted by LIHEAP, which consists of six different sections, outlines assistance given to households and households applying for assistance. Both reports are required

to separate the data by regular LIHEAP funding and additional LIHEAP funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan Act (ARPA).

In fiscal year 2022, the Department spent more than $102 million in federal program funds, approximately $94 million of which it paid to subrecipients.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate controls over and did not comply with reporting requirements for the Annual Report on Households Assisted. The prior finding number was 2021-032.

Description of Condition

The Department did not have adequate internal controls over and did not comply with reporting requirements for the Low-Income Home Energy Assistance Program.

We reviewed the LIHEAP Performance Data Form and the Annual Report on Households Assisted that were due during the audit period. We examined the report the Department submitted for the federal fiscal year ending September 30, 2021, and attempted to recalculate the information reported using data the Department pulled from its LIHEAP database. The Department informed us that for the first five weeks of the reporting period, this data did not contain sufficient information to fully recalculate the values reported for the program year under review.

Based on the data the Department provided, we identified the following:

- LIHEAP Performance Data Form
  - 160 of the 225 fields (71 percent) were inaccurate.
  - The difference between values reported and the data provided varied between less than 1 percent and 200 percent.
  - The "all household" categories had the most significant variance, ranging from (921) to 29,301 in households reported.
- Annual Report on Households Assisted
  - 100 of the 138 fields (72 percent) were inaccurate.
  - The difference between values reported and the data provided varied between 1 percent and 783 percent.
  - The "all household" categories had the most significant variance, ranging from (1,052) to 38,151 in households reported.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Prior to the audit period, the Department designed an automated system to sort and categorize funds that were traditional LIHEAP and funds that were from CARES and ARPA, and automatically populate those numbers on the report. However, this automated system was not in place for the first five weeks of the reporting period, covering October 1, 2020, to November 11, 2020. Therefore, the data for this period did not contain information necessary to identify the funding source of each household benefit payment. Although management reviewed the report, the staff responsible for preparing and submitting it did not retain the data used to support the amounts listed in the report.

Furthermore, management said that the grantor instructed the Department to include only traditional LIHEAP-related data in the "all households" category, but was not able to provide written documentation of this guidance.

Effect of Condition

By not retaining supporting documentation for the report, management was unable to demonstrate the amounts the Department reported to the federal grantor were complete and accurate.

Additionally, the terms and conditions of the federal award allow the grantor to penalize the Department for noncompliance with reporting requirements by suspending or terminating the award, or withholding future awards, should it choose to do so.

Recommendations

We recommend the Department:

- Establish effective internal controls to ensure the report is accurate and complete
- Strengthen its management reviews to ensure amounts reported are accurate and staff retain adequate documentation to support amounts included in the reports
- Consult with the federal grantor to determine if revision and resubmission of both reports is necessary to correct amounts reported

Department's Response

The Department agrees with this finding. The program was instructed by the United States Department of Health and Human Services (HHS) that with the additional funding we received in response to the COVID pandemic, we were to track and report all funds separately. The program manager assumed incorrectly that this meant program reporting as well as financial reporting and reported Regular LIHEAP-funded households (contract #32606) separately from the CARES Act-funded households (contract #3260C) and ARP-funded households (contract #3260A) when they should have been counted together in module 2A of the report. This caused all other numbers

in the reports to be off when the data was pulled from the LIHEAP data system by SAO data analysts per the compliance supplemental instructions. The program manager has reached out to the LIHEAP liaison at HHS for guidance on updating the reports and will proceed with the corrections once guidance is received from HHS.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 75, Subpart 342, *Monitoring and reporting program performance*, states in part:

> (b) *Non-construction performance reports.* The HHS awarding agency must use standard, OMB-approved data elements for collection of performance information (including performance progress reports, Research Performance Progress Report, or such future collections as may be approved by OMB and listed on the OMB Web site).
>
> > (1) The non-Federal entity must submit performance reports at the interval required by the HHS awarding agency or pass-through entity to best inform improvements in program outcomes and productivity. Intervals must be no less frequent than annually nor more frequent than quarterly except in unusual circumstances, for example where more frequent reporting is necessary for the effective monitoring of the Federal award or could significantly affect program outcomes. Annual reports must be due 90 calendar days after the reporting period; quarterly or semiannual reports must be due 30 calendar days after the reporting period. Alternatively, the HHS awarding agency or pass-through entity may require annual reports before the anniversary dates of multiple year Federal awards. The final performance report will be due 90 calendar days after the period of performance end date. If a justified request is submitted by a non-Federal entity, the HHS awarding agency may extend the due date for any performance report.

Title 45 CFR Part 96, Subpart 82, *Required report on households assisted*, states in part:

> (a) Each grantee which is a State or an insular area which receives an annual allotment of at least $200,000 shall submit to the Department, as part of its LIHEAP grant application, the data required by section 2605(c)(1)(G) of Public Law 97-35 (42 U.S.C. 8624(c)(1)(G)) for the 12-month period corresponding to the Federal fiscal year (October 1-September 30) preceding the fiscal year for which funds are requested. The data shall be reported separately for LIHEAP heating, cooling, crisis, and weatherization assistance.

Office Management and Budget, *2022 Compliance Supplement*, Assistance Listing 93.568 Low-Income Home Energy Assistance, states in part:

> As part of the application for block grant funds each year, a report is required for the preceding fiscal year of (1) the number and income levels of the households assisted for each component and any type of LHEAP assistance (heating, cooling, crisis, and weatherization); and (2) the number of households served that contained young children, elderly, or persons with disabilities, or any vulnerable household for each component. Territories with annual allotments of less than $200,000 and all Indian tribes are required to report only on the number of households served for each program component (42 USC 8629; 45 CFR section 96.82).

The U.S. Department of Health and Human Services, Division of Energy Assistance, Office of Community Services, Administration of Children and Families' *Instructions for the LIHEAP Household Report Long Form FY2021*, states in part:

> Introduction:
>
> > ***Federal LIHEAP Funds***
> >
> > The purpose of the *LIHEAP Household Report* is to report on the number of households assisted with **all** available federal LIHEAP funds during FY 2021, including those LIHEAP funds obligated in FY 2020, but not expended until FY 2021.
> >
> > LIHEAP funding includes **all federal funds** allocated to LIHEAP. To separately identify the impact of supplemental federal LIHEAP funding, HHS requires grantees to report three pieces of information for each item in the Household Report.
> >
> > - The first line is for grantees to report information for *all households regardless of funding source*. This is consistent with what grantees were required to report in the past. Grantees should report the total count of households, counting each household once if it received that type of assistance during FY 2021. Report households assisted with regular LIHEAP funds, LIHEAP CARES funds, LIHEAP ARPA funds, or any combination of these funds.

- The second line is for grantees to report information on the subset of households that were assisted with CARES Act supplemental LIHEAP funding. Include households that received a benefit that was fully or partially funded with CARES Act funds. Exclude households that did not receive a benefit that was fully or partially funded by CARES Act funds. Important Note: This is a subset of the households reported in the first line, meaning that a household that received a benefit that was fully or partially funded with CARES Act funds should be reported in this line and in the first line as well.
- The third line is for grantees to report information on the subset of households that were assisted with American Rescue Plan Act supplemental LIHEAP funding. Include households that received a benefit that was fully or partially funded with ARPA Act funds. Exclude households that did not receive a benefit that was fully or partially funded by ARPA Act funds. Important Note: This is a subset of the households reported in the first line, meaning that a household that received a benefit that was fully or partially funded with ARPA Act funds should be reported in this line and in the first line as well.

To report this information, grantees will need to identify which funding sources were used to provide each household with each type of LIHEAP assistance during FY 2021.

General Requirements:

Reporting Period

Household data are for the reporting period for FY2021 (October 1, 2020 – September 30, 2021). Grantees may operate their programs on a different program year (e.g. starting January 1 or July 1). However, complete household data still need to be reported for the reporting period of FY 2021.

Data Consistency

The data will be checked for consistency against the type of LIHEAP assistance that states report in their *LIHEAP Model Plan for FY 2021* and later with the data reported in each state's *LIHEAP Performance Data Form for FY 2021*. For example, if obligated funds are reported for cooling assistance and there are no household data reported for cooling assistance, then the state should include a note which explains the inconsistency. States may correct such issues by creating a revision and submitting their *LIHEAP Household Report* or *LIHEAP Performance Data Form* in OLDC.

State of Washington
July 1, 2021 through June 30, 2022

2022-040 The Department of Commerce did not have adequate internal controls over and did not comply with requirements to issue management decisions for audit findings to subrecipients of the Low-Income Home Energy Assistance Program.

Assistance Listing Number and Title:	93.568 Low-Income Home Energy Assistance Program 93.568 COVID-19 Low-Income Home Energy Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2201WALIEA; 2101WALIEA; 2201WALIEI; 2101WALWC5; 2101WEA5C6; 2102WALWC6
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Department of Commerce administers the Low-Income Home Energy Assistance Program, which provides financial assistance to low-income households to meet their home energy needs. The Department makes subawards to community-based organizations to provide this assistance. In fiscal year 2022, the Department spent more than $102 million in federal program funds, approximately $98 million of which it paid to subrecipients.

Federal regulations require the Department to monitor its subrecipients' activities. This includes verifying that subrecipients that spend $750,000 or more in federal awards during a fiscal year obtain a single audit. The audit must be completed and submitted to the Federal Audit Clearinghouse within 30 days after receiving the auditor's report or nine months after the end of the subrecipient's audit period, whichever is earlier.

Additionally, for the awards it passes on to subrecipients, the Department must follow up and ensure its subrecipients take timely and appropriate corrective action on all deficiencies identified through audits, onsite reviews and other means. When a subrecipient receives an audit finding for a Department-funded program, federal law requires the Department to issue a management decision to the subrecipient within six months of acceptance of the audit report by Federal Audit Clearinghouse. The management decision must clearly state whether the audit finding is sustained, the reasons for the decision, and the actions the subrecipient is expected to take, such as repaying unallowable costs or making financial adjustments. These requirements help ensure subrecipients use federal program funds for authorized purposes and within the provisions of contracts or grant agreements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to issue management decisions for audit findings to the program's subrecipients.

The Department had a process in place to monitor that program subrecipients received single audits. However, for the first half of the audit period, it did not have a process in place to issue, communicate and follow up on management decisions to its subrecipients when program findings were issued.

During the audit period, the Department had 26 subrecipients that were required to submit a single audit. One subrecipient received a finding for which the Department was required to issue a management decision. We found the Department did not issue a management decision for this subrecipient.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not establish sufficient internal controls or monitoring procedures to ensure the Department issued the required management decisions. The Department also lacks written policies over issuing management decisions to its federal program subrecipients.

Effect of Condition

Without establishing adequate internal controls, the Department cannot ensure it is following up on subrecipient single audit findings and communicating required management decisions to subrecipients. By failing to ensure subrecipients establish corrective actions and management monitor them for effectiveness, the Department cannot determine whether subrecipients have sufficiently corrected issues identified in audit findings.

Recommendations

We recommend the Department:

- Establish effective internal controls to ensure it issues management decisions by the due date and follows up on all subrecipient audit findings related to the program
- Ensure subrecipients develop and perform acceptable corrective actions to adequately address all audit recommendations

Department's Response

The Department of Commerce concurs with the finding. The Department hired an Internal Control Officer in November 2021 assigned to complete the required verification of Federal Audit Clearinghouse (FAC) submissions. This process was completed for all recipients who expended $750,000 or more in federal funds passed through the Department. One subrecipients submission selected for testing was verified, however, a formal management decision was not issued. The audit report submitted to the FAC included various errors which included no identification of the pass through entity (the Department of Commerce) as part of the finding and the Schedule of Expenditure of Federal Awards (SEFA) reported the wrong state agency's acronym. The Department of Corrections was listed, not Commerce as required. The accurate reporting of the pass through entity in the audit report is imperative for Commerce to identify who they are required to issue a management decision for. A comprehensive spreadsheet of the Department's management decision was maintained, however, the subrecipient selected for testing was omitted.

The Department currently has a robust and comprehensive process to identify required reporters, verify their submission to the FAC, document late or non-reporters, and document communication requests for information related to submissions. The Department has also created a method to formally communicate the management decision to our subrecipients who have received Commerce funded audit findings. Our prior process included verbally discussing the finding, corrective action plans and Commerce requests with the subrecipient. Internal controls for the monitoring of federal reporting and issuing of management decisions have been in place since March 2022. Commerce management will continue to monitor the process and implement efficiencies to ensure continued compliance with all respects of the code of federal regulations.

We appreciate the State Auditor's Office thorough review of this process and recommendations. We anticipate all future audits will find the Department has employed strong internal controls supporting compliance with all requirements.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, establishes the following applicable requirements:

Section 200.332 Requirements for pass-through entities, states in part:

All pass-through entities must:

(d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. Pass-through entity monitoring of the subrecipient must include:

(2) Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award provided to the subrecipient from the pass-through entity detected through audits, on-site reviews, and written confirmation from the subrecipient, highlighting the status of actions planned or taken to address Single Audit findings related to the particular subaward.

(3) Issuing a management decision for applicable audit findings pertaining only to the Federal award provided to the subrecipient from the pass-through entity as required by § 200.521.

(4) The pass-through entity is responsible for resolving audit findings specifically related to the subaward and not responsible for resolving crosscutting findings. If a subrecipient has a current Single Audit report posted in the Federal Audit Clearinghouse and has not otherwise been excluded from receipt of Federal funding (e.g., has been debarred or suspended), the pass-through entity may rely on the subrecipient's cognizant audit agency or cognizant oversight agency to perform audit follow-up and make management decisions related to cross-cutting findings in accordance with section § 200.513(a)(3)(vii). Such reliance does not eliminate the responsibility of the pass-through entity to issue subawards that conform to agency and award-specific requirements, to manage risk through ongoing subaward monitoring, and to monitor the status of the findings that are specifically related to the subaward.

Section 200.339 Remedies for noncompliance, states:

If a non-Federal entity fails to comply with the U.S. Constitution, Federal statutes, regulations or the terms and conditions of a Federal award, the Federal awarding agency or pass-through entity may impose additional conditions, as described in § 200.208. If the Federal awarding agency or pass-through entity determines that noncompliance cannot be remedied by imposing additional conditions, the Federal awarding agency or pass-through entity may take one or more of the following actions, as appropriate in the circumstances:

(a) Temporarily withhold cash payments pending correction of the deficiency by the non-Federal entity or more severe enforcement action by the Federal awarding agency or pass-through entity.

(b) Disallow (that is, deny both use of funds and any applicable matching credit for) all or part of the cost of the activity or action not in compliance.

(c) Wholly or partly suspend or terminate the Federal award.

(d) Initiate suspension or debarment proceedings as authorized under 2 CFR part 180 and Federal awarding agency regulations (or in the case of a pass-through entity, recommend such a proceeding be initiated by a Federal awarding agency).

(e) Withhold further Federal awards for the project or program.

(f) Take other remedies that may be legally available.

Section 200.501 Audit requirements, states in part:

(a) Audit required. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

(b) Single audit. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single audit conducted in

accordance with § 200.514 except when it elects to have a program-specific audit conducted in accordance with paragraph (c) of this section.

Section 200.521 Management decision, states in part:

(a) General. The management decision must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. If the auditee has not completed corrective action, a timetable for follow-up should be given. Prior to issuing the management decision, the Federal agency or pass-through entity may request additional information or documentation from the auditee, including a request for auditor assurance related to the documentation, as a way of mitigating disallowed costs. The management decision should describe any appeal process available to the auditee. While not required, the Federal agency or pass-through entity may also issue a management decision on findings relating to the financial statements which are required to be reported in accordance with GAGAS.

(c) Pass-through entity. As provided in § 200.332(d), the pass-through entity must be responsible for issuing a management decision for audit findings that relate to Federal awards it makes to subrecipients.

(d) Time requirements. The Federal awarding agency or pass-through entity responsible for issuing a management decision must do so within six months of acceptance of the audit report by the FAC. The auditee must initiate and proceed with corrective action as rapidly as possible and corrective action should begin no later than upon receipt of the audit report.

(e) Reference numbers. Management decisions must include the reference numbers the auditor assigned to each audit finding in accordance with § 200.516(c).

State of Washington
July 1, 2021 through June 30, 2022

2022-041 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers for the Child Care and Development Fund Cluster programs were allowable and properly supported.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$260,552,979

Background

The Department of Children, Youth, and Families (Department) administers the federal Child Care and Development Fund (CCDF) grants to help eligible working families pay for child care and fund improvements to child care quality. In fiscal year 2022, the Department spent about $668.6

million in CCDF federal funding, which was an increase of about $341.1 million compared to the prior fiscal year.

The Department is responsible for establishing policies to ensure payments to providers for child care services are allowable. In fiscal year 2022, the Department spent more than $260.5 million on monthly child care subsidy payments to child care providers.

There are three child care provider types: licensed centers, licensed family homes, and licensed exempt providers referred to as Family, Friends and Neighbor providers. The Department uses the Social Service Payment System (SSPS) to process the payments it makes to child care providers. The system allocates payments to various funding sources, based on the eligibility of the client. These funding sources include multiple federal programs, multiple CCDF federal grant awards, and state funding. The Department uploads the SSPS payment data into the state's accounting system at a summary level based on the various funding sources. There is always a need to transfer the funding sources for some payments throughout the year to manage federal and state funds properly.

In prior audit periods up until fiscal year 2021, the Department prepared supporting documentation for transfers that included details of what payments it was transferring. The purpose of documenting this detail was to maintain proper support for federal expenditures.

The Department of Health and Human Services (HHS), which oversees the CCDF program at the federal level, requires recipients have accounting procedures that are sufficient for tracing grants to a level of expenditure adequate to show that they have been used in accordance with program requirements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers were allowable and properly supported. We have reported this condition since 2005. The most recent audit finding numbers were 2021-033, 2020-038, 2019-035, 2018–034, 2017-024, 2016-021, 2015-023, 2014-023, 2013-016, 12-28, 11-23, 10-31, 9-12 and 8–13.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure payments to child care providers for the CCDF programs were allowable and properly supported.

In fiscal year 2021, management informed us that the Department changed its grant management practices to process expenditure transfers at the grant level. This new process made the original

expenditure coding in SSPS inaccurate and unreliable for testing. As a result, we could not trace the federal funds to a level of expenditure adequate to establish whether the Department spent CCDF funds in accordance with federal and state regulations. Further, this meant we could not test the Department's payments to child care providers for compliance with activities allowed and cost principles.

By processing these adjustments at the fund level, the Department invalidated the transaction-level documentation of the original child care expenditure in SSPS and did not identify the new allocation at the payment level. Additionally, the Department transferred some of these child care expenditures more than once at the fund level, making the underlying data increasingly unreliable with each transfer.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department is required to maintain sufficient documentation for each payment it makes with federal dollars. Management decided to modify the Department's accounting practices in a way that now prevents it from meeting this requirement.

The Department implemented what management referred to as fund-level accounting. This consisted of making significant accounting adjustments between funding sources in its general ledger without identifying the underlying transactions from SSPS that supported the adjustments. This affected all populations of child care expenditures for every month of the fiscal year. HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant.

Effect of Condition and Questioned Costs

By not complying with federal law regarding maintaining adequate supporting documentation for expenditures, the Department created a condition that made it impossible for our Office to audit the federal dollars it used for payments to child care providers. Because we could not test transaction-level detail, we also could not determine whether the issues we identified in prior audits had improved or worsened, including the Department's lack of adequate internal controls and significant rate of noncompliance for payments to child care providers.

The total amount of known child care payments with federal CCDF funds in the audit period was $260,552,979. The Department also partially funded these payments with an additional $37,374,731 in state dollars.

Because the Department did not comply with HHS requirements to allow for the tracing of grant expenditures to a payment level, we are questioning all $260,552,979 in federal program costs the

Department incurred during the audit period. The payments the Department partially paid with state funds are not included in the federal questioned costs.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Design and implement internal controls to ensure transaction-level data is sufficient to comply with federal law and state rules
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Department's Response

The Department has managed the CCDF program since 2019, prior to that it was managed by the Department of Social and Health Services and the Department of Early Learning. The Department implemented grant-level management of all federal funds, including the CCDF grant. The Department allocated the CCDF grants to eligible clients and allowable activities in compliance with 45 CFR 98.67.

This process consists of making grant level adjustments between allowable grant sources to properly spend grant dollars within the allowable period of performance and ensure level of effort and matching requirements. The Department's grant adjustments were processed based on eligible clients and allowable activities. However, the adjustments did not include child-level data as required by SAO.

In state fiscal year 2021, the SAO issued a finding in the amount of $32 in the area of CCDF eligibility, no other findings, management letters, or exit items in the area of eligibility or the cost allocation of funds based on eligibility were determined. Given that eligibility or cost allocation is not an area of concern and transfers were processed between CCDF source of funds with the same eligibility requirements, the Department is confident CCDF funding was spent appropriately within federal regulations.

In the Cause of Condition, the SAO stated, "HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant." The Department does not agree with this interpretation of the meeting outcome. During this informal meeting, on February 23, 2022, the State Auditor's Office, Office of Financial Management, and the Department met with HHS and they stated they would not offer an opinion until they received the completed finding from the state. The opinion will be part of the Management Decision letter that is expected around February 2023.

The Department is committed to improving our internal controls. The Department does not currently have the staff to develop and maintain the business process redesign, as well as the information technology initiatives necessary to meet the level of assurance as identified by SAO. In response to the 2021 auditor's recommendations, the Department has submitted a budget request for staffing to the Legislature for the 2023-2025 biennial budget. The staff would process adjustments to include transaction-level data. The Department will continue to review other options available for processing adjustments to include transaction-level data.

Auditor's Remarks

The level of documentation needed to support grant expenditures is not established by our Office, but in titles 2 and 45 of the Code of Federal Regulations and the State's grant award. During the meeting with HHS that the Department referenced in their response, the grantor stated the specific federal law the Department's accounting procedures were noncompliant with was 45 CFR 98.67.

While the Department references the eligibility finding as a basis for asserting federal funds were spent properly, the program has received findings related to improper payments for child care since 2005, including over $21 million in likely questioned costs identified during the 2020 audit. Because we are unable to test the child care payments during the last two audits, we are unable to determine the current status of the conditions previously reported.

We appreciate the Department's commitment to resolving these matters and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR, Section 98.67 – Fiscal requirements, states:

> (a) Lead Agencies shall expend and account for CCDF funds in accordance with their own laws and procedures for expending and accounting for their own funds.

(b) Unless otherwise specified in this part, contracts that entail the expenditure of CCDF funds shall comply with the laws and procedures generally applicable to expenditures by the contracting agency of its own funds.

(c) Fiscal control and accounting procedures shall be sufficient to permit:

   (1) Preparation of reports required by the Secretary under this subpart and under subpart H; and

   (2) The tracking of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the provisions of this part.

State of Washington
July 1, 2021 through June 30, 2022

2022-042 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with matching, level of effort, and earmarking requirements for the Child Care and Development Fund Cluster.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2113WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Matching, Level of Effort, Earmarking
Known Questioned Cost Amount:	None

Background

The Department of Children, Youth, and Families (Department) administers the federal Child Care and Development Fund (CCDF) grants to help eligible working families pay for child care and fund improvements to child care quality. In fiscal year 2022, the Department spent about $668.6 million in federal funding, which was an increase of about $341.1 million compared to the prior fiscal year.

The CCDF consists of three distinct funding sources: Discretionary Fund, Mandatory Fund, and Matching Fund. Additionally, under the Temporary Assistance for Needy Families (TANF) program, the Department may transfer TANF funds to the CCDF, which are then treated as Discretionary Funds. The Department is instructed how to spend this federal money. For the Department to receive its allotted share of the Matching Fund, it must meet the Maintenance of Effort (MOE) requirement and match the federal Matching Fund claimed with state expenditures at the Federal Medical Assistance Percentage rate for the applicable fiscal year. The Department must also meet earmarking requirements for expenditures for administrative and quality activities.

The U.S. Department of Health and Human Services (HHS), which oversees the CCDF program at the federal level, requires recipients have accounting procedures that are sufficient for tracing grants to a level of expenditure adequate to show that they have been used in accordance with program requirements. Department staff run monthly and quarterly expenditure reports from the accounting system to track requirements over matching, level of effort, and earmarking for each open grant award.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over matching, level of effort, and earmarking requirements for the CCDF Cluster programs. The prior audit finding numbers were 2021-036 and 2020-040.

Description of Condition

The Department did not have adequate internal controls over and did not comply with matching, level of effort, and earmarking requirements for the CCDF programs.

The Department's accounting records should be used to verify it has met matching, level of effort, and earmarking requirements. In fiscal year 2021, management informed us that the Department changed its grant management practices to process expenditure transfers at the grant level. This new process made the original expenditure coding in the payment system inaccurate and unreliable for testing.

Without identifying which expenditures it transferred, the Department's monitoring is insufficient for properly managing matching, level of effort, and earmarking requirements. Our Office could not rely on the data supporting the Department's expenditures or verify that the accounting records were accurate. As a result, we could not trace the federal funds to a level of expenditure adequate to establish whether the Department spent CCDF funds in accordance with federal and state regulations. Further, this meant we could not test the Department's payments for compliance with matching, level of effort, and earmarking requirements.

By processing these adjustments at the fund level, the Department invalidated the transaction-level documentation of the original child care expenditure in the payment system, and did not identify the new allocation at the payment level. Additionally, the Department transferred some of these child care expenditures more than once at the fund level, making the underlying data increasingly unreliable with each transfer. This condition is also referenced in audit finding 2022-041.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department is required to maintain sufficient documentation for each payment it makes with federal dollars. Management decided to modify the Department's accounting practices in a way that now prevents it from meeting this requirement.

The Department implemented what management referred to as fund-level accounting. This consisted of making significant accounting adjustments between funding sources in its general ledger without identifying the underlying transactions in the payment system that supported the adjustments. This affected all populations of child care expenditures for every month of the fiscal year. HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant.

Effect of Condition

By not complying with federal law regarding maintaining adequate supporting documentation for expenditures, the Department created a condition that made it impossible for our Office to determine if it had met matching, level of effort, and earmarking requirements.

Recommendations

We recommend the Department:

- Design and implement internal controls to ensure transaction-level data is sufficient to comply with federal law and state rules
- Develop effective ongoing monitoring procedures

Department's Response

The Department has managed the CCDF program since 2019, prior to that it was managed by the Department of Social and Health Services and the Department of Early Learning. The Department implemented grant-level management of all federal funds, including the CCDF grant. The Department allocated the CCDF grants to eligible clients and allowable activities in compliance with 45 CFR 98.67.

This process consists of making grant level adjustments between allowable grant sources to properly spend grant dollars within the allowable period of performance and ensure level of effort and matching requirements. The Department's grant adjustments were processed based on eligible clients and allowable activities. However, the adjustments did not include child-level data as required by SAO.

In state fiscal year 2021, the SAO issued a finding in the amount of $32 in the area of CCDF eligibility, no other findings, management letters, or exit items in the area of eligibility or the cost allocation of funds based on eligibility were determined. Given that eligibility or cost allocation is not an area of concern and transfers were processed between CCDF source of funds with the same eligibility requirements, the Department is confident CCDF funding was spent appropriately within federal regulations.

In the Cause of Condition, the SAO stated, "HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant." The Department does not agree with this interpretation of the meeting outcome. During this informal meeting, on February 23, 2022, the State Auditor's Office, Office of Financial Management, and the Department met with HHS and they stated they would not offer an opinion until they received the completed finding from the state. The opinion will be part of the Management Decision letter that is expected around February 2023.

The Department is committed to improving our internal controls. The Department does not currently have the staff to develop and maintain the business process redesign, as well as the information technology initiatives necessary to meet the level of assurance as identified by SAO. In response to the 2021 auditor's recommendations, the Department has submitted a budget request for staffing to the Legislature for the 2023-2025 biennial budget. The staff would process adjustments to include transaction-level data. The Department will continue to review other options available for processing adjustments to include transaction-level data.

Auditor's Remarks

The level of documentation needed to support grant expenditures is not established by our Office, but in titles 2 and 45 of the Code of Federal Regulations and the State's grant award. During the meeting with HHS that the Department referenced in their response, the grantor stated the specific federal law the Department's accounting procedures were noncompliant with was 45 CFR 98.67.

While the Department references the eligibility finding as a basis for asserting federal funds were spent properly, the program has received findings related to improper payments for child care since 2005, including over $21 million in likely questioned costs identified during the 2020 audit. Because we are unable to test the child care payments during the last two audits, we are unable to determine the current status of the conditions previously reported.

We appreciate the Department's commitment to resolving these matters and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR, Section 98.67 – Fiscal requirements, states:

(a) Lead Agencies shall expend and account for CCDF funds in accordance with their own laws and procedures for expending and accounting for their own funds.

(b) Unless otherwise specified in this part, contracts that entail the expenditure of CCDF funds shall comply with the laws and procedures generally applicable to expenditures by the contracting agency of its own funds.

(c) Fiscal control and accounting procedures shall be sufficient to permit:

    (1) Preparation of reports required by the Secretary under this subpart and under subpart H; and

    (2) The tracking of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the provisions of this part.

State of Washington
July 1, 2021 through June 30, 2022

2022-043 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with period of performance requirements for the Child Care and Development Fund.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Period of Performance
Known Questioned Cost Amount:	None

Background

The Department of Children, Youth, and Families (Department) administers the federal Child Care and Development Fund (CCDF) grants to help eligible working families pay for child care and fund improvements to child care quality. In fiscal year 2022, the Department spent about $668.6 million in CCDF federal funding, which was an increase of about $341.1 million compared to the prior fiscal year.

Each federal grant specifies a performance period during which recipients must obligate and liquidate program costs. These periods typically align with the federal fiscal year of October 1 through September 30. Payments for costs charged before a grant's beginning date or after the ending date are not allowed without the grantor's prior approval.

The CCDF consists of three distinct funding sources: Discretionary Fund, Mandatory Fund, and Matching Fund. Each of these funds has specific period of performance requirements established in federal regulation (45 CFR § 98.60(d)):

- Discretionary Funds must be obligated by the end of the succeeding fiscal year after award and expended by the end of the third fiscal year after award.
- Mandatory Funds must be obligated by the end of the fiscal year in which they are awarded if the state also requests Matching Funds. If no Matching Funds are requested for the fiscal year, then the Mandatory Funds are available until liquidated.
- Matching Funds must be obligated by the end of the fiscal year in which they are awarded and liquidated by the end of the succeeding fiscal year after award.

During the audit period, the Department also received supplemental funds under the Coronavirus Aid, Relief, and Economic Security (CARES) and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Acts. These funds are treated as Discretionary Funds, however, they have their own specific obligation and liquidation timeframes.

The U.S. Department of Health and Human Services (HHS), which oversees the CCDF at the federal level, requires recipients to have accounting procedures that are sufficient for tracing grants to a level of expenditure adequate to show that they have been used in accordance with program requirements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Department did not have adequate internal controls over period of performance requirements for the CCDF program. The prior finding numbers were 2021-037 and 2020-041.

Description of Condition

The Department did not have adequate internal controls over and did not comply with period of performance requirements for the CCDF program.

Our Office uses the Department's accounting records to verify it has met the period of performance requirements. In fiscal year 2021, management informed us that the Department changed its grant management practices to process expenditure transfers at the grant level. This new process made the original expenditures coded in the payment system inaccurate and unreliable for audit testing.

As a result, we could not trace the federal funds to a level of expenditure adequate to establish whether the Department spent CCDF funds in accordance with federal and state regulations. Further, this meant we could not test the Department's payments for compliance with period of performance requirements. This condition is also referenced in audit finding 2022-041.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department is required to maintain sufficient documentation for each payment it makes with federal dollars. Management decided to modify the Department's accounting practices in a way that now prevents it from meeting this requirement.

The Department implemented what management referred to as fund-level accounting. This consisted of making significant accounting adjustments between funding sources in its general ledger without identifying the underlying transactions in the payment system that supported the adjustments. This affected all populations of child care expenditures for every month of the fiscal year. HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant.

Effect of Condition

By not complying with federal law regarding maintaining adequate supporting documentation for expenditures, the Department created a condition that made it impossible for our Office to determine if it materially met the period of performance requirements. Furthermore, without adequate internal controls in place, the Department is at a higher risk of making improper payments with grant funds.

Recommendations

We recommend the Department:

- Design and implement internal controls to ensure transaction-level data is sufficient to comply with federal law and state rules
- Develop written policies and procedures over federal period of performance requirements

Department's Response

The Department has managed the CCDF program since 2019, prior to that it was managed by the Department of Social and Health Services and the Department of Early Learning. The Department implemented grant-level management of all federal funds, including the CCDF grant. The

Department allocated the CCDF grants to eligible clients and allowable activities in compliance with 45 CFR 98.67.

This process consists of making grant level adjustments between allowable grant sources to properly spend grant dollars within the allowable period of performance and ensure level of effort and matching requirements. The Department's grant adjustments were processed based on eligible clients and allowable activities. However, the adjustments did not include child-level data as required by SAO.

In state fiscal year 2021, the SAO issued a finding in the amount of $32 in the area of CCDF eligibility, no other findings, management letters, or exit items in the area of eligibility or the cost allocation of funds based on eligibility were determined. Given that eligibility or cost allocation is not an area of concern and transfers were processed between CCDF source of funds with the same eligibility requirements, the Department is confident CCDF funding was spent appropriately within federal regulations.

In the Cause of Condition, the SAO stated, "HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant." The Department does not agree with this interpretation of the meeting outcome. During this informal meeting, on February 23, 2022, the State Auditor's Office, Office of Financial Management, and the Department met with HHS and they stated they would not offer an opinion until they received the completed finding from the state. The opinion will be part of the Management Decision letter that is expected around February 2023.

The Department is committed to improving our internal controls. The Department does not currently have the staff to develop and maintain the business process redesign, as well as the information technology initiatives necessary to meet the level of assurance as identified by SAO. In response to the 2021 auditor's recommendations, the Department has submitted a budget request for staffing to the Legislature for the 2023-2025 biennial budget. The staff would process adjustments to include transaction-level data. The Department will continue to review other options available for processing adjustments to include transaction-level data.

Auditor's Remarks

The level of documentation needed to support grant expenditures is not established by our Office, but in titles 2 and 45 of the Code of Federal Regulations and the State's grant award. During the meeting with HHS that the Department referenced in their response, the grantor stated the specific federal law the Department's accounting procedures were noncompliant with was 45 CFR 98.67.

While the Department references the eligibility finding as a basis for asserting federal funds were spent properly, the program has received findings related to improper payments for child care since 2005, including over $21 million in likely questioned costs identified during the 2020 audit.

Because we are unable to test the child care payments during the last two audits, we are unable to determine the current status of the conditions previously reported.

We appreciate the Department's commitment to resolving these matters and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR, Section 98.60 – Availability of funds, states in part:

> (d) The following obligation and liquidation provisions apply to States and Territories:
>
> > (1) Discretionary Fund allotments shall be obligated in the fiscal year in which funds are awarded or in the succeeding fiscal year. Unliquidated obligations as of the end of the succeeding fiscal year shall be liquidated within one year.
> >
> > (2)
> >
> > > (i) Mandatory Funds for States requesting Matching Funds per § 98.55 shall be obligated in the fiscal year in which the funds are granted and are available until expended.
> > >
> > > (ii) Mandatory Funds for States that do not request Matching Funds are available until expended.
> >
> > (3) Both the Federal and non-Federal share of the Matching Fund shall be obligated in the fiscal year in which the funds are granted and liquidated no later than the end of the succeeding fiscal year.

Title 45 CFR, Section 98.67 – Fiscal requirements, states:

> (a) Lead Agencies shall expend and account for CCDF funds in accordance with their own laws and procedures for expending and accounting for their own funds.

(b) Unless otherwise specified in this part, contracts that entail the expenditure of CCDF funds shall comply with the laws and procedures generally applicable to expenditures by the contracting agency of its own funds.

(c) Fiscal control and accounting procedures shall be sufficient to permit:

  (1) Preparation of reports required by the Secretary under this subpart and under subpart H; and

  (2) The tracking of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the provisions of this part.

State of Washington
July 1, 2021 through June 30, 2022

2022-044 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with financial reporting requirements for the Child Care and Development Fund Cluster.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Department of Children, Youth, and Families (Department) administers the federal Child Care and Development Fund (CCDF) grants to help eligible working families pay for child care and fund improvements to child care quality. In fiscal year 2022, the Department spent about $668.6 million in federal funding, which was an increase of about $341.1 million compared to the prior fiscal year.

The Department is required to submit a quarterly ACF-696 financial report for each open grant. These reports contain information on expenditures for three CCDF funding sources: the Mandatory Fund, the Matching Fund, and the Discretionary Fund. The Department uses CCDF expenditures recorded in the state's accounting system to compile and support the ACF-696 report.

The U.S. Department of Health and Human Services (HHS), which oversees the CCDF program at the federal level, requires recipients to have accounting procedures that are sufficient for tracing grants to a level of expenditure adequate to show that they have been used in accordance with program requirements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate controls over and did not comply with financial reporting requirements for the CCDF Cluster programs. The prior finding number was 2021-038.

Description of Condition

The Department did not have adequate internal controls over and did not comply with financial reporting requirements for the CCDF program.

The Department's accounting records must provide and support the financial information reported on ACF-696 reports. During the audit period, the Department's grant management practice was to process expenditure transfers at the grant level without identifying which expenditures it transferred. Therefore, we could not rely on the data supporting the Department's reported ACF-696 expenditures, and could not test whether the reports were accurate and complete. This condition is also referenced in audit finding 2022-041.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department is required to maintain sufficient documentation for each payment it makes with federal dollars. Management decided to modify the Department's accounting practices in a way that now prevents it from meeting this requirement.

The Department implemented what management referred to as fund-level accounting. This consisted of making significant accounting adjustments between funding sources in its general ledger without identifying the underlying transactions in the payment system that supported the adjustments. This affected all populations of child care expenditures for every month of the fiscal

year. HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant.

Effect of Condition

By not complying with federal law regarding maintaining adequate supporting documentation for expenditures, the Department created a condition that made it impossible for our Office to audit the federal expenditures reported on the ACF-696 financial report.

Recommendation

We recommend the Department design and implement internal controls to ensure the ACF-696 report is supported with transaction-level data that is sufficient to comply with federal law and state rules.

Department's Response

The Department has managed the CCDF program since 2019, prior to that it was managed by the Department of Social and Health Services and the Department of Early Learning. The Department implemented grant-level management of all federal funds, including the CCDF grant. The Department allocated the CCDF grants to eligible clients and allowable activities in compliance with 45 CFR 98.67.

This process consists of making grant level adjustments between allowable grant sources to properly spend grant dollars within the allowable period of performance and ensure level of effort and matching requirements. The Department's grant adjustments were processed based on eligible clients and allowable activities. However, the adjustments did not include child-level data as required by SAO.

In state fiscal year 2021, the SAO issued a finding in the amount of $32 in the area of CCDF eligibility, no other findings, management letters, or exit items in the area of eligibility or the cost allocation of funds based on eligibility were determined. Given that eligibility or cost allocation is not an area of concern and transfers were processed between CCDF source of funds with the same eligibility requirements, the Department is confident CCDF funding was spent appropriately within federal regulations.

In the Cause of Condition, the SAO stated, "HHS officials informed the Department that these accounting practices do not comply with federal law, but management said they believe they are compliant." The Department does not agree with this interpretation of the meeting outcome. During this informal meeting, on February 23, 2022, the State Auditor's Office, Office of Financial Management, and the Department met with HHS and they stated they would not offer an opinion

until they received the completed finding from the state. The opinion will be part of the Management Decision letter that is expected around February 2023.

During the audit, SAO tested the reporting requirements for Federal Funding Accountability and Transparency Act for internal controls and compliance and found no deficiencies or internal control weaknesses. The state fiscal year 2022 ACF-696 reports that were filed during the audit period where submitted timely and accurately to reflect the grant level expenditures as document in the agency financial reporting system.

Auditor's Remarks

The level of documentation needed to support grant expenditures is not established by our Office, but in titles 2 and 45 of the Code of Federal Regulations and the State's grant award. During the meeting with HHS that the Department referenced in their response, the grantor stated the specific federal law the Department's accounting procedures were noncompliant with was 45 CFR 98.67.

While the Department references the eligibility finding as a basis for asserting federal funds were spent properly, the program has received findings related to improper payments for child care since 2005, including over $21 million in likely questioned costs identified during the 2020 audit. Because we are unable to test the child care payments during the last two audits, we are unable to determine the current status of the conditions previously reported.

We appreciate the Department's commitment to resolving these matters and we will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR, Section 98.67 – Fiscal requirements, states:

> (a) Lead Agencies shall expend and account for CCDF funds in accordance with their own laws and procedures for expending and accounting for their own funds.

(b) Unless otherwise specified in this part, contracts that entail the expenditure of CCDF funds shall comply with the laws and procedures generally applicable to expenditures by the contracting agency of its own funds.

(c) Fiscal control and accounting procedures shall be sufficient to permit:

    (1) Preparation of reports required by the Secretary under this subpart and under subpart H; and

    (2) The tracking of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the provisions of this part.

State of Washington
July 1, 2021 through June 30, 2022

2022-045 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with health and safety requirements for the Child Care and Development Fund program.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCC5; 2103WACCDD; 2203WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Health and Safety Requirements
Known Questioned Cost Amount:	$412

Background

The Department of Children, Youth, and Families administers the federal Child Care and Development Fund (CCDF) grant to help eligible working families pay for child care. In fiscal year 2022, the Department spent about $668.6 million in CCDF federal funding.

The Department oversees two types of providers: licensed providers and license-exempt Family, Friend, and Neighbor (FFN) providers. The Department is responsible for ensuring all these providers meet health and safety standards. The monitoring activity varies for licensed and FFN providers.

The Department has an approved CCDF State Plan for federal fiscal year 2022-2024 that outlines how it will meet the health and safety requirements for licensed and FFN providers.

Licensed providers

Department licensors conduct annual monitoring visits of licensed providers. During visits, they use a monitoring checklist to verify whether providers have met required health and safety standards. The licensors use the WA Compass system to document their activities. The system allows licensing staff to monitor the completion of visits, make timely updates and streamline their processes.

When licensors identify health and safety violations during a monitoring visit, they document them on an inspection report. The inspection report contains the areas of provider noncompliance and establishes deadlines for correcting them. The Department is required to conduct timely follow-up visits on noncompliance issues to ensure providers correct them. Depending on the severity of the noncompliance, the Department has five, 10 or 15 business days to verify the noncompliance has been corrected.

FFN providers

Washington's CCDF State Plan and a state rule (WAC 110-16-0025) require non-relative FFN providers to complete health and safety training within 90 days of their subsidy payment start date. They also must complete ongoing health and safety training. The Department conducts an annual health and safety visit to ensure providers are following health and safety rules.

The Department adopted a rule (WAC 110-16-0030) that states it must conduct annual technical assistance visits for non-relative FFN providers within a year of subsidy approval. During these visits, an FFN specialist reviews health and safety requirements and conducts the ongoing training requirements with the provider.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the seven prior audits, we reported that the Department did not have adequate internal controls over and did not comply with health and safety requirements. The previous finding numbers were 2021-039, 2020-042, 2019-039, 2018-035, 2017-025, 2016-022 and 2015–024.

Description of Condition

The Department did not have adequate internal controls over and did not comply with health and safety requirements for the CCDF program.

Licensed provider annual monitoring and noncompliance follow-ups

We used a statistical sampling method to randomly select 59 out of a total population of 5,875 licensed providers. We examined this sample of licensed providers to determine if they received an annual monitoring visit and that the Department performed timely, appropriate follow-ups when they found noncompliance issues. We identified 30 instances (50.8 percent) where providers did not receive their required annual monitoring visit. Of the remaining 29 providers that did receive a monitoring visit, we identified two instances (6.9 percent) where the licensor did not conduct the appropriate follow-up visit on noncompliance issues.

Non-relative FFN provider initial training

We were not able to obtain complete populations of FFN providers for the purposes of our initial training testing. We made multiple requests for the list of FFN providers, and the Department first provided a list of 85 providers that it asserted needed initial training. When it was determined this list was incomplete, we received another list from the Department that contained 702 providers. This list was also found to be incomplete due to system limitations. However, we still performed testing based on the data made available to us.

We randomly selected 57 out of 702 FFN providers that the Department asserted were required to complete initial training. Of those reviewed, we determined 34 of the providers did not meet the criteria for testing because they were not subject to initial training for different reasons, such as they were relative providers, had never provided care, or were closed prior to the initial training requirement deadline. Of the remaining 23 providers that were applicable to our testing, we found one instance where the provider did not complete its initial training and was not closed within 90 days of its first subsidy payment.

Non-relative FFN provider ongoing training and annual technical visits

We were not able to obtain complete populations of FFN providers for the purposes of our ongoing training and technical visit testing. We made multiple requests for the list of FFN providers, and the Department first provided a list of 77 providers that it asserted were required to complete ongoing training and have a technical visit during the audit period. When it was determined this list was incomplete due to system limitations, we received another list from the Department that contained 1,443 providers. This list was also found to be incomplete, but we still performed testing based on the data made available to us.

We randomly selected 58 out of 1,443 FFN providers that the Department asserted were required to complete ongoing training and have a technical visit. Of those reviewed, we determined 55 of

the providers did not meet the criteria for testing because they were not subject to ongoing training or annual technical visits for different reasons, such as they were relative providers, had never provided care, or were closed prior to the training requirement and annual technical visit deadlines. Of the remaining three providers that were applicable to our testing, we found two instances where the providers completed their technical visits, but they did not receive ongoing training.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Licensed provider annual monitoring and noncompliance follow-ups

The Department did not conduct 30 of the 59 monitoring visits we reviewed because it has been unable to maintain the needed level of staffing. This has made it difficult for management to ensure monitoring visits and follow-up visits on identified noncompliance have occurred, as the CCDF program requires.

Non-relative FFN provider initial training, ongoing training, and annual technical visits

Management did not monitor sufficiently to ensure that staff completed technical visits or monitored FFN providers to ensure they met the training requirements. Further, due to system limitations, the Department did not effectively identify during the audit period which providers were subject to training and technical visit requirements.

Effect of Condition and Questioned Costs

Licensed provider annual monitoring and noncompliance follow-ups

By not completing monitoring visits or following up on noncompliance in a timely manner, the Department did not have assurance that providers met health and safety requirements. Further, not following up on noncompliance violations in a timely manner can put children in jeopardy of harm, neglect, and unhealthy environments.

Non-relative FFN provider initial training, ongoing training, and technical visits

By not monitoring FFN training requirements or conducting technical visits, the Department did not have assurance that providers met health and safety requirements. System limitations and the inability to obtain a complete population for sampling and testing created a condition that prevented our Office from fully auditing the Department's compliance with these requirements.

Because the Department did not timely terminate the FFN provider who did not complete initial training, we identified $412 of improperly paid program funds. We question costs when we find

an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Although we identified known questioned costs, we do not have reasonable assurance that the payment in question is appropriately represented in the Department's accounting records because of the grant management practice issue reported in finding 2022-041. Additionally, the payments in question are duplicative of the costs already questioned in the aforementioned provider payment finding.

Recommendations

We recommend the Department:

- Strengthen internal controls to ensure it sufficiently monitors all health and safety requirements
- Ensure management follows established policies and procedures to ensure licensors complete all monitoring visits and conduct thorough, timely follow-ups on any identified noncompliance issues
- Ensure management follows established policies and procedures to ensure non-relative FFN providers complete their required initial training, ongoing training, and receive technical visits

We also recommend the Department consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid.

Department's Response

The Department is strongly committed to ensuring the health, safety, and well-being of all children in care. The Department would like to acknowledge the child care providers that continued to operate during the COVID-19 pandemic and provided support to families and their community.

As to the Auditor's specific findings, the Department concurs and offers the following detail:

Licensed provider annual monitoring and noncompliance follow-ups

In response to the COVID-19 pandemic and under the Washington State Governor's Stay Home, Stay Healthy Order, the Department received from Administration for Children and Families (ACF) a waiver of CCDF's annual unannounced monitoring requirement and allowing for virtual monitoring, through September 30, 2021. The Department updated its CCDF Plan accordingly with ACF approval, but some providers were unable to participate in the virtual process resulting in monitoring visits not being conducted during SFY22. In addition, due to their COVID-19 safety concerns, some providers denied the licensor access or were not available for recheck within the required recheck time-line.

Due to the COVID-19 pandemic, the Department experienced a high level of child care licensor turnover. The Department focused available resources on assisting new and current providers to ensure access to child care for families, first responders, and health care workers per the Governor's directive. The Department processed 1,080 health and safety waivers during calendar years 2020-2022, and prioritized allocating resources to DOH COVID-19 related requirements. Given the Department's limited staffing resources and high volume of providers, the Department was unable to complete all monitoring visits and was unable to send licensing staff to assist other offices with this work. Starting in fall 2022, the Department began work to recruit new staff and train them on child care licensing rules and regulations to address turnover; however, this effort takes time, due to the extensive training we give our staff.

As part of its quality improvement initiates, the Department is now implementing data driven decisions to assist providers and their staff to meet health and safety requirements, and prioritizing monitoring visits to come back into compliance with health and safety requirements. In addition, the Department is implementing new recruitment and training plans for child care licensors. In November 2022, the Department added a new position to assist supervisors with onboarding and training of new staff hired during the audit period. The Department concurs that health and safety monitoring visits were not properly completed during the fiscal year and acknowledge that state fiscal year 2023 audit will indicate similar numbers while the Department implements a corrective action plan along aggressive timelines. The Department is focusing resources to strengthening internal controls around all health and safety requirements.

Non-relative FFN provider initial training, ongoing training, and annual technical visits

The Department tracks health and safety requirements for FFN providers using the limited tools and fields currently available in WA Compass. The WA Compass system was implemented for licensed child care providers and has not been fully developed for the FFN provider type. The State Auditor's Office requested data from the WA Compass system for their audit testing in a format the system does not currently support. Due to the fluid nature of the FFN providers, and their payment start dates, the Department was unable to pull data that reflected only providers with open authorizations during the audit period. Further, WA Compass does not currently include all health and safety requirements for FFN providers. The Department has dedicated staff resources to update WA Compass to include all health and safety requirements for FFNs and address data format issues. Staff will continue to track and monitor FFN health and safety requirements with available tools until all system development is completed.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 98.41, *Health and safety requirements*, states in part:

(a) Each Lead Agency shall certify that there are in effect, within the State (or other area served by the Lead Agency), under State, local or tribal law, requirements (appropriate to provider setting and age of children served) that are designed, implemented, and enforced to protect the health and safety of children. Such requirements, which are subject to monitoring pursuant to § 98.42, shall:

(1) Include health and safety topics consisting of, at a minimum:

(a) The prevention and control of infectious diseases (including immunizations); with respect to immunizations, the following provisions apply:

(1) As part of their health and safety provisions in this area, Lead Agencies shall assure that children receiving services under the CCDF are age-appropriately immunized. Those health and safety provisions shall incorporate (by reference or otherwise) the latest recommendation for childhood immunizations of the respective State, territorial, or tribal public health agency.

(2) Notwithstanding this paragraph (a)(1)(i), Lead Agencies may exempt:

(1) Children who are cared for by relatives (defined as grandparents, great grandparents, siblings (if living in a separate residence), aunts, and uncles), provided there are no other unrelated children who are cared for in the same setting.

(2) Children who receive care in their own homes, provided there are no other unrelated children who are cared for in the home.

(3) Children whose parents object to immunization on religious grounds.

(4) Children whose medical condition contraindicates immunization.

(3) Lead Agencies shall establish a grace period that allows children experiencing homelessness and children in foster care to receive services under this part while providing their families (including foster families) a reasonable time to take any necessary action to comply with immunization and other health and safety requirements.

(1) The length of such grace period shall be established in consultation with the State, Territorial or Tribal health agency.

(2) Any payment for such child during the grace period shall not be considered an error or improper payment under subpart K of this part.

(3) The Lead Agency may also, at its option, establish grace periods for other children who are not experiencing homelessness or in foster care.

(4) Lead Agencies must coordinate with licensing agencies and other relevant State, Territorial, Tribal, and local agencies to provide referrals and support to help families of children receiving services during a grace period comply with immunization and other health and safety requirements;

(ii) Prevention of sudden infant death syndrome and use of safe sleeping practices;

(iii) Administration of medication, consistent with standards for parental consent;

(iv) Prevention and response to emergencies due to food and allergic reactions;

(v) Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic;

(vi) Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment;

(vii) Emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused event (such as violence at a child care facility), within the meaning of those terms under section 602(a)(1) of the Robert T. Stafford Disaster Relief and

Emergency Assistance Act (42 U.S.C. 5195a(a)(1)) that shall include procedures for evacuation, relocation, shelter-in-place and lock down, staff and volunteer emergency preparedness training and practice drills, communication and reunification with families, continuity of operations, and accommodation of infants and toddlers, children with disabilities, and children with chronic medical conditions;

(viii) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants;

(ix) Appropriate precautions in transporting children, if applicable;

(x) Pediatric first aid and cardiopulmonary resuscitation; (xi) Recognition and reporting of child abuse and neglect, in accordance with the requirement in paragraph (e) of this section; and

(xi) May include requirements relating to:

(A) Nutrition (including age-appropriate feeding);

(B) Access to physical activity;

(C) Caring for children with special needs; or

(D) Any other subject area determined by the Lead Agency to be necessary to promote child development or to protect children's health and safety.

(2) Include minimum health and safety training on the topics above, as described in § 98.44.

(b) Lead Agencies may not set health and safety standards and requirements other than those required in paragraph (a) of this section that are inconsistent with the parental choice safeguards in § 98.30(f).

(c) The requirements in paragraph (a) of this section shall apply to all providers of child care services for which assistance is provided under this part, within the area served by the Lead Agency, except the relatives specified at §98.42(c).

(d) Lead Agencies shall describe in the Plan standards for child care services for which assistance is provided under this part, appropriate to strengthening the adult and child relationship in the type of child care setting

involved, to provide for the safety and developmental needs of the children served, that address:

(1) Group size limits for specific age populations;

(2) The appropriate ratio between the number of children and the number of caregivers, in terms of age of children in child care; and

(3) Required qualifications for caregivers in child care settings as described at §98.44(a)(4).

(e) Lead Agencies shall certify that caregivers, teachers, and directors of child care providers within the State or service area will comply with the State's, Territory's, or Tribe's child abuse reporting requirements as required by section 106(b)(2)(B)(i) of the Child Abuse and Prevention and Treatment Act (42 U.S.C. 5106a(b)(2)(B)(i)) or other child abuse reporting procedures and laws in the service area.

Washington Administrative Code (WAC) 110-16-0025 Health and safety training:

(1) A provider described in WAC 110-16-0015 (4)(b) or (c) must complete the following training within ninety calendar days of the subsidy payment begin date:

(a) Infant, child, and adult first aid and cardiopulmonary resuscitation (CPR):

(i) This training must be taken in person and the provider must demonstrate learned skills to the instructor.

(ii) The instructor must be certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program.

(b) Prevention of sudden infant death syndrome and safe sleep practices when caring for infants; and

(c) Department approved health and safety training which includes the following topic areas:

(i) Prevention and control of infectious diseases;

(ii) Administration of medication;

(iii) Prevention of, and response to, emergencies due to food and allergic reactions;

(iv) Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic;

(v) Prevention of shaken baby syndrome, abuse head trauma, and child maltreatment;

(vi) Emergency preparedness and response planning for natural disasters and human-caused events;

(vii) Handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(viii) Appropriate precautions in transporting children;

(ix) Recognition and reporting of child abuse and neglect, including the prevention of child abuse and neglect as defined in RCW 26.44.020 and mandatory reporting requirements under RCW 26.44.030; and

(x) Other topic areas as determined by the department.

(2) A provider described in WAC 110-16-0015 (4)(b) or (c) can meet the health and safety training in subsection (1)(c) of this section if the department verifies that the provider has completed any of the following either prior to or within ninety calendar days of the subsidy payment begin date:

(a) Child care basics, a department approved thirty-hour health and safety training.

(b) Washington state early childhood education initial certificate (twelve credits) that includes early childhood education and development 105 health, safety, and nutrition.

(3) A provider described in WAC 110-16-0015 (4)(b) or (c) must complete a minimum of two hours of health and safety training annually, using the subsidy payment begin date. The training must include, but is not limited to, one or more of the following:

(a) Prevention and control of infectious diseases;

(b) Emergency preparedness and response planning for natural disasters and human-caused events;

(c) Recognizing and prevention of shaken baby syndrome, head trauma abuse, neglect, and child maltreatment; and

(d) Prevention of sudden infant death syndrome and safe sleep practices, if caring for an infant or toddler.

WAC 110-16-0030 Health and safety activities:

(1) A provider described in WAC 110-16-0015 (4)(b) or (c), must participate in an annual, scheduled visit conducted by department staff in the home where care is provided.

(2) The purpose of the visit is to:

(a) Provide technical assistance to the provider regarding the health and safety requirements described in this chapter;

(b) Observe the provider's interactions with the child, and discuss health and safety practices;

(c) Provide written information and local resources about child development to include the major domains of cognitive, social, emotional, physical development, and approaches to learning; and

(d) Provide regional contact information for FFN child care services and resources.

(3) A provider will be considered out of compliance with the requirements of this chapter if, after three attempts, the department is not able to complete an annual, scheduled visit in the home where care is provided.

(4) At the annual, scheduled visit, the provider must show, unless previously provided to the department:

(a) Proof of identity;

(b) Proof of current certification for first aid and cardiopulmonary resuscitation (CPR) in the form of a card, certificate, or instructor letter;

(c) Proof of vaccination against or acquired immunity for vaccine-preventable diseases for all children in care, if the provider's children are on-site at any time with the eligible children. Proof can include:

(i) A current and complete department of health (DOH) certificate of immunization status (CIS) or certificate of exemption (COE) or other DOH approved form; or

(ii) A current immunization record from the Washington state immunization information system (WA IIS).

(d) Written permission from the parent to:

(i) Allow children to use a swimming pool;

(ii) Administer medication for treatment of illnesses and allergies of the children in care;

(iii) Provide for and accommodate developmental and special needs; and

(iv) Provide transportation for care, activities, and school when applicable.

(e) The written emergency preparedness and response plan required in WAC 110-16-0035 (8)(c).

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-046 The Department of Social and Health Services did not have adequate internal controls over and did not comply with requirements to ensure potential fraud was correctly identified and reported for the Child Care and Development Fund Cluster.

Assistance Listing Number and Title:	93.575 Child Care and Development Block Grant 93.575 COVID-19 Child Care and Development Block Grant 93.596 Child Care Mandatory and Matching Funds of the Child Care and Development Fund
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2003WACCDF; 2103WACCDF; 2203WACCDF; 2003WACCC3; 2103WACDC6; 2103WACSC6; 2103WACCDD
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Fraud Detection and Repayment
Known Questioned Cost Amount:	None

Background

The Department of Children, Youth, and Families (DCYF) administers the federal Child Care and Development Fund (CCDF) grants to help eligible working families pay for child care and fund improvements to child care quality. In fiscal year 2022, the Department spent about $668.6 million in CCDF federal funding, which was an increase of about $341.1 million compared to the prior fiscal year. The Department spent more than $260.5 million of this CCDF federal funding on monthly child care subsidy payments to child care providers.

Although DCYF is the lead agency for the CCDF program, the Department of Social and Health Services' (Department) Office of Fraud and Accountability (OFA) has the statutory authority to conduct investigations related to allegations of fraud in the program. State law requires DCYF to refer suspected incidents of child care subsidy fraud to OFA for appropriate investigation and action. Both DCYF and the Department accept reports of suspected fraud online, by mail, phone or fax. Staff from either agency can report suspected fraud through internal systems or to a hotline.

When the Department receives a report of suspected client fraud in a program it oversees, it runs the report through an automated process in its Barcode system to assess the level of potential fraud risk. The process considers which programs the client receives benefits from, the total benefits (dollars) the client receives, whether the client has come up on prior reports, the client's overpayment history, and how the suspected fraud was referred. These factors are all assigned point values that vary based on the client's particular case, including adding four points if the case was referred through the OFA hotline. These point values are summed and, based on this total, the priority level of the suspected fraud is rated from 1 to 5, with 1 being the highest risk level. Each priority level is separated by five points. Once OFA receives the priority rating, the case is assigned to an investigator for review.

OFA supervisors attempt to assign all reports rated as 1 or 2 and then work their way down to lower-rated reports. In 2018, the OFA Director issued a directive to managers that all Fraud Early Detection (FRED) reports rated as 1 or 2 should be assigned within 90 days of the case being referred. OFA management explained that some reports are not assigned to investigators because of workload capacity. No matter what priority level is assessed, if a FRED report is not assigned to an investigator within 90 days, it is "aged out" and sent back to Department program staff. Program staff review the original reported information and decide whether to send the case back through the automated process to be reassessed or dismiss the fraud report.

In fiscal year 2022, OFA received 2,324 child care fraud reports. Of those, 294 (13 percent) reports aged out of the system.

If an OFA Intentional Overpayment Investigation (IOI) concludes that potential fraud occurred, the results are sent to a local prosecuting attorney's office or United States attorney's office. If a court responds with the legal determination of fraud, the case is forwarded to the Department's Office of Financial Recovery to seek repayment from the client.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure potential child care fraud was correctly identified and reported for the program.

During our review of CCDF fraud cases, we found that the Department's Barcode system did not add the required four-point value to 143 child care fraud cases that originated from the OFA hotline. This resulted in cases receiving a lower priority level than they should have.

Additionally, the Department did not retain documentation supporting the priority level of cases received. Therefore, we were unable to accurately recalculate the assigned priority level to determine how many were improperly assigned a lower priority level.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not establish sufficient internal controls to ensure the Barcode algorithm was properly assigning point values to child care fraud cases received from the OFA hotline, and that data supporting the priority level assigned to potential fraud cases was retained and reviewed for accuracy.

Effect of Condition

By not establishing adequate internal controls, the Department cannot ensure it is properly prioritizing and reviewing potential child care fraud cases originating from the fraud hotline.

Because the Department did not retain support for its original calculations, we could not recalculate the priority levels that should have been originally assigned to child care fraud cases and therefore cannot determine the overall effect of this internal control weakness.

By failing to ensure that all fraud hotline referrals for child care fraud cases are being correctly identified and reviewed, the Department cannot ensure it is recovering fraudulent child care payments.

Recommendation

We recommend the Department:

- Establish effective internal controls to ensure the Barcode algorithm properly scores potential fraud cases
- Establish effective internal controls to ensure the original data supporting case priority levels is retained for managerial monitoring and review

Department's Response

The Department concurs with the finding.

The barcode algorithm was updated to fix the improper scoring of the Fraud Early Detection referrals (FRED) when the deficiency was identified. Referrals are being scored as per the details of the algorithm to include the additional four points for FRED referral received from hotline calls.

A request to store the information for the prioritization tool was made to the Economic Services Administration (ESA). ESA maintains the Barcode system and server space that it is hosted on. This request must go through all appropriate review and considerations to be worked on by the Barcode team. ESA will decide if it is feasible to store this information on all processed referrals.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 98, *Child Care and Development Fund*, section 60, Availability of funds, states in part:

> (i) Lead agencies shall recover child care payments that are the result of fraud. These payments shall be recovered from the party responsible for committing the fraud.

Directive / Prioritizing FRED Cases – dated January 31, 2018, states in part:

> As is current practice, all Regional Managers are directed to assign FRED cases using the prioritization scoring system. Cases should be assigned based on priority level starting with Priority level 1 cases and working down to priority level 5 as workloads permit.

A manager’s focus should be on getting all the priority 1 and 2 cases assigned within 90 days of the referral from CSD based on available staffing in each region. After priority level 1 and 2 cases are assigned, the balance of the priority levels should be assigned based on the scoring, geography of the region and worker availability.

This has been the practice of OFA since the FREDS were given scores but a recent state audit recommended it become written policy.

State of Washington
July 1, 2021 through June 30, 2022

2022-047 The Department of Children, Youth, and Families did not have adequate controls over and did not comply with certain requirements of its Public Assistance Cost Allocation Plan.

Assistance Listing Number and Title:	93.658 Foster Care Title IV-E 93.658 COVID-19 Foster Care Title IV-E
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award Number:	2102WAFOST; 2202WAFOST
Pass-through Entity:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed
Known Questioned Cost Amount:	None

Background

As a condition of receiving federal grant funds, the Department of Children, Youth, and Families must submit a Public Assistance Cost Allocation Plan (PACAP) to the U.S. Department of Health and Human Services each state fiscal year. The PACAP describes how the Department is authorized to allocate indirect costs like overhead and general administrative expenses to all funding sources, including federal grants.

The Department uses the Cost Allocation System (CAS), a subsystem of the Agency Financial Reporting System (AFRS), to execute its PACAP. The Department develops appropriate methodologies and updates cost allocation base input tables that contain cost objectives, which automatically distribute the cost of payments to either state, local or federal funding sources. The tables in CAS can be added, deleted, changed, or inactivated each calendar month.

As part of its cost allocation process, the Department establishes bases that are used to distribute costs to multiple funding sources. Each base consists of elements that are assigned a percentage that dictates how much of the original payment is allocated to it. For example, a base could be made up of three elements that allocate 35 percent, 25 percent, and 40 percent, respectively, that will total 100 percent. Records of these bases are kept in workbooks that management review and approve before they are uploaded or keyed into AFRS for use.

In fiscal year 2022, the Department allocated about $17 million in indirect costs to the Foster Care grant.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate controls over and did not comply with certain requirements of its PACAP. According to the Department's PACAP, Base 100, which are charges for administrative costs, should be updated monthly with full-time equivalents disbursed to reflect the work that agency staff have performed. This method allows the Department to allocate administrative charges proportionately to the staffing level required to meet the program's needs.

We examined nine monthly workbooks completed during the audit period. While the Department was supposed to complete 12 workbooks, we found it did not complete them for the first three months of the audit period (July, August and September of 2021).

We determined this internal control deficiency is a material weakness that led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Management did not assign sufficient staffing resources to ensure all monthly workbooks were completed in accordance with the Department's approved PACAP.

Effect of Condition

The Department's inadequate internal controls affected the accuracy of the indirect costs charged to the Foster Care grant for the first three months of the audit period. Specifically, we found the Department undercharged the Foster Care program by $154,113. When workbooks are not updated, the Department increases its risk of undercharging or improperly allocating indirect costs to the Foster Care program.

Recommendation

We recommend the Department strengthen internal controls to ensure that monthly workbooks are properly updated in accordance with the approved PACAP.

Department's Response

The Department concurs with the finding.

During July through September, the first three months of the audit period, the Department did not have adequate staffing levels to maintain the business processes for Base 100 entries. Available staff were focused on grant reconciliations and closing out the prior fiscal year financial transactions. The Department is committed to improving our internal controls and has reviewed the base edit form written procedures with staff and added monthly reminders for the Cost Allocation and Grants Management Unit.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 95, *Subpart E – Cost Allocation Plans,* section 95.501, Purpose, states:

> (a) Preparation, submission, and approval of State agency cost allocation plans for public assistance programs; and
>
> (b) Adherence to approved cost allocation plans in computing claims for Federal financial participation.

Public Assistance Cost Allocation Plan – Appendix 3 Administrative Costs, Base 100, states in part: FTEs are based on actual months and are reported by funding source. This information is obtained on a monthly basis from the Enterprise Reporting system at DCYF and is used on a rolling period with a one-month lag. For example, the FTEs for July would be used in the September plan.

State of Washington
July 1, 2021 through June 30, 2022

2022-048 The Department of Children, Youth, and Families did not have adequate internal controls to ensure payments to providers for travel and family visits were allowable and adequately supported for the Foster Care program.

Assistance Listing Number and Title:	93.658 Foster Care Title IV-E 93.658 COVID-19 – Foster Care Title IV-E
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2102WAFOST; 2202WAFOST
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	None

Background

The federal Foster Care Title IV-E (Foster Care) program helps states provide safe and stable out-of-home care for children under the jurisdiction of the state's child welfare agency until the children are returned home, placed with adoptive families, or placed in other planned, permanent arrangements. The program provides funds to reduce the costs of foster care for eligible children, reduce administrative costs to manage the program, and provide training for the adults in the Foster Care program, including state agency staff, foster parents and certain private agency staff.

In Washington, the Department of Children, Youth, and Families (Department) administers the Foster Care program. During fiscal year 2022, the Department spent about $123 million in federal grant funds, including approximately $7.3 million for travel and family visits.

Parent-child visits are a key strategy for minimizing a child's time in out-of-home care and working toward family reunification. The Department creates a visit plan based on dependency court order visit requirements and other information to ensure the child's safety. This visit plan is created and saved in FamLink. When the Department needs contracted family time services, the Department sends a visit plan/referral through a Famlink-Sprout interface. Visit coordinators send

this referral to the most appropriate contracted service provider through the Sprout system. These referrals authorize the contracted provider to provide the needed services. After the visit is completed, contracted service providers complete visit reports, which include travel mileage and travel time. Based on these reports and information the contractor enters into the Sprout system, the Department will determine reimbursement on the invoice. These reports and invoices are to be reviewed and approved by the contracted provider administrator or manager, to catch errors and ensure quality assurance. The Department pays the provider solely based on the summary-level information it enters into Sprout.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate internal controls to ensure payments to providers for travel and family visits were allowable and adequately supported for the Foster Care program. The prior finding number was 2021-040.

Description of Condition

The Department did not have adequate internal controls to ensure payments to providers for travel and family visits were allowable and adequately supported for the Foster Care program.

The Department did not follow its procedures for performing fiscal monitoring of foster care service providers to ensure federally funded payments for travel and family visits were adequately supported and only for allowable activities.

We consider this internal control deficiency to be a significant deficiency.

Cause of Condition

Management did not perform fiscal monitoring of the Department's providers because it thought Sprout had fiscal monitoring features and did not verify they were in place and operating effectively.

Effect of Condition

By not performing adequate fiscal monitoring, the Department cannot ensure payments for travel and family visits are allowable and adequately supported.

Recommendation

We recommend the Department follow its fiscal monitoring procedures to ensure payments to providers for travel and family visits are allowable and adequately supported.

Department's Response

The Department of Children, Youth, and Families appreciates, acknowledges, and supports the State Auditor's Office's (SAO) mission to provide citizens with independent and transparent examinations of how state and local governments use public funds, and develops strategies to make government more efficient and effective.

The Department is committed to strengthening internal controls and complying with grant requirements. The Department will work with Financial and Business Services Division and Foster Care Program to review the fiscal monitoring procedures to ensure payments to providers for travel and family visits are allowable and adequately supported.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-049 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with some Public Assistance Cost Allocation Plan requirements.

Assistance Listing Number and Title:	93.658 Foster Care Title IV-E 93.658 COVID-19 Foster Care Title IV-E 93.659 Adoption Assistance 93.659 COVID-19 Adoption Assistance
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2102WAFOST; 2202WAFOST; 2102WAADPT; 2202WAADPT
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	None

Background

The Department of Children, Youth, and Families uses the Random Moment Time Study (RMTS) to allocate costs for its headquarters and regional operations to the proper state and federal programs.

Department staff generally work on multiple programs and cases throughout a workday, which makes maintaining a timesheet difficult and time consuming. The RMTS simplifies how the Department allocates the cost of time and effort to state and federal programs. The RMTS is a sampling tool that the Department uses to generate statistically valid statewide estimates of various activities employees have performed. The Department also uses a system called FamLink, which allows staff to work on client cases, document information, generate samples and compile RMTS results.

The Department's use of the RMTS is included in its Public Assistance Cost Allocation Plan (PACAP) with the federal grantor. The PACAP is approved annually and outlines the general operating policies and procedures that the RMTS staff must follow.

For the RMTS to properly calculate the percentages of activities Department staff have performed, it must start by identifying a sampling universe that is accurate and complete. The sampling universe lists the eligible worker types to be included and is updated monthly to ensure all eligible workers are included in the sample. The RMTS Coordinators and RMTS Headquarters (HQ) are responsible for keeping the list of sample workers current.

To ensure the sample worker population is complete, the RMTS HQ runs the worker report, filters it, and then communicates the report to the RMTS Coordinators to verify proper workers are included, excluded, or documented with the right worker type to maintain an accurate RMTS population. The RMTS Coordinators send the RMTS HQ emails informing them of the changes that need to be made to assigned workers and the unassigned workers. The RMTS HQ will then update the workers' profiles in FamLink as updates come in.

Sampled workers are responsible for completing an accurate and timely RMTS sample within three business days. The RMTS HQ performs a quality control review of all completed samples to ensure staff are completing them correctly. At the end of the month, the Department uses FamLink to summarize the sample results for the month. The results are then compiled and used to fill out the Cost Allocation Base Data Input Sheets for each RMTS base. The results are then entered into the Cost Allocation System.

During fiscal year 2022, the Department used the RMTS to allocate about $34.8 million to the Foster Care-Title IV-E and Adoption Assistance programs.

Federal regulations require recipients to establish and follow internal controls that ensure compliance with program requirements. These controls include understanding program requirements and monitoring the effectiveness of established controls.

In the prior three audits, we reported the Department did not have adequate internal controls over and did not comply with some PACAP requirements. The prior finding numbers are 2021-042, 2020-044 and 2019-044.

Description of Condition

The Department did not have adequate internal controls over and did not comply with some PACAP requirements.

We randomly selected five out of the 12 monthly employee updates to determine whether the sampling universe was complete.

The RMTS HQ Program Manager is responsible for creating monthly employee reports that show current staff who are in the sampling population, as well as a report of employees who may be RMTS eligible. The Program Manager forwards these reports to the RMTS Coordinators asking for updates of employees on each report. Once the Program Manager receives the RMTS Coordinators' responses, the Program Manager updates FamLink to ensure the sampling universe is complete.

For all five of the sampled months that we examined, the Department was unable to demonstrate the RMTS sampling universe was completed due to a lack of documentation.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department did not retain documentation detailing which workers were added and removed from the sampling universe each month. Because of this, it was not possible to verify the completeness of the RMTS population.

Effect of Condition

The Department's inadequate internal controls affected the integrity of its RMTS sampling universe. An erroneous sample could cause the costs the Department has charged to federally funded programs for its headquarters and regional operations to be unallowable, according to the PACAP.

Recommendation

We recommend the Department ensure staff follow its own established procedures to ensure RMTS sampling populations are accurate and complete.

Department's Response

The Department maintains that the sampling universe is accurate and complete. There is not a deficiency with the integrity of the RMTS sample and the Department complies with federal requirements. The Department's RMTS instructions included in the federally approved Public Assistance Cost Allocation Plan (PACAP) are more restrictive than federal requirements.

Communication with the Regional RMTS Coordinators occurs regularly and cost pools are updated within the parameters identified within the RMTS instructions. The HQ RMTS Coordinator pulls three monthly reports from FamLink, the Child Welfare case management system, which the RMTS is a component of, and the Human Resource Management System to verify

worker eligibility and proper classification to strengthen the internal controls around RMTS samples pulled. For these reasons, the Department maintains the position that the sampling universe complies with federal regulations.

The Department contracted with the University of Massachusetts, effective October 2022, for the design and implementation of the RMTS mechanism. The Department has updated the RMTS instructions in the PACAP based on the new quarterly process implemented under the University of Massachusetts contract. The new process remains in compliance with federal law while alleviating the department-imposed restrictions and addresses the auditor's concerns regarding the internal controls applicable to the RMTS worker types included in the sampling universe.

Auditor's Remarks

Our audit procedures were designed to determine whether the Department charged only allowable costs to federal grants in compliance with their approved PACAP and federal law. 2 CFR 200.430 requires the following:

- The sampling universe must include all employees whose salaries and wages are to be allocated based on sample results.
- The entire time period involved must be covered by the sample.
- The results must be statistically valid and applied to the period being sampled.

During the audit period, the Department was unable to provide sufficient documentation showing the sampling universe was complete.

We reaffirm our finding, and we will follow up on the Department's corrective action during the next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Department of Children Youth and Families Public Assistance Cost Allocation Plan, RMTS

Program Instructions, page 37, states in part:

> Headquarters RMTS staff shall be responsible for the following actions:
>
> Overseeing the system's monthly batching of new samples which includes three variables:
>
> - Random Moment Starting Time
> - Random Interval Time Random
> - Employee List
>
> The Headquarters RMTS Staff work with the RMTS Coordinators in order to keep the list of sampled workers current. Worker employment status changes should be reported by the social workers' supervisors to RMTS Coordinators. In addition, HQ Staff need to verify that each worker has an RMTS Worker Type associated with him or her and an RMTS Group linking the worker to his or her coordinator.
>
> The Regional RMTS Coordinator shall be responsible for the following actions:
>
> > Notify HQ RMTS Staff of any updates to their worker list when there is any change in employment status of a worker participating in the RMTS survey within five working days of change. In addition, the coordinator needs to provide HQ RMTS Staff with an appropriate RMTS Worker Type code for each worker added to the system.

State of Washington
July 1, 2021 through June 30, 2022

2022-050 The Department of Children, Youth, and Families did not have adequate internal controls to ensure group care facility employees had cleared background checks before having unsupervised access to children.

Assistance Listing Number and Title:	93.658 Foster Care Title IV-E 93.658 COVID-19 Foster Care Title IV-E
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2102WAFOST; 2202WAFOST
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Eligibility
Known Questioned Cost Amount:	None

Background

The federal Foster Care Title IV-E (Foster Care) program helps states provide safe and stable out-of-home care for children under the jurisdiction of the state's child welfare agency until they are returned home, placed with adoptive families, or placed in other planned, permanent arrangements. The program provides funds to reduce the costs of foster care for eligible children, reduce administrative costs to manage the program, and provide training for the adults in the Foster Care program, including state agency staff, foster parents and certain private agency staff.

In Washington, the Department of Children, Youth and Families administers the Foster Care program. During fiscal year 2022, the Department spent about $123 million in federal grant funds, including approximately $28.5 million dollars for payments to providers for direct client services with $1.2 million being payments to licensed group care facilities.

Licensed group care facilities are maintained and operated for groups of children on a 24-hour basis to provide safe, healthy living environments that meet the developmental needs of the children in care. These facilities are not permanent homes for foster children, but they provide a higher level of care for the children who are in them. Before a facility becomes licensed, it must

complete an application that the Department reviews to ensure the facility is compliant with licensing requirements. This includes ensuring all people working in the facility have cleared background checks, which is a requirement in state and federal law.

After the initial application, the Department requests the group care facility provide quarterly reports of new and existing employees to ensure all have cleared background checks before they are allowed unsupervised access to children. To track this, the Department enters employees' information and the facility they work at into the FamLink system. FamLink is a service delivery and support system the Department uses to track clients statewide, and management uses it to track service performance and outcomes.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls to ensure group care facility employees had cleared background checks before having unsupervised access to children.

The Department has established monitoring procedures to ensure group care facility employees have cleared background checks before beginning work. To determine if these procedures were effective for ensuring employees had cleared the required background checks before beginning work, we used a statistical sampling method to randomly select and examine 59 group care facility employees out of a total population of 4,900. We reviewed the 59 employees' background checks and compared them to their employment start dates. We found the Department did not document employees' start dates, and it could not verify that 28 employees we selected had cleared background checks before beginning work in a group care facility.

We consider this internal control deficiency to be a material weakness.

This issue was not reported as a finding in the prior audit.

Cause of Condition

FamLink does not have a function that allows the Department to effectively monitor when an employee first starts working in a facility. The Department attempted to use quarterly rosters to assist with tracking start dates, but this process did not work as intended.

Effect of Condition

Without documenting employees' start dates, the Department cannot ensure they have cleared background checks before beginning work. By not adequately monitoring group care facility

employee start dates, ineligible employees could have unsupervised access to children before they have cleared the required background checks.

To ensure the 28 employees had cleared background checks before beginning work, we independently reviewed additional information the Department requested from the group care facilities during our audit. Our review confirmed all 28 employees had cleared background checks before beginning work.

Recommendation

We recommend the Department strengthen its internal controls and ensure all group care facility employees have cleared backgrounds check before beginning work.

Department's Response

The Department partially concurs with the finding.

As stated in the audit finding section, Effect of Condition, all group care facility staff sampled during the audit had a cleared background check prior to working in the facility. While we agree the use of definitions such as "effective date" and "start date" could be misleading, we do not concur the Department did not have adequate internal controls to ensure group care facility employees had cleared background checks before having unsupervised access to children. The Department is committed to ensuring the health, safety and well-being of all children in our care. We are confident that staff who work with children and youth have a cleared background check.

The Department concurs we do not document staff members' start dates in FamLink. FamLink is used to document background clearance information, but it only allows for one date to be entered as the "effective date." This "effective date" is imported to the Background Check System as the "start date." The Department's Licensing Division enters the "effective date" as the date that the background check paperwork on an applicant/staff member is received from the facility, this is to verify the correct applicant/staff member whose background check is being processed. The data pulled as part of the audit referenced the "start date" from the Background Check System, which the auditor's office interpreted as hire date or first date they began work in the facility, which was not accurate.

To strengthen internal controls and documentation, effective April 1, 2023, the Department implemented a new process for processing background checks for group care facilities. Applicant/staff member background check request forms are submitted directly to the Background Check Unit by the facility. The Background Check Unit processes a fingerprint background check, a child abuse/neglect history check, and if applicable, a suitability assessment. The results are then provided to the Licensing Division and the group care facility. If the applicant is cleared, the Licensing Division staff adds the staff member to the group care facility in FamLink. The new

"effective date" in FamLink is the final approval from the Background Check Unit. In addition, Regional licensors continue to conduct yearly health and safety monitoring visits, which includes a random sample review of personnel files containing background check information.

Auditor's Remarks

The purpose of our testing was to ensure employees had a clear background check prior to them working at the group home facility. During our review, the Department was unable to demonstrate whether some employees had clear background checks before working because they did not have the start date of their employment. For these employees, the Department had to go to each facility to determine the start date of employees to verify the employee we selected for our testing had a clear background check before working.

We reaffirm our finding and will follow up on the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 1356.30, Safety requirements for foster care and adoptive home providers, states in part:

> (f) In order for a child care institution to be eligible for title IV-E funding, the licensing file for the institution must contain documentation which verifies that safety considerations with respect to the staff of the institution have been addressed.

RCW 43.43.837, Fingerprint-based background checks—Requirements for applicants and service providers—Shared background checks—Fees—Rules to establish financial responsibility, states in part:

> (1) Except as provided in subsection (2) of this section, in order to determine the character, competence, and suitability of any applicant or service provider to have unsupervised access, the secretary of the department of social and health services and the secretary of

the department of children, youth, and families may require a fingerprint-based background check through both the Washington state patrol and the federal bureau of investigation at any time, but shall require a fingerprint-based background check when the applicant or service provider has resided in the state less than three consecutive years before application, and:

(a) Is an applicant or service provider providing services to children or people with developmental disabilities under RCW 74.15.030;

(b) Is an individual sixteen years of age or older who: (i) Is not under the placement and care authority of the department of children, youth, and families; and (ii) resides in an applicant or service provider's home, facility, entity, agency, or business or who is authorized by the department of children, youth, and families to provide services to children under RCW 74.15.030;

(c) Is an individual who is authorized by the department of social and health services to provide services to people with developmental disabilities under RCW 74.15.030; or

(d) Is an applicant or service provider providing in-home services funded by:

(i) Medicaid personal care under RCW 74.09.520;

(ii) Community options program entry system waiver services under RCW 74.39A.030;

(iii) Chore services under RCW 74.39A.110; or

(iv) Other home and community long-term care programs, established pursuant to chapters 74.39 and 74.39A RCW, administered by the department of social and health services.

(2) Long-term care workers, as defined in RCW 74.39A.009, who are hired after January 7, 2012, are subject to background checks under RCW 74.39A.056.

(3) To satisfy the shared background check requirements provided for in RCW 43.216.270 and 43.20A.710, the department of children, youth, and families and the department of social and health services shall share federal fingerprint-based background check results as permitted under the law. The purpose of this provision is to allow both departments to fulfill their joint background check responsibility of checking any individual who may have unsupervised access to vulnerable adults, children, or juveniles. Neither department may share the federal background check results with any other state agency or person.

(4) The secretary of the department of children, youth, and families shall require a fingerprint-based background check through the Washington state patrol identification and criminal history section and the federal bureau of investigation when the department seeks to approve an applicant or service provider for a foster or adoptive placement of children in accordance with federal and state law. Fees charged by the Washington state patrol and the federal bureau of investigation for fingerprint-based background checks shall be paid by the department of children, youth, and families for applicant and service providers providing foster care as required in RCW 74.15.030.

(5) Any secure facility operated by the department of social and health services or the department of children, youth, and families under chapter 71.09 RCW shall require applicants and service providers to undergo a fingerprint-based background check through the Washington state patrol identification and criminal history section and the federal bureau of investigation.

(6) Service providers and service provider applicants, except for those long-term care workers exempted in subsection (2) of this section, who are required to complete a fingerprint-based background check may be hired for a one hundred twenty-day provisional period as allowed under law or program rules when:

   (a) A fingerprint-based background check is pending; and

   (b) The applicant or service provider is not disqualified based on the immediate result of the background check.

Department of Children, Youth, and Families, Policies and Procedures 6800 – Background Checks, states in part:

> 3(c) Requestors must, prior to authorizing unsupervised access to children or youth, review background check decisions on the completed Background Check Request/Decision DCYF 09-131 form received from the BCU.

State of Washington
July 1, 2021 through June 30, 2022

2022-051 The Department of Children, Youth, and Families did not have adequate internal controls over and did not comply with reporting requirements for the Foster Care program.

Assistance Listing Number and Title:	93.658 Foster Care Title IV-E 93.658 COVID-19 – Foster Care Title IV - E
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2102WAFOST; 2202WAFOST
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The purpose of the Foster Care program is to provide safe and stable out-of-home care for children under placement and care authority of state welfare agencies. To accomplish this, the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (HHS) offers financial support to states to offset the cost of foster care maintenance for eligible children, administrative costs to manage the program, and training for state agency staff, foster parents and qualified private agency staff. As of June 2022, approximately 8,000 children were in Washington's foster care system. In fiscal year 2022, the Department spent almost $126 million in federal program funds.

Within 30 days after each fiscal quarter, the Department of Children, Youth, and Families (Department) is required to file the CB-496: Title IV-E Programs Quarterly Financial Report with HHS to report its Foster Care program expenditures and the number of children it has served. The ACF relies on the information reported to award funds, determine the allowability of the reported expenditures, and to provide reports to Congress.

Federal regulations require recipients to establish and follow internal controls that ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with reporting requirements for the Foster Care program.

We reviewed all four reports the Department submitted during the audit period, and we found that three were inaccurate. In the three reports with errors, the Department misstated its program expenditures by a total of $10,097,303, including approximately $9.6 million in understatements and $500,000 in overstatements. The Department also overstated the total number of children receiving foster care benefits by 10,115.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

When completing the quarterly reports, the Department did not follow HHS's published instructions. In addition, while the Department has an established review process, the reviews that staff performed were insufficient for detecting errors in the reports. Management said that due to competing priorities and staffing shortages, the Department did not thoroughly review the reports before submitting them to HHS.

Effect of Condition

Because HHS uses these reports to determine award amounts and whether reported expenditures are allowable, it may have relied on inaccurate data to make these determinations for the Department. The grant agreement also allows HHS to take action for the Department's noncompliance, which can include temporarily withholding funds, wholly or partly suspending or terminating the award, and withholding further program awards.

Recommendation

We recommend the Department:

- Follow HHS's published instructions when completing the quarterly CB-496 reports
- Strengthen its review processes to ensure the reports are accurate and supported before submitting them to HHS

Department's Response

The Department of Children, Youth, and Families appreciates, acknowledges, and supports the State Auditor's Office's (SAO) mission to provide citizens with independent and transparent examinations of how state and local governments use public funds, and develops strategies to make government more efficient and effective.

During the audit period, the Department acknowledges errors were made in the quarterly reports. While the Department understands accuracy is vital, the error understating expenditures by $9.0 million in the first report was identified and corrected in the FFY 2022, second quarter report. We will review and strengthen our internal processes in order to complete the quarterly reports accurately.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 201*, Grants to States for Public Assistance Programs,* establishes the following applicable requirements:

Section 201.5 Grants, states in part:

(a) Form and manner of submittal.

(1) Time and place: The estimates for public assistance grants for each quarterly period must be forwarded to the regional office 45 days prior to the period of the estimate. They include a certification of State funds available and a justification statement in support of the estimates. A statement of quarterly expenditures and any necessary supporting schedules must be forwarded to the

Department of Health and Human Services, Family Support Administration, not later than 30 days after the end of the quarter.

(2) Description of forms: “State Agency Expenditure Projection – Quarterly Projection by Program” represents the State agency’s estimate of the total amount and the Federal share of expenditures for assistance, services, training, and administration to be made during the quarter for each of the public assistance programs under the Act. From these estimates the State and Federal shares of the total expenditures are computed. The State’s computed share of total estimated expenditures is the amount of State and local funds necessary for the quarter. The Federal share is the basis for the funds to be advanced for the quarter. The State agency must also certify, on this form or otherwise, the amount of State funds (exclusive of any balance of advances received from the Federal Government) actually on hand and available for expenditure; this certification must be signed by the executive officer of the State agency submitting the estimate or a person officially designated by him, or by a fiscal officer of the State if required by State law or regulation. (A form “Certificate of Availability of State Funds for Assistance and Administration during Quarter” is available for submitting this information, but its use is optional.) If the amount of State funds (or State and local funds if localities participate in the program), shown as available for expenditures is not sufficient to cover the State’s proportionate share of the amount estimated to be expended, the certification must contain a statement showing the source from which the amount of the deficiency is expected to be derived and the time when this amount is expected to be made available.

(3) The State agency must also submit a quarterly statement of expenditures for each of the public assistance programs under the Act. This is an accounting statement of the disposition of the Federal funds granted for past periods and provides the basis for making the adjustments necessary when the State’s estimate for any prior quarter was greater or less than the amount the State actually expended in that quarter. The statement of expenditures also shows the share of the Federal Government in any recoupment, from whatever source, including for title IV-A the appropriate share of child support collections made by the State, of expenditures claimed in a prior period, and also in expenditures not properly subject to Federal financial participation which are acknowledged by the State agency, including the share of the Federal Government for uncashed and cancelled checks as described at 45 CFR 201.67 and replacement checks as described at 45 CFR 201.70 in this part, or which have been revealed in the course of an audit.

State of Washington
July 1, 2021 through June 30, 2022

2022-052 The Department of Children, Youth, and Families did not have adequate internal controls over level of effort requirements for the Adoption Assistance program.

Assistance Listing Number and Title:	93.659 Adoption Assistance 93.659 COVID-19 Adoption Assistance
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2102WAADPT; 2202WAADPT
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Level of Effort
Known Questioned Cost Amount:	None

Background

The Adoption Assistance program is administered at the federal level by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families (ACF), a component of the U.S. Department of Health and Human Services (HHS). Since federal fiscal year 2010, the Title IV-E Adoption Assistance program has provided eligibility provisions for any child who meets the expanded eligibility criteria, which resulted in more children being determined as eligible for Title IV-E. The increased eligibility allows states to receive additional federal funding for adoption, thereby allowing them to reduce the level of nonfederal funds they use for these services. The reduction in nonfederal spending is referred to as "adoption savings."

Beginning in federal fiscal year 2015, each Title IV-E agency must annually calculate and report on the amount of any adoption savings, how savings are spent, and on what services. Agencies must use their adoption savings to expand services that may be provided under Title IV-B or IV-E programs. Additionally, agencies must spend no less than 30 percent of the savings on post-adoption services, post-guardianship services, and services to support positive outcomes for children at risk of entering foster care. Agencies must also spend at least two-thirds of this 30 percent on post-adoption and post-guardianship services.

In Washington, the Department of Children, Youth, and Families (Department) administers the Adoption Assistance program to encourage people to adopt children out of the foster care system.

The program supports approximately 17,000 children and 11,000 families. In fiscal year 2022, the Department spent about $58.6 million in federal funding, and had $1.9 million in state funding for Adoption Savings.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Department did not have adequate internal controls over and did not comply with level of effort requirements for the Adoption Assistance program. The prior finding number was 2021-045.

Description of Condition

The Department did not have adequate internal controls over level of effort requirements for the Adoption Assistance program.

In the prior audit, we determined the Department split the responsibility for tracking and managing adoption savings expenditures between staff for the Child Welfare Program and Cost Allocation and Grant Management Unit, and that coordination between these areas was insufficient for ensuring that staff maintained accounting records to verify adoption savings expenditures. We also determined the Department did not have policies or procedures to monitor its compliance with the program's level of effort requirements.

During this audit period, the Department created a new position to manage and track its adoption savings spending, but the position was not filled until February 2022. The Department has also not implemented policies or procedures to monitor its compliance with the program's level of effort requirements.

We consider these internal control deficiencies to be a material weakness.

Cause of Condition

In response to the prior audit finding, the Department developed a corrective action plan to address the internal control deficiencies our Office identified. However, the Department did not fully implement the action plan during the current audit period.

Effect of Condition

If the Department does not have adequate internal controls and is noncompliant with program requirements, the grant agreement allows the grantor to take action, including temporarily withholding funds, wholly or partly suspending or terminating the award, and withholding further awards from the program.

Recommendation

We recommend the Department implement written policies and procedures to properly track its adoption savings spending.

Department's Response

As stated in the Cause of Condition, the Department did not fully implement the corrective action plan during the audit period. Due to the timing and frequency of the statewide single audits, the Department is not made aware of a finding until months after the state fiscal year (SFY) concludes. It is not always feasible to correct audit issues before a new audit cycle begins. Thereby, the previous year's audit issues will remain outstanding up to nine months of the current audit period. For this reason, the Department anticipates receiving repeat findings for consecutive years.

The Department created a new position to manage the adoption support program and to oversee the adoption saving expenditures through FamLink in February 2022. In May 2022, the Department established reoccurring monthly meetings between Child Welfare Program and Cost Allocation and Grant Management Unit to review expenditures and level of effort requirements for the calculated adoption savings dollars. Written procedures for federal adoption savings expenditure requirements and tracking were reviewed and adoption savings reports were accurate during the audit period.

While this is a repeat finding, the Department received the SFY 2021 finding from the State Auditor's Office in May 2022, eleven months after SFY 2022 started. Therefore, the Department was unable to revise its internal controls prior to the SFY 2022 audit. The Department and the State Auditor's Office will not see the full benefit of these corrective actions until the SFY 2023 audit.

As to the auditor's recommendation, the Department maintains that there are no federal regulations that require an agency to have a written policy for level of effort reporting. The Department has written procedures for federal adoption savings expenditure requirements and tracking of adoption savings. In addition, we have written procedures for the use of adoption savings paid through FamLink using assigned service codes. These service codes include evidence-based practices, parental counseling, catastrophic circumstances, and the Promoting and Support Permanency Committee for both adoption and guardianship families. The Department assigns specific FamLink service codes for payment and tracking purposes.

The Department has reviewed and incorporated the guidance published by the U.S. Government Accountability Office report on Better Data and Guidance Could Help States Reinvest Adoption Savings and Improve Federal Oversight into our processes and procedures. The Department also follows the ACF reporting guidelines and uses tools they provide to track expenditures in compliance with the grant and no exceptions were noted for the audit period.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

42 U.S. Code § 673 – Adoption and guardianship assistance program

(a) Agreements with adoptive parents of children with special needs; State payments; qualifying children; amount of payments; changes in circumstances; placement period prior to adoption; nonrecurring adoption expenses

(8)

(A) A State shall calculate the savings (if any) resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, using a methodology specified by the Secretary or an alternate methodology proposed by the State and approved by the Secretary.

(B) A State shall annually report to the Secretary—

(i) the methodology used to make the calculation described in subparagraph (A), without regard to whether any savings are found;

(ii) the amount of any savings referred to in subparagraph (A); and

(iii) how any such savings are spent, accounting for and reporting the spending separately from any other spending reported to the Secretary under part B or this part.

(C) The Secretary shall make all information reported pursuant to subparagraph (B) available on the website of the Department of Health and Human Services in a location easily accessible to the public.

(D)

(i) A State shall spend an amount equal to the amount of the savings (if any) in State expenditures under this part resulting from the application of paragraph (2)(A)(ii) to all applicable children for a fiscal year, to provide to children of families any service that may be provided under part B or this part. A State shall spend not less than 30 percent of any such savings on post-adoption services, post-guardianship services, and services to support and sustain positive permanent outcomes for children who otherwise might enter into foster care under the responsibility of the State, with at least ⅔ of the spending by the State to comply with such 30 percent requirement being spent on post-adoption and post-guardianship services.

(ii) Any State spending required under clause (i) shall be used to supplement, and not supplant, any Federal or non-Federal funds used to provide any service under part B or this part.

State of Washington
July 1, 2021 through June 30, 2022

2022-053 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure clients were eligible for the Children's Health Insurance Program.

Assistance Listing Number and Title:	93.767 Children's Health Insurance Program 93.767 COVID-19 Children's Health Insurance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2005WA5021; 1905WA5021; 2105WA5021; 2205WA5021;
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Eligibility
Known Questioned Cost Amount:	$3,036,657

Background

The Health Care Authority administers the Children's Health Insurance Program (CHIP). CHIP is a jointly funded state and federal partnership providing insurance coverage for almost 90,000 children and pregnant people in families with incomes too high to qualify for Medicaid. Federal CHIP financing is capped, and each state operates under an allotment. During fiscal year 2022, the Authority spent more than $229 million in state and federal funds to administer CHIP.

To determine initial eligibility for CHIP, families must complete an application in the Washington Health Benefit Exchange, known as Washington Healthplanfinder, or through a streamlined paper application. Once families complete their applications, electronic verification sources confirm their income, immigration status and Social Security numbers (SSNs).

The Authority automatically reviews applicants' eligibility first for Medicaid and then for CHIP if they are ineligible for Medicaid. Children in low-income families who are ineligible for Medicaid are enrolled in CHIP under the state CHIP plan. Washington has also elected to cover the prenatal period of some low-income pregnant people under the state CHIP plan.

CHIP clients must be either U.S. citizens or lawfully present qualified noncitizens, and their eligibility is based on self-attested income in their applications; therefore, clients with verified citizenship and SSNs would be determined eligible if their reported income was between 210 percent and 312 percent of the federal poverty level.

Once the Authority determines clients' initial eligibility, their start date is recorded as the first of the month in which their application was submitted, thus allowing for payments prior to approval to be processed after the fact. Children found eligible for medical assistance remain continuously eligible for a full 12 months, regardless of any changes in their household income or third-party liability. Households must report financial and nonfinancial changes, but these will not render them ineligible during the continuous eligibility period. However, if recipients' household income decreases, the Authority can move children to a more favorable program, such as Medicaid, to eliminate the premium payment requirements. Termination during the continuous eligibility period is acceptable only for the following reasons:

- Changes in residency (permanent move out of state)
- Death
- Fraud (unless it is going to prosecution)
- Failure to pay the premium for more than three months
- The child turns 19 years old (remains eligible through the end of their birth month)
- After the end of the month in which the postpartum period ends for pregnant people
- When a client requests to be removed from the program

In response to the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) approved waivers and disaster relief state plan amendments (SPA), effective March 1, 2020, through the end of the public health emergency declaration, allowing flexibilities to ensure the continuity of coverage through the public health emergency. The waivers and SPA allowed the Authority to implement flexibilities, including the following:

- Allow self-attestations for all eligibility requirements, excluding citizenship and immigration status, on a case-by-case basis
- Extend the redetermination timeline for current CHIP enrollees in the state to maintain continuity of coverage as permissible

From the start of the pandemic, CMS kept an ongoing Frequently Asked Questions (FAQs) document to aid state Medicaid and CHIP agencies in their response to COVID-19, including guidance on eligibility, benefits and financing regarding the pandemic. This document was finalized on January 6, 2021.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit we reported the Authority did not have adequate internal controls to ensure clients were eligible for CHIP. The prior finding number was 2021-046.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure clients were eligible for CHIP.

We used a statistically valid sampling method to randomly select and examine 59 out of a total population of 93,793 clients who had a federally verified SSN.

We also used a statistically valid sampling method to randomly select and examine 59 out of a total population of 10,933 clients who did not have a federally verified SSN.

For the sample of clients who had a verified SSN, we identified:

- One instance where the client aged out of services and was not referred to Washington Healthplanfinder to be redetermined eligible for Medicaid during the COVID-19 pandemic, as required.
- One instance where the Authority continued CHIP coverage for a client after the allowable postpartum period.

For the sample of clients who did not have a federally verified SSN, we identified:

- Seventeen instances where the Authority continued CHIP coverage for clients after the allowable postpartum period.

We also used computer-assisted audit techniques to analyze the entire client population. We found 3,416 clients who were over the age of 19 that were still receiving CHIP services during fiscal year 2022.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

The Authority chose not to remove clients from CHIP even when they aged out of coverage or their postpartum period ended.

Effect of Condition and Questioned Costs

By not having adequate internal controls, the Authority is at risk of not detecting or preventing ineligible payments of federal CHIP funds on behalf of recipients. We determined the following questioned costs:

Audit Area	Known Questions Costs (state and federal)	Known questioned costs – Federal portion only	Likely improper payments (state and federal)	Likely improper payments – federal portion only
Verified SSNs	$ 2,117	$ 1,468	$ 3,365,166	$ 2,333,411
Non-Verified SSNs	$14,760	$ 10,236	$ 2,735,142	$ 1,896,870
Over 19 years old	$ 4,353,425	$ 3,024,953	$ 0	$ 0
Totals	**$ 4,370,302**	**$ 3,036,657**	**$ 6,100,308**	**$ 4,230,281**

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflect this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Implement internal controls to ensure all clients meet CHIP eligibility requirements
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Authority's Response

The Authority does not concur with any of the results cited by the auditor related to CHIP program eligibility.

The agency has worked with the Governor's Office and the Office of Financial Management to continue equity of state funded coverage for all individuals during the public health emergency, including CHIPRA pregnancy coverage. The postpartum period in CHIPRA coverage is state-funded. The State Auditor's Office did not allow the Authority enough time to obtain the journal vouchers from our accounting partners that show the use of state funds for these expenditures.

Regarding the clients receiving CHIP benefits who were aged 19 and over, the agency has pursued, and been notified of approval for, an 1115 disaster waiver from the Centers for Medicare & Medicaid Services. The waiver approves funding for CHIP clients aged 19 and over during the public health emergency and is retroactive to March 18, 2020. Once the approval letter is received by the Authority, the associated federal expenditures identified by the auditor will be valid.

The agency was provided very little time and flexibility to respond to the audit results during a time when the agency and its federal counterparts are inundated and backlogged with unwinding the public health emergency.

Auditor's Remarks

We provided the Authority with preliminary exceptions on February 27, 2023 and on March 15th, the Authority provided additional information that cleared some of the exceptions. The draft finding was provided to the Authority on April 17, 2023. It was not until April 18th, after audit work was concluded, that the Authority asserted the postpartum exceptions we identified were transferred from federal funding to state funding with journal vouchers. Despite not conveying this information to us timely, we requested copies of the journal vouchers to attempt to confirm the Authority's assertion. On April 25, 2023, the Authority informed us that staff were not able to pull the journal vouchers and we therefore could not determine whether any of the federally funded payments were subsequently transferred to state funding.

For the clients aged 19 and over, there was no formal approval from CMS in place during the audit period or currently. Therefore, we conducted our audit in accordance with codified eligibility rules.

We reaffirm our finding and will follow up on the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR, *Public Health Part 435 Subpart J, Eligibility in the States and District of Columbia,* establishes the following applicable requirements:

Section 435.926 Continuous eligibility for children, states in part:

(b) ***Eligibility.*** The agency may provide continuous eligibility for the period specified in paragraph

(c) of this section for an individual who is:

(1) Under age 19 or under a younger age specified by the agency in its State plan; and

(2) Eligible and enrolled for mandatory or optional coverage under the State plan in accordance with subpart B or C of this part.

(c) ***Continuous eligibility period.***

(1) The agency must specify in the State plan the length of the continuous eligibility period, not to exceed 12 months.

(2) A continuous eligibility period begins on the effective date of the individual's eligibility under § 435.915 or most recent redetermination or renewal of eligibility under § 435.916 and ends after the period specified by the agency under paragraph (c)(1) of this section.

(d) ***Applicability.*** A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) The child attains the maximum age specified in accordance with paragraph (b)(1) of this section;

(2) The child or child's representative requests a voluntary termination of eligibility;

(3) The child ceases to be a resident of the State;

(4) The agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) The child dies.

Title 42 CFR, *Public Health*, Part 457 establishes the following applicable requirements:

Section 457.342 Continuous eligibility for children, states in part:

(a) A State may provide continuous eligibility for children under a separate CHIP in accordance with the terms of § 435.926 of this chapter, and subject to a child remaining ineligible for Medicaid, as required by section 2110(b)(1) of the Act and § 457.310 (related to the definition and standards for being a targeted low-income child) and the requirements of section 2102(b)(3) of the Act and § 457.350 (related to eligibility screening and enrollment).

Section 457.380 Eligibility verification.

(a) General requirements. Except where law requires other procedures (such as for citizenship and immigration status information), the State may accept attestation of information needed to determine the eligibility of an individual for CHIP (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this subchapter, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

(b) Status as a citizen, national or a non-citizen.

(1) Except for newborns identified in § 435.406(a)(1)(iii)(E) of this chapter, who are exempt from any requirement to verify citizenship, the agency must –

(i) Verify citizenship or immigration status in accordance with § 435.956(a) of this chapter, except that the reference to § 435.945(k) is read as a reference to paragraph (i) of this section; and

(ii) Provide a reasonable opportunity period to verify such status in accordance with § 435.956(a)(5) and (b) of this chapter and provide benefits during such reasonable opportunity period to individuals determined to be otherwise eligible for CHIP.

(2) [Reserved]

(c) State residents. If the State does not accept self-attestation of residency, the State must verify residency in accordance with § 435.956(c) of this chapter.

(d) Income. If the State does not accept self-attestation of income, the State must verify the income of an individual by using the data sources and following standards and

procedures for verification of financial eligibility consistent with § 435.945(a), § 435.948 and § 435.952 of this chapter.

(e) Verification of other factors of eligibility. For eligibility requirements not described in paragraphs (c) or (d) of this section, a State may adopt reasonable verification procedures, consistent with the requirements in § 435.952 of this chapter, except that the State must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation.

(f) Requesting information. The terms of § 435.952 of this chapter apply equally to the State in administering a separate CHIP.

(g) Electronic service. Except to the extent permitted under paragraph (i) of this section, to the extent that information sought under this section is available through the electronic service described in § 435.949 of this chapter, the State must obtain the information through that service.

(h) Interaction with program integrity requirements. Nothing in this section should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits or its obligation to provide for methods of administration that are in the best interest of applicants and enrollees and are necessary for the proper and efficient operation of the plan.

(i) Flexibility in information collection and verification. Subject to approval by the Secretary, the State may modify the methods to be used for collection of information and verification of information as set forth in this section, provided that such alternative source will reduce the administrative costs and burdens on individuals and States while maximizing accuracy, minimizing delay, meeting applicable requirements relating to the confidentiality, disclosure, maintenance, or use of information, and promoting coordination with other insurance affordability programs.

(j) Verification plan. The State must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in this section in a format and manner prescribed by the Secretary.

Plan Amendment Approval Letter from CMS dated July 15, 2020 states in part:

> This letter is to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), WA-20-0001, submitted on May 4, 2020, has been approved. This SPA has an effective date of March 1, 2020.

This amendment, as it applies to the COVID-19 public health emergency (PHE), makes the following changes beginning March 18, 2020, unless otherwise noted, through the duration of the Federally-declared PHE:

- Delay acting on changes in circumstances for CHIP beneficiaries other than the required changes in circumstances described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d);

COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies (Last Updated January 6, 2021)

Section J. *Children's Health Insurance Program (CHIP)* states in part:

4. Can states continue coverage for the duration of the Public Health Emergency for individuals in a separate CHIP who are aging out of eligibility or ending their postpartum period?

No. The requirement in section 6008(b)(3) of the FFCRA to maintain coverage in Medicaid in order to receive the temporary increase in the Medicaid federal medical assistance percentage does not apply to separate CHIPs. Therefore, states may not continue to provide separate CHIP coverage to young adults aging out or women ending their postpartum period. If the state determines that the individual is eligible for Medicaid, they may be transitioned to the appropriate Medicaid eligibility group.

States may not transition individuals to Medicaid without first determining them eligible in accordance with 42 C.F.R § 457.350(b). States are required to transfer the accounts of individuals losing CHIP eligibility who are determined to be ineligible for Medicaid to the Exchange, in accordance with 42 C.F.R § 457.350(b)(3) and (i).

State of Washington
July 1, 2021 through June 30, 2022

2022-054 The Health Care Authority did not have adequate internal controls over and did not comply with managed care financial audit requirements.

Assistance Listing Number and Title:	93.767 Children's Health Insurance Program 93.767 COVID-19 Children's Health Insurance Program 93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2005WA5021; 2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 1905WA5021; 2105WA5021; 2205WA5021; 2205WA5MAP; 2205WA5ADM;
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Managed Care Financial Audit
Known Questioned Cost Amount:	None

Background

The Health Care Authority (Authority) administers both the Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one third of the state's federal expenditures. CHIP provides health coverage for almost 90,000 children and pregnant people in families with incomes too high to qualify for Medicaid. During fiscal year 2022, the Medicaid program spent more than $17.6 billion in federal and state funds, and CHIP spent more than $229 million in federal and state funds.

Managed Care Organizations (MCO) contract with the Authority under a comprehensive risk contract to provide prepaid health care services to eligible enrollees under their managed care programs. In fiscal year 2022, the Authority contracted with five MCOs and paid them more than $9.2 billion for Medicaid and CHIP services.

Under federal regulations, contracts between states and MCOs must include a requirement that MCOs annually submit an audited financial report to the state. These audits must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

At least once every three years, the Authority must conduct or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data each MCO submits. The Authority must also post these audit results on its website. These requirements went into effect for contract years starting after July 1, 2017.

Federal regulations require recipients to establish and follow internal controls that ensure compliance with program requirements. These controls include understanding program requirements and monitoring the effectiveness of established controls.

In the prior audit, we reported the Authority did not have adequate internal controls over and did not comply with managed care financial audit requirements. The prior finding number was 2021-048.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with managed care financial audit requirements.

Audited financial reports

The Authority did not include this requirement in its MCO contracts, and it did not have internal controls in place to ensure it complied with the requirement to collect financial reports. During the audit period, the Authority took steps toward updating the MCO contract language to include the

audited financial report requirements; however, the changes were not implemented until after the audit period. As a result, the Authority did not obtain any audited financial reports from the MCOs. The Authority expects to receive its first MCO financial reports in June 2023.

Periodic audits

The Authority did not establish internal controls to ensure it complied with the periodic audit requirements of MCO encounter and financial data.

To meet the periodic audit requirements, the Authority would have needed to complete MCO audits of both the encounter and financial data within the last three years. Though the Authority completed encounter data audits in July 2021, it did not complete any financial data audits.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The audited financial reports and periodic audits are newer requirements that became applicable for the MCO contracts beginning January 2018. The Authority did not have policies or procedures on collecting audited financial reports or on how and when to perform periodic audits. While the Authority was in the process of implementing procedures for meeting these requirements, the implementation was delayed because of staff turnover in the leadership of the unit in charge.

Effect of Condition

By not collecting the audited financial reports and conducting periodic audits, the Authority increases its risk of relying on inaccurate or incomplete information. This could lead to an increased risk of making improper payments and reduced public transparency. The Authority could also be subject to sanction by the federal grantor for not meeting Medicaid and CHIP requirements.

Recommendations

We recommend the Authority:

- Implement policies and procedures over obtaining audited financial reports
- Implement policies and procedures over conducting required periodic audits
- Establish a process to ensure it collects audited financial reports annually
- Establish a process to conduct audits of encounter and financial data at least once every three years

Authority's Response

The authority concurs with the recommendations and has taken the following steps:

- *Amended managed care contracts to require annual submission of audited financial reports. The amended contract language directs managed care organizations when and where to submit audited financial reports. Failure to submit reports is sanctionable.*
- *Conducted an encounter data validation audit and began a financial report validation audit. Processes have been established to ensure that audits will be conducted no less than once every three years.*

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 42 CFR Part 438, *Managed Care*, establishes the following applicable requirements:

Section 438.3 Standard Contract Requirements states in part:

(m) *Audited financial reports.* The contract must require MCOs, PIHPs, and PAHPs to submit audited financial reports specific to the Medicaid contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

Section 438.600 Statutory basis, basic rule, and applicability states in part:

(c) Applicability. States will not be held out compliance with the following requirements of this subpart prior to the dates noted below so long as they comply with the corresponding standard(s) in 42 CFR part 438 contained in the CFR, parts 430 to 481, edition revised as of October 1, 2015:

(1) States must comply with §438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d), no later than the rating period for contracts starting on or after July 1, 2017.

(2) States must comply with §438.602(b) and § 438.608(b) no later than the rating period for contracts beginning on or after July 1, 2018.

Section 438.602 State responsibilities states in part:

(e) Periodic audits. The State must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP.

(g) Transparency. The State must post on its Web site, as required in §438.10(c)(3), the following documents and reports:

(1) The MCO, PIHP, PAHP, or PCCM entity contract.

(2) The data at §438.604(a)(5).

(3) The name and title of individuals included in §438.604(a)(6).

(4) The results of any audits under paragraph (e) of this section.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

State of Washington
July 1, 2021 through June 30, 2022

2022-055 The Health Care Authority did not have adequate internal controls over and did not comply with federal provider eligibility requirements for the Medicaid and Children's Health Insurance Program.

Assistance Listing Number and Title:	93.767 Children's Health Insurance Program 93.767 COVID-19 Children's Health Insurance Program 93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2005WA5021; 2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 1905WA5021; 2105WA5021; 2205WA5021; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Provider Eligibility (Screening and Enrollment)
Known Questioned Cost Amount:	$612,277

Background

The Health Care Authority administers both Medicaid and the Children's Health Insurance Program (CHIP). Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one third of the state's federal expenditures. CHIP provides health coverage for almost 90,000 children and pregnant people in families with incomes too high to qualify for Medicaid. During fiscal year 2022, the Medicaid program spent more than $17.6 billion in federal and state funds, and CHIP spent more than $229 million in federal and state funds.

The Authority ensures medical providers for both programs are eligible to provide services for clients. Providers must continue to meet eligibility requirements to receive payments under the programs. Washington had more than 127,000 participating providers in fiscal year 2022. During that time, the Authority paid more than $6.6 billion to providers for direct client services under the programs.

The Authority is responsible for performing screening measures appropriate for the provider type at application and initial enrollment. Federal regulations require state Medicaid agencies to revalidate the enrollment of all Medicaid and CHIP providers at least every five years. To meet this requirement, the Authority has implemented an automated revalidation notification process that is supposed to send a letter to providers in time for them to be revalidated before the end of the five-year period. Federal law also requires state Medicaid agencies to check federal databases at least monthly to confirm the identity and exclusion status of providers, as well as any person with ownership, controlling interest, or acting as an agent or managing employee of the provider.

The provider enrollment and revalidation processes are similar. The first step in both processes is to determine the provider's screening risk level. A provider can be designated as one of three risk levels: limited, moderate or high. Each risk level requires progressively greater scrutiny of the provider before it can be enrolled or revalidated. For providers enrolled with both Medicare and Medicaid, state Medicaid agencies must assign them to the same or higher risk category applicable under Medicare. Additionally, certain provider behaviors require them to be moved to a higher screening level. The following are the required screening procedures for all risk types:

- Verify that the provider meets applicable federal regulations or state requirements for the provider type before making an enrollment determination
- Conduct license verifications, including for licenses in states other than where the provider is enrolling
- Conduct database checks to ensure providers continue to meet the enrollment criteria for their provider type. Such database checks include the National Plan and Provider Enumeration System, List of Excluded Individuals/Entities, Excluded Parties List System, and Death Master File index.

If state Medicaid agencies assess providers at a moderate or high risk, they are required to conduct onsite visits for those that did not have one as part of their Medicare enrollment. Federal regulations require a high-risk provider, or a person with a 5 percent or more direct or indirect ownership in the provider, to receive a fingerprint-based criminal background check. The deadline to fully implement a fingerprint-based criminal background check was July 1, 2018.

The Authority is also responsible for ensuring that providers obtain the proper signed attestations and disclosures. For servicing only providers, a direct link must be made to a billing provider that has an active Core Provider Agreement (CPA) on file. A CPA contains the required attestation and disclosures of the billing provider to allow for the payment of medical claims.

To ensure the Authority has completed all applicable screening and enrollment or revalidation steps before enrolling or revalidating providers, staff members use checklists for each enrollment and revalidation. The staff member signs and dates the checklist to indicate the provider is eligible to render services and receive payments.

In response to the COVID-19 pandemic, the Authority obtained flexibilities under blanket waivers approved by the Centers for Medicare and Medicaid Services (CMS), which were effective March 1, 2020, through the end of the emergency declaration period. These included the waiving of provider application fees and fingerprint-based criminal background checks. The CMS waivers also allowed for expedited processing of any new or pending provider applications, as well as the postponement of all revalidation actions until November 1, 2020.

Also in response to the COVID-19 pandemic, the Authority's Chief Medical Officer approved a blanket waiver for the backdating of all providers effective dates, as allowed by CMS and Washington Administrative Code. This waiver allows providers to submit claims for services provided before their enrollment and revalidation applications are approved.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Authority did not have adequate internal controls over and did not comply with requirements to ensure it revalidated providers every five years and met screening requirements. The prior finding numbers were 2021-047, 2020-046, 2019-048, 2018-042, 2017-033, and 2016-035.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with federal provider eligibility requirements for the Medicaid and CHIP programs.

During the audit period, the Authority processed 10,959 new provider enrollments and was required to perform ongoing eligibility determinations for 114,427 active providers. We used a

statistical sampling method to randomly select and examine 59 newly enrolled providers and 59 active providers to determine if the Authority properly screened them based on their enrollment status and correctly determined their eligibility status. Of the 118 providers examined, we found seven instances for six providers (5 percent) when the Authority did not take the appropriate actions to ensure providers met eligibility requirements. Specifically, we found:

- Staff enrolled three providers without a valid CPA on file. Because the providers were not covered by a CPA, they were improperly enrolled.
- Staff did not conduct a proper license check for three providers. A proper license check for these providers would have led staff to identify that their license was either expired or did not cover the enrollment period, and, therefore, were ineligible.
- Staff did not properly screen one provider based on a moderate risk level. The improper screening checklist was used and the risk level was not properly addressed.

To determine if the Authority had revalidated providers every five years or had taken actions to deactivate providers, we used computer-assisted audit techniques to analyze the entire population of 2,049 providers that should have been revalidated or deactivated during the fiscal year. We found the Authority's internal controls were insufficient and resulted in none of the 2,049 providers (100 percent) being revalidated before the due date. We determined 648 providers were subsequently revalidated, and the Authority backdated them. We also determined 1,242 providers were deactivated, but the Authority did not process the deactivation until at least 30 days after the eligibility end date. There were an additional 159 providers that should have been deactivated, but the Authority did not take actions to deactivate or revalidate them.

Federal law requires the Authority to check federal databases at least monthly to confirm the identity and exclusion status of providers. However, the automated system that performs these checks and notifies the Authority of possible problems with providers was not operating correctly, and it frequently provided incorrect information. Management decided to ignore this information and stopped performing the monthly database checks. The Authority did review the results of the check once during the fiscal year, in July of 2021.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Although the Authority has established internal controls over screening and enrolling providers, they were ineffective for preventing or detecting noncompliance. Management also did not ensure staff consistently followed the procedures in place.

Additionally, the automated revalidation notification was inadequate for ensuring the Authority complied with the five-year revalidation requirement. To comply with this requirement, the Authority should notify providers about their revalidations and ensure they are started and

completed before the due date. Our audit found that the Authority's automated system is designed to notify providers of their revalidations one day after the due date. Due to this inadequate system design, all provider revalidations were completed after their due dates.

Although management directed staff to stop performing the monthly database checks because of issues with the automated system, they did not reinstate the procedures used before the system was implemented so staff could continue verifying providers' identity and exclusion status.

Effect of Condition and Questioned Costs

By not conducting required licensing, screening, and enrollment processes in a timely manner, the Authority is at risk of not detecting or preventing ineligible providers from providing services to clients and receiving federal Medicaid and CHIP funds. Payments to providers who are ineligible are unallowable, and the Authority could be required to repay the grantor for these payments. We identified the following payments made to ineligible providers:

Audit Area	Known questioned costs (state and federal)	Known questioned costs (federal portion only)	Likely improper payments (state and federal)	Likely improper payments (federal portion only)
New Providers	$7,092	$3,985	$1,317,224	$740,280
Deactivated Providers	$302,372	$292,051	$399,999	$351,698
Not Revalidated or Deactivated	$509,702	$316,241	n/a	n/a
Total	$819,166	$612,277	$1,717,223	$1,091,978

In addition to the questioned costs in the table above, we also identified $26,148,599 in costs at risk for those providers whose revalidations were backdated. If the providers had not been revalidated, these costs would also be considered questioned costs.

Our sampling methodology meets statistical sampling criteria under generally accepted auditing standards in AU-C 530.05. It is important to note that the sampling technique we used is intended to support our audit conclusions by determining if expenditures complied with program requirements in all material respects. Accordingly, we used an acceptance sampling formula designed to provide a high level of assurance, with a 95 percent confidence of whether exceptions exceeded our materiality threshold. Our audit report and finding reflects this conclusion. However, the likely improper payment projections are a point estimate and only represent our "best estimate of total questioned costs," as required by 2 CFR § 200.516(3).

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Strengthen internal controls to ensure providers are adequately screened, licensed, enrolled, and eligible to provide and bill for services
- Implement internal controls designed to bring it into material compliance with the provider revalidation process

Authority's Response

The Authority partially concurs with the finding.

The Authority agrees that ProviderOne sends revalidation notifications one day after the due date rather than before the due date to allow time for the revalidation process. A system revision is in process, and we expect this issue to be resolved by the beginning of 2024.

The Authority does not concur with the remainder of the auditor's findings.

The auditor provided the final exceptions and this finding at the close of the audit. The document with the final exceptions did not contain enough information for the Authority to adequately review the results of the auditor's testing or the methodology used to calculate questioned costs. The time allotted to the Authority to review the testing results, seek clarification, and provide an agency response was not sufficient to analyze the results and provide an informed response.

Due to the lack of complete information and time provided, the Authority is unable to agree or disagree with the results of the audit.

Finally, on March 19, 2020, the Centers for Medicare & Medicaid Services (CMS) approved Washington's request for an 1135 COVID-19 Emergency Declaration Blanket Waiver for Health Care Providers, effective through the end of the federal Public Health Emergency. This waiver temporarily suspended provider enrollment and revalidation requirements. Should the Authority agree with any or all of the results from the audit, it would not concur that questioned costs be returned because provider enrollment and revalidations requirements were temporarily suspended by CMS.

Auditor's Remarks

We provided the Authority with preliminary exceptions on December 20, 2022 for "Not Revalidated or Deactivated Providers" and on December 30, 2022 for "New Providers", "Active Providers", and "Deactivated Providers". The Authority provided additional information on January 31, 2023 that cleared some of the exceptions. We provided final exceptions on March 3, 2023 which included the unique transaction identifier for each exception. The Authority requested that we perform additional testing for the "Deactivated Providers" on March 15th. The draft finding was provided to the Authority on April 14, 2023 and the Authority provided their response on May 3rd.

Despite several years of the known system weaknesses, the Authority has not updated the system or implemented compensating processes to ensure providers are eligible to provide Medicaid and CHIP services.

Regarding the 1135 COVID-19 Emergency Declaration Blanket Waiver, the Authority informed us that beginning October 1, 2020, Authority management had reinstated the majority of provider eligibility requirements that had been waived.

We reaffirm our finding with questioned costs and will follow up on the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR Part 433, *State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers*, describes the requirements for identifying, reporting, collecting, and remitting Medicaid overpayments.

Title 42 CFR section 438 subpart H – Additional Program Integrity Safeguards, states in part:

Section 438.602 State responsibilities.

(a) Monitoring contractor compliance. Consistent with § 438.66, the State must monitor the MCO's, PIHP's, PAHP's, PCCM's or PCCM entity's compliance, as applicable, with §§ 438.604, 438.606, 438.608, 438.610, 438.230, and 438.808.

(b) Screening and enrollment and revalidation of providers.

(1) The State must screen and enroll, and periodically revalidate, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to FFS beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries.

(2) MCOs, PIHPs, and PAHPs may execute network provider agreements pending the outcome of the process in paragraph (b)(1) of this section of up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider, and notify affected enrollees.

(c) Ownership and control information. The State must review the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors as required in § 438.608(c).

(d) Federal database checks. Consistent with the requirements at § 455.436 of this chapter, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it must promptly notify the MCO, PIHP, PAHP, PCCM, or PCCM entity and take action consistent with § 438.610(c).

Title 42 CFR section 455 Subpart B – Disclosure of Information by Providers and Fiscal Agents, states in part:

Section 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)

(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

(c) When the disclosures must be provided –

(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

(i) Upon the provider or disclosing entity submitting the provider application.

(ii) Upon the provider or disclosing entity executing the provider agreement.

(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

(iv) Within 35 days after any change in ownership of the disclosing entity.

(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

(ii) Upon the fiscal agent executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the fiscal agent.

(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

(ii) Upon the managed care entity executing the contract with the State.

(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.

(4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph (c)(1) of this section.

(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.

(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

Title 42 CFR section 455 Subpart E – Provider Screening and Enrollment, states in part:

Section 455.410 Enrollment and screening of providers

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:

(1) Medicare contractors.

(2) Medicaid agencies or Children's Health Insurance Programs of other States.

Section 455.412 Verification of provider licenses

The State Medicaid agency must –

(a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.

(b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

Section 455.414 Revalidation of enrollment

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

Section 455.436 Federal database checks

The State Medicaid agency must do all of the following:

(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

(c)

(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

(2) Check the LEIE and EPLS no less frequently than monthly.

Section 455.450 Screening levels for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "limited," "moderate," or "high." If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(a) Screening for providers designated as limited categorical risk. When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following:

(1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.

(2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with § 455.412.

(3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

(b) Screening for providers designated as moderate categorical risk. When the State Medicaid agency designates a provider as a "moderate" categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the "limited" screening requirements described in paragraph (a) of this section.

(2) Conduct on-site visits in accordance with § 455.432.

(c) Screening for providers designated as high categorical risk. When the State Medicaid agency designates a provider as a “high” categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the “limited” and “moderate” screening requirements described in paragraphs (a) and (b) of this section.

(2)

(i) Conduct a criminal background check; and

(ii) Require the submission of a set of fingerprints in accordance with § 455.434.

(d) Denial or termination of enrollment. A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its –

(1) Application denied under § 455.434; or

(2) Enrollment terminated under § 455.416.

(e) Adjustment of risk level. The State agency must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

(1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State’s Medicaid program within the previous 10 years.

(2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

Medicaid Provider Enrollment Compendium (MPEC)

B. Enrolled Provider’s Payment Eligibility for Retroactive Dates of Service

The practice of “backdating” enrollment involves approving an enrollment with a retroactive billing date. This practice allows a provider, once enrolled, to submit claims for services dated prior to the date upon which the SMA approved the enrollment. As discussed earlier, provider screening enables states to identify ineligible parties before they are able to enroll and start billing. Components of provider screening include database and licensure

checks, and may also include site visits and FCBCs. To the extent a SMA approves the enrollment of a new provider and permits the provider to bill for services dated prior to applicable screening(s), this practice creates risk. For example, if a newly enrolling provider is subject to a site visit, and the SMA completes a site visit for the provider but nonetheless permits the provider to bill for services dated prior to the date on which the site visit occurred, there is risk the provider was not present at the site on the date of service for which the provider is subsequently approved to bill.

It is incumbent upon the SMA to mitigate risk of improper payments as it determines a provider's eligibility for enrollment, including the date upon which a provider is deemed eligible to service Medicaid beneficiaries. The SMA should have a process to determine whether and when it is appropriate to approve an enrollment with a retroactive billing date, as doing so represents the SMA's determination of prior compliance. This process should be designed to mitigate risk.

Factors the SMA must take into consideration when approving a retrospective billing date include, but may not be limited to:

- Survey or certification requirements that supersede a state's ability to determine prior compliance

Factors the SMA might take into consideration when approving a retrospective billing date may include, but are not limited to:

- Emergency access
- Pre-authorization
- Whether a provider is enrolled in Medicare or another state's Medicaid Program

CMS recommends documenting the basis for establishing an enrollment with a retroactive billing eligibility date. Medicaid payment issued to a provider prior to the SMA's screening and enrollment of the provider is an improper payment, unless an exception applies as described under Section 1.5.1.

Washington Administrative Code AC 182-502-0005 Core provider agreement (CPA), states:

(1) The agency only pays claims submitted by or on behalf of a health care professional, health care entity, supplier or contractor of service that has an approved core provider agreement (CPA) with the agency, is a performing provider on an approved CPA with the agency, or has an approved agreement with the agency as a nonbilling provider in accordance with WAC 182-502-0006.

(2) Performing providers of services to a medical assistance client must be enrolled under the billing providers' CPA.

(3) Any ordering, prescribing, or referring providers must be enrolled in the agency's claims payment system in order for any services or supplies ordered, prescribed, or referred by them to be paid. The national provider identifier (NPI) of any referring, prescribing, or ordering provider must be included on the claim form. Refer to WAC 182-502-0006 for enrollment as a nonbilling provider.

(4) For services provided out-of-state, refer to WAC 182-501-0180, 182-501-0182 and 182-501-0184.

(5) The agency does not pay for services provided to clients during the CPA application process or application for nonbilling provider process, regardless of whether the agency later approves or denies the application, except as provided in subsection (6) of this section or WAC 182-502-0006(5).

(6) Enrollment of a provider applicant is effective on the date the agency approves the provider application.

   (a) A provider applicant may ask for an effective date earlier than the agency's approval of the provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

      (i) Earlier than the effective date of any required license or certification; or

      (ii) More than three hundred sixty-five days prior to the agency's approval of the provider application.

   (b) The chief medical officer or designee may approve exceptions as follows:

      (i) Emergency services;

      (ii) Agency-approved out-of-state services;

      (iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

      (iv) Retroactive client eligibility; or

      (v) Other critical agency need as determined by the agency's chief medical officer or designee.

   (c) For federally qualified health centers (FQHCs), see WAC 182-548-1200. For rural health clinics (RHCs), see WAC 182-549-1200.

   (d) Exceptions granted under this subsection (6) do not supersede or otherwise change the agency's timely billing requirements under WAC 182-502-0150.

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-056 The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid payments to supported living providers were allowable and adequately supported.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 - State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 – Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles
Known Questioned Cost Amount:	$237,404,150

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one-

third of the state's federal expenditures. During fiscal year 2022, the program spent about $17.6 billion in federal and state funds.

The Department of Social and Health Services' Developmental Disabilities Administration administers the Home and Community-Based Services (HCBS) program for people with developmental disabilities. The HCBS is a waiver program that permits states to provide an array of community-based services to help Medicaid clients live in the community and avoid institutionalization. States have broad discretion to design waiver programs, but they must be approved by the Centers for Medicare and Medicaid Services (CMS).

Supported living services support Medicaid clients to live in their own homes, generally with one to three other people, and receive instruction and support delivered by contracted service agencies (providers). Supported living clients pay their own rent, food and other personal expenses. Supported living is an option under the HCBS Core and Community Protection waivers. In fiscal year 2022, the state Medicaid program paid about $638.8 million in federal and state funds to supported living agencies that provided care to about 4,000 Medicaid clients.

Client assessment, Person-Centered Service Plan, and tiered rate

The Department uses a rate assessment tool to evaluate client support needs to live in the community. With this assessment, the Department develops a Person-Centered Service Plan (PCSP) to determine the support and instruction a client is expected to receive. The economies of scale are applied to the assessed level of care generated by the rate assessment tool to produce a daily rate in one of nine tiers that is paid to the supported living agency. The tiered rate is comprised of two components: payment for direct client services (known as instruction and support services, ISS) and administrative (known as non-ISS). A tiered rate methodology is used to allow providers more flexibility in delivering services to clients. A daily tiered rate is loaded into the Department's payment system, and providers claim payment for each day they provide services to the clients. The supported living agency is contractually obligated to fulfill the client's support needs outlined in the PCSP.

Cost report and settlements

Providers are required to prepare and submit a cost report by March 31st for the prior calendar year, with each cost report covering the last six months of one fiscal year and the first six months of the next fiscal year. Providers must attest to the accuracy of the reported information. The Department uses the cost report information to:

- Provide program cost data to regional managers and residential providers;
- Determine settlements with supported living providers;
- Provide accountability and transparency for the use of public funds.

In the HCBS waiver, the Department states it reconciles purchased support services with provided support services for the calendar year. Using the cost report, the Department calculates settlements to determine if the provider received more reimbursement for ISS care than what it paid to its employees who provided the client care. Department policy states that when staff reviews a cost report to determine if a settlement is required, the following will be verified:

a. All sections of the cost report are complete;
b. The information in Residential Rates for Developmental Disabilities (RRDD) matches the ProviderOne payment report;
c. The report conforms with generally accepted accounting principles;
d. The report meets the requirements of the provider's contract; and
e. Expenses are accurately reported.

If the provider does not spend all ISS reimbursement funds on costs to provide direct care to clients, then it is required to pay the Department back the difference. In the HCBS waiver, the Department states that there is no settlement for administrative or indirect client support costs.

Cost report payroll verifications

The Department conducts payroll verifications of the cost report for selected providers to determine the accuracy and reasonableness of the self-attested expenditures reported. Before verifying payroll, the Department requires the provider to submit supporting documentation, including detailed payroll cost support for two to three months of the calendar year. Department staff review the provider's detailed support, which shows that it only used ISS funds received from the Department to provide ISS care. The Department's ISS Payroll Verification Process guide outlines the payroll verification process and the documents providers must maintain to support expenditures recorded on their cost reports. The guide states:

- The payroll summary must include detail for employees who performed direct support.
- The payroll data must be by employee with job titles.
- The providers are responsible for demonstrating how their records tie to the amounts reported on the cost reports.
- If payroll summaries do not match amounts providers reported on the cost reports, then the Department will review additional months up to the entire calendar year.

Provider documentation requirements

According to Department policy, providers are required to maintain detailed payroll records to verify the cost of services provided to clients. Upon request, the providers must provide job descriptions for employees who are allocated to both ISS and non-ISS duties. Providers must retain detailed monthly or quarterly payroll and supporting records that support the amounts on their cost reports.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior ten audits, we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure payments to supported living providers were allowable. The finding numbers were 2021-049, 2020-051, 2019-054, 2018-058, 2017-044, 2016-041, 2016-045, 2015-049, 2015-052, 2014-041, 2014-042, 2013-036, 2013-038 and 2012-039.

After the fiscal year 2019 audit, the grantor, the Center for Medicaid and CHIP Services (CMS), issued a management decision letter in which it requested "the state provide documentation that shows an adequate payment review process was implemented that occurs more frequently than once a year," and it requested the state repay the questioned costs identified in the finding. After the fiscal year 2020 audit, CMS requested that the state provide documentation that justifies its position on current adequate internal controls regarding Medicaid payments to supported living providers, and it requested the state also repay the questioned costs from that finding.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure Medicaid payments to supported living providers were allowable and adequately supported.

July 1 to December 31, 2021

Cost reports and settlements – completed during audit period

The Department reconciled and settled all of the 140 cost reports it received during this period. Of these reports, 74 were completed during the audit period, but they did not receive a payroll verification. For calendar year 2021, the Department did not require documentation to support the self-attested provider costs. Because of the Department's insufficient monitoring activity, we determined the cost report reconciliation and settlement process was insufficient for ensuring payments made to providers for ISS care were for allowable activities and met cost principles.

Cost report payroll verifications

During the audit period, the Department verified payroll for 66 providers for calendar year 2021. We randomly selected 12 of these providers to examine and identified the following issues in the cost report review process that Department staff had performed:

- The cost report payroll verifications only cover 7.9 to 11.8 percent of all months of payments in calendar year 2021. This is insufficient coverage in our judgment.
- Eleven of the providers examined (92 percent) included overtime and nine of the providers (75 percent) included bonus payments in their ISS payroll expenditures. Department policy

allows overtime and bonus payroll expenditures to be included as support for cost reports, but these are not factors considered in the tiered rate calculation. We do not believe this is appropriate because considering overtime and bonus dollars to be the same as regular pay dollars does not accurately reflect the services being provided to clients.

We do not consider these reviews effective for ensuring providers' self-attested expenditures on the cost reports were allowable and supported.

January 1 to June 30, 2022

Because cost reports and payroll verifications are prepared on a calendar year basis, the Department had not collected the reports and verified payroll for 2022 by the end of the audit period. The Department did not perform any other systematic review of these expenditures; therefore, we determined the Department did not have sufficient controls over the federal compliance requirements of activities allowed/unallowed and allowable costs/cost principles during this period.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Management believed that when the Department switched to using a tiered rate system, the level of monitoring it was conducting was sufficient for meeting federal requirements. However, the grantor has since informed the Department that it must implement an adequate payment review process that occurs more than once a year, but management has chosen not to do so.

Cost reports and settlements

The Department does not require providers to submit supporting documentation with their cost reports. Instead, the Department allows self-attested payroll expenditures as adequate support for the cost report settlements.

Effect of Condition and Questioned Costs

Without establishing an adequate payment review process, the Department had little assurance that it used program funds only for allowable purposes and payments to providers were adequately supported.

We are questioning:

Payments made from July 1, 2021, through December 31, 2021

Cost reports and settlements

- $136,400,692 in ISS payments made to 74 providers for which the Department did not verify payroll. The federal share of these questioned costs is $76,657,188.

Payments made from January 1, 2022, through June 30, 2022

We are questioning all $286,026,617 in supported living payments during this period. The federal share of these questioned costs is $160,746,962.

Summary of questioned costs

The table below summarizes, by audit area, the known questioned costs and likely improper payments:

Audit Area	Known Questioned Costs (State and Federal)	Known Questioned Costs (Federal Portion Only)
Costs reports reconciled, but no payroll verification performed	$136,400,692	$76,657,188
Expenditures with no cost reports	$286,026,617	$160,746,962
Totals	$422,427,309	$237,404,150

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Department:

- Implement an adequate payment review process that occurs more frequently than once a year to ensure federal funds paid to providers are used only for allowable purposes and are adequately supported
- Consult with its grantor about whether the questioned costs identified in the audit should be repaid

Department's Response

The Department respectfully does not concur with the finding.

The State Auditor's Office (SAO) has questioned large portions of the Department's reimbursements for instruction and support services provided to supported living clients. This includes questioning all reimbursements from the second half of fiscal year 2022, and all costs from the first half of the fiscal year that are associated with the seventy-four providers who did not undergo a payroll verification review. The Department strongly disagrees that all these costs

should be questioned. The Department had numerous internal controls in place during the fiscal year. These controls are detailed later in this response and together they provide sufficient assurance that the paid services were provided.

It is noteworthy that the SAO did not have any questioned costs from the first half of the fiscal year (July 1, 2021, through December 31, 2021) that were associated with the sixty-six providers who were subject to the Department's payroll verification review. In fact, the SAO apparently, and appropriately, considered the Department's payroll verification process an internal control that is generally sufficient to ensure payments to supported living providers are allowable.

For the second half of the fiscal year (January 1, 2022, through June 30, 2022) the Department had the same internal control in place. That is, the Department's verifications were performed based upon provider payroll received from the second half of the year in the same way that they were performed on payroll from the first half of the fiscal year. While we disagree with how the auditor arrived at known questioned costs, as the Department had the same internal control in place in both halves of the fiscal year one would expect to see similar, while incorrect, questioned costs (relating to providers who received a payroll verification). Instead, the SAO questioned all the costs from the second half of the fiscal year. The SAO appears to have errantly concluded that this internal control was non-existent for the second half of the year, which is neither true nor accurate. As stated above, the same internal control was in place, a control that the SAO otherwise considers to be sufficient.

The stated reason that the SAO did not consider this control for the second half of the year is based solely on the timing of the SAO's audit cycle, rather upon reasonable doubt regarding the sufficiency of the control. In fact, the Department reconciles payments on a calendar year basis which is set forth in policy and is approved by the federal government as part of its waiver approval process. The SAO audits on a fiscal year basis and counter-intuitively, does not consider control activities when they fall outside of their audit period. As the SAO does not consider the payroll verification reviews that applied to the second half of the fiscal year, the Department considers the SAO's audit incomplete. This incompleteness results in the contradictory conclusion that payments over which the Department had sufficient controls were completely unallowable:

Audit Area	*Known Questioned Costs (Federal Portion Only)*
7/1/21-12/31/21 *74 Costs reports reconciled, but no payroll verification performed.*	*$76,657,188*
1/1/22-6/30/22 *140 Providers with expenditures but no cost reports submitted.* *(Cost Reports are not submitted until 12/31/22)*	*$156,784,641*
Totals	*$237,404,150*

We would also like to speak to SAO's opinion on overtime and bonuses. The fact that overtime and bonuses are actually paid for client support is evidence of, and an accurate reflection that, the services and supports were being provided to clients. Additionally, it is clear evidence of trends that CMS and every State Medicaid agency are aware of: the health care service sector has been hit with unprecedented staff shortages. Overtime is a necessary expense needed to cover these shortages and assure that clients are receiving their Medicaid services. Bonuses are also increasingly a necessary retention tool in the tight labor pool to help agencies compete for staff to reduce the shortages. Bonuses increase retention and reduce turnover. Bonuses also reward quality services and supports to clients.

The Department does not control how a provider operates their business. The Department does follow the federal directive of necessary an ordinary when reviewing expenditures. The Department considers overtime and bonuses as ordinary and necessary costs for supportive living businesses. Federal cost reporting equally considers overtime and bonuses as normal expenses/costs of doing business. The Department conducted ISS payroll audits of all eleven providers in the SAO test. Overtime and bonuses were reviewed and determined to be supported by the documentation in the ISS payroll reviews that the Cost Analysts conducted.

Overtime is a necessary cost of doing business inside and outside of state government. Providers who pay overtime are demonstrating that they are willing to pay their employees the amount necessary to cover every shift for client support and safety, even if it means they end up spending more than they were reimbursed by DDA. Average turnover at the direct service provider level is approximately 50% each year in the residential provider industry. Rather than the current posture, the SAO should be concerned about providers with high turnover who don't report any overtime. The Department would question whether such a provider truly honored their contracted financial obligations to their clients in such scenarios. Just because a provider pays out overtime does not mean they provided any less of a service. It simply means that they spent more money out of their own pockets for the cost of client care than they were contracted to spend for that contracted care.

The SAO would be challenged to find many companies operating today that do not pay any overtime. Overtime is a necessary cost of any business, particularly when employees are granted paid time off, sick, and holiday pay. Even companies who are fully staffed must occasionally pay out overtime to ensure that necessary work gets completed when employees are out sick, take holidays, and vacations. When individuals work with intellectually disabled children and adults, often someone must be available 24/7 to support these clients. This means that someone must work on holidays and weekends. Someone must be there when a co-worker is on vacation, or sick. Without overtime pay, critically needed work would be left unattended. In the Department's work, work left unattended could result in clients left unattended. It is difficult to understand why the SAO would support the potential that DDA clients would be left without support and at risk of being unattended.

The SAO interpretation of overtime and bonuses is another example of some continuing and fundamental misunderstandings as to how supported living in the context of State Medicaid service delivery works. The SAO's unique interpretation of the allowability of overtime and bonuses makes no sense in relation to the clients that the Department is empowered and directed by the Legislature to serve.

The Department continues to assert that payment reconciliations, cost reports, and settlement are all primary internal controls. As an additional measure, ISS payroll reviews are selected annually to further validate the primary internal controls.

The SAO also did not consider supported living daily rates/payments as adequate internal controls. As an example, the Department completed internal control for all of the January 1, 2022 rate/payment increases, a total of some 3,800 plus payments, all mandated by the Legislature. The SAO's audit did not review this payment change or even factor it in for internal controls in their finding.

The Department remains concerned that the SAO appears to place 100% of the weight towards ISS payroll reviews as DDA's only measure of internal control. Cost reporting and ISS payroll reviews are only one piece of many other processes that DDA employs to provide internal controls over their residential programs.

The Department has many significant oversight and monitoring strategies for internal controls. They are as follows:

- ***Medicaid Service Verifications***

  The Developmental Disabilities Administration (DDA) Quality Compliance Coordinator (QCC) team carries out Medicaid Service Verifications each month for a random sample of 79 clients who receive Medicaid services. This includes clients receiving supported living services. Clients or their legal representatives receive a service verification survey which asks if they received the services identified in their plan. If a client or their representative responds "no" to this or any other question, a member of the QCC team follows up with a phone call to determine the next steps.

- ***Segregation of duties***

  Service planning and service authorization are separate duties. Case managers are responsible for service planning. Resource managers are responsible for the rate assessment. There are also separate oversight processes for each of these duties. Oversight of service planning is performed by supervisors. Oversight of the rate approval process is performed by Resource Manager Supervisors and the DDA headquarters Community Residential Services Program Manager.

- ***Verification and approval process***

Resource managers complete the rate assessment. The rate assessment process applies multiple efficiencies to achieve cost effectiveness. Oversight of the rate approval process is performed by Resource Manager Supervisors and the DDA headquarters Community Residential Services Program Manager. A rate sheet (called "Exhibit C" in the contract) is generated, and the provider confirms and signs it as part of their contract. The rates are uploaded into the Health Care Authority's ProviderOne payment system, allowing the provider to claim the authorized rate. Rates assessed as tier nine and single-person households require an exception to policy, which is reviewed and approved by managerial staff.

- ***Allowable Costs Payment Reconciliation***

Twice per year the Department reconciles the provider's payments for services provided to individual clients. There is a six-month review of payments for the first half of the calendar year and then a twelve-month review at the end of the calendar year. The final payments and cost settlement are adjusted for all variances in costs as determined by the reviews.

- ***Rate Payment and Increases***

For calendar year 2022, over 3,800 individual supported living daily rates and payments were reviewed because of a legislative mandate for the rates and payments to increase.

- ***Rate, cost report, settlement, and reconciliation processes***

Supported living uses a tiered rate reimbursement methodology. The tiered rate is a daily rate for an individual client. It is based upon the client's assessed needs and economies of scale. The tier level and rate amount are calculated by algorithms established in rule. The systems involved include the Comprehensive Assessment, Review & Evaluation (CARE) tool, Residential Rates for Developmental Disabilities (RRDD), and Provider One. ALTSA and DDA staff monitor the systems and rates for accuracy. The tier methodology was reviewed and approved by CMS.

The cost report is a financial report prepared by the contracted provider that identifies the costs related to community residential habilitative services and supports provided in the calendar year. Allowable costs are detailed in DDA policy 6.04. DDA rate analysts and agency providers both receive annual training on the cost report process and accuracy in the recording of all the financial information involved. When the cost report is submitted to the Department, the provider attests to its accuracy and completeness. DDA rate analysts review the cost report, checking for accuracy and completion in accordance with generally accepted accounting rules, and DDA polices 6.02 and 6.04.

The initial review includes a checklist of instructions the analyst follows to ensure the cost report is reasonable, allowable, and completed accurately. The review includes a

reconciliation of payments. The reconciliation process verifies the provider claimed the correct number of days of service and rate for every client in their contract. Reconciliation is done by comparing payments in the DDA RRDD database to those claimed in the Health Care Authority ProviderOne database. Variances are corrected in ProviderOne and on the cost report settlement when they are determined and verified by both the rate section and DDA field staff.

The RRDD approval process for rates is a 3-step approval process that must pass the inspection of an RMA, Program Manager, and Cost Analyst for each rate to be approved and paid to a provider. The reconciliation process ensures that each client rate is paid exactly as it was contracted to be paid. For setting a rate, a case manager must approve the time allotted to each client and a resource manager must create each rate based on each case manager's assessment.

The cost report is not used to set rates. The cost report is used to calculate a financial settlement that compares payment revenue to actual expenses. When instruction and support services (ISS) payment revenue is more than the ISS expenses, a settlement is generated. The provider returns the amount owed (per the settlement) to the Department's Office of Financial Recovery (OFR).

- ***Payroll verification process***

A sample of providers is required to submit payroll records that support the instruction and support services (ISS) expenses claimed on the cost report. Over the past three years, these verifications have increased from 25%, to 33% and for FY22 47% of providers were included in the sample. Samples are selected in mid-March, and the review process begins in mid-April after cost reports are submitted. Providers are given two weeks to provide payroll records. DDA's rate analyst compares the provider payroll records to the ISS expenses reported on the cost report to verify that their payroll supports their reported ISS expenses. If inaccuracies are identified, the analyst may request additional information, or that corrections be made to the documentation submitted.

- ***Quality Assurance Review***

DDA's Residential Quality Assurance unit had one employee who provides technical assistance for certified community residential settings during FY22. With the transition from the legacy ISS hour-driven rate system to the person-centered assessment driven tiered rate system, a formalized and more holistic quality assurance oversight process was developed. It was implemented in July 2019. This new QA oversight approach includes routine reviews to ensure selected supports listed in clients' person-centered service plans (PCSPs) align with the supports provided.

The PCSP is the state's primary instruction to the provider for the provision of contracted services. The quality assurance staff conducts virtual reviews of the quality and quantity of service in relation to individuals' assessed needs across ten domains of the CARE tool (the tool which contains the algorithm that drives the tiered rate).

Reviews were historically conducted for approximately two providers per month, which resulted in 24 reviews. These reviews included a sample of clients across multiple homes and different service levels. During calendar year 2023, the Residential Quality Assurance unit hired three additional staff. With four staff, the goal will be 96 reviews per calendar year.

The quality assurance staff provides recommendations if the providers' practices should be revised. This increases security and helps achieve better compliance with WAC 388-101D requirements.

The quality assurance staff provides thorough, written feedback following the review, and requests a written plan of correction from the provider. The quality assurance staff monitors to ensure all providers submit the written plan.

- ***Duplicate Payment Report***

On a monthly basis the Department checks for overlapping service claims made by more than one provider for the same client – that is, payments made to a provider on the same day that there is another claim for Medicaid funding (such as a claim for services provided by a hospital). When such claims are detected the Department contacts providers to gather further information and to provide guidance. Claims and authorizations are adjusted, as necessary.

Additionally, in the ProviderOne system there is an automated system check which denies payments for multiple identical (or near identical) claims for the same client on the same day. If patterns are detected, the Department will contact providers to gather information and provide guidance.

- ***Residential Care Services (RCS) certification process and DDA follow up***

RCS evaluates providers' compliance with Chapter 388-101 and 388- 101(D) WAC, and the DDA contract at minimum of every two years. RCS also monitors for evidence of working toward person-centered service plan goals and investigates complaints of provider practice and RCW 74.34 violations. Citations issued by RCS require providers to respond with plans of correction.

DDA regional staff and headquarters quality assurance staff monitor provider compliance and provide technical assistance to providers in developing plans of correction and maintaining compliance with requirements. Regional staff verify providers' compliance with their plans of correction. This is documented in the Residential Agency Tracking database on the SharePoint site.

Quality assurance staff report on citation trends monthly. Quality assurance staff review the most frequent citations quarterly, and implement systemic interventions such as training, provider messaging, and developing provider tools and resources.

- ***Contract monitoring***

Headquarters quality assurance staff and regional resource managers and quality assurance staff monitor providers' performance in relation to their contract to ensure compliance.

Resource managers' contract monitoring activities are documented in the Residential Agency Tracking Database. These activities include visits to clients' homes. The number of monitoring visits is determined by various factors including the number of incident reports and technical assistance requests from the provider.

Case managers (CRMs) visit clients' homes when performing the annual DDA assessment. CRMs monitor to ensure that clients are receiving services according to their person-centered service plan and that clients' health and welfare needs are addressed. This monitoring frequency depends upon the needs of the client but must occur at least every six months. The monitoring typically includes a conversation with the client and/or their legal representative.

During monitoring of services, the frequency of services and the amount of each service are reviewed to ensure the client's assessed needs are addressed. This monitoring is recorded in CARE under the "monitor plan" tab. A question on DDA's Quality Compliance Coordinator annual review checks that CRMs completed plan monitoring. This annual QCC review includes a sample of client files. For waiver and Community First Choice clients, the sample size is set to have a confidence level of 95% and an error rate of + or – 5%. For Roads to Community Living clients, the sample size is 100%.

The Residential Quality Assurance Program Manager conducts a quarterly survey to obtain information about clients' inclusion in the community. The survey is based on a random selection of 350 clients and includes clients in the supported living program.

Every six months the Residential Quality Assurance Program Manager requests current Individual Instruction and Support Plans (IISPs) and information on progress toward IISP goals for the clients identified in the above survey. This is to review the IISPs for compliance with WAC and DDA policy 5.08 (Individual Instruction and Support Plan and Risk Summary), as well as to ensure progress is being tracked for habilitative goals.

- ***Plan Review***

A Plan Review is a mandatory screen in CARE Web that must be completed to open an Annual Assessment. Plan Reviews give case managers the opportunity to directly ask the individual or their legal representative if the services they received over the year were provided to their satisfaction. DDA completes the Plan Review at the Annual Assessment and more often if

warranted. DDA considers this an important screen for all clients as it gives them a voice to adjust their support if needed. In addition, DDA believes that asking the individual directly if their services were provided satisfactorily is a metric we can use to hear directly from the individual, in their own words, rather than receiving a form with a checkbox filled out by someone who may or may not be the individual receiving the services. This method of data gathering is critical to ensuring individuals are not only receiving but are satisfied with the services authorized.

The Department strongly believes that its current oversight and monitoring adequately confirms that services received by clients meet the certification standards for supported living agencies. The Department continues its efforts to bring quality services to clients who receive habilitative residential support. The Department has followed all requirements, including reconciling the settlement amounts that were issued to agencies in the cost report settlement process. The Department intends to send a request to CMS through the Management Decision Letter process, asking that the questioned costs recommended by the SAO be rescinded.

Based on the information provided above, the Department asserts that the questioned costs for this audit should be revised to zero. The Department considers it unfortunate that the SAO did not choose a more collaborative approach aimed at supporting the Department in its continuing quality improvement efforts. The Department continues to adjust its processes openly and appropriately as needed and remains interested in partnering with SAO to resolve disagreements in this regard and to find common ground together.

Auditor's Remarks

Broadly, one of the goals of the single audit is one of fiscal accountability – to assure the federal government that state programs follow the relevant regulations in spending public money, and that they can provide evidence they did so. Both the Department and the federal government have long been aware of the issues identified in this audit, and the federal government has concurred with previous audit findings. As in the previous ten years' audits, this year's audit found the Department did not comply with requirements to ensure Medicaid payments to supported living providers were allowable and adequately supported. For the last two years, the federal government also said the state's process for reviewing those payments was inadequate and has requested documentation to justify the Department's position. Because of its concerns, the federal government requested the state repay $114 million, $252 million, and $285 million of federal funds over the last three years.

This audit finding is a result of procedures performed to determine if the Department is compliant with federal requirements over Activities Allowed/Unallowed and Allowable Costs/Cost Principles. We considered the Department's asserted internal controls during the audit and found them to be inadequate to meet these requirements. We did not state that we believe none of the services occurred. We reported the Department did not adequately review documentation from

providers or perform other procedures to determine that federal funds were only used for allowable purposes and were adequately supported, and therefore, we are required to question costs.

The Department's response includes that "the tier methodology was reviewed and approved by CMS." CMS approval of provider payment methodology has no effect on the compliance requirement to ensure payments to providers are spent on allowable activities and meet cost principles. The Department received a management decision letter from CMS dated October 22, 2021 that addressed the prior year finding the Department received for this same issue (2020-051). In this letter, CMS stated:

> *CMS request that the state provide documentation that justifies their position on current adequate internal controls regarding Medicaid payments to supported living providers. Additionally, the state should refund the questioned costs of $284,918,428 FFP on the next CMS 64 report.*

We confirmed the Department received this letter. Therefore, the Department should be aware this guidance from CMS is in conflict with the Department's assertion that CMS approval of the tiered rate methodology relieves them of the requirement to ensure payments are used only for allowable purposes and are adequately supported.

Internal control is a perpetual process, effected by those charged with governance, management, and other employees, designed to provide reasonable assurance regarding the achievement of the entity's objectives relating to operations, reporting, and compliance. At the beginning of the audit, we requested the Department provide in writing the key internal controls it has in place to ensure compliance with federal requirements. We extensively reviewed each control the Department identified and determined only the cost report payroll verification process could ensure payments are used only for allowable purposes and are adequately supported. In our judgment, a review of an annual cost report does not provide the Department with reasonable assurance that federal Medicaid funds paid for ISS services were only spent for ISS services.

Even when internal controls are determined to be insufficient, we are required to test the Department's compliance with federal requirements. We examined the cost reports and tested to the requirements outlined in the Department's policy 6.04 that states providers must maintain supporting records for the amounts reported on the cost report. The Department response stated:

> *DDA rate analysts review the cost report, checking for accuracy and completion in accordance with generally accepted accounting rules, and DDA polices 6.02 and 6.04.*

During the cost report settlement process, it is not possible to check for accuracy and completion without having supporting documentation to compare to the cost report. The Department performs the reconciliation to determine whether the provider was paid the correct daily rate, which does not ensure payments were spent on allowable activities. For the settlement process, the Department provided no evidence that the rate analysts review supporting documentation to confirm accuracy

or completeness of provider self-attested expenditures. We found there is no review of these supporting records when the Department conducts the annual cost report reconciliation and settlement.

The only time the Department reviews provider supporting documentation is during the payroll verification. In its response the Department stated:

> *The cost report is not used to set rates. The cost report is used to calculate a financial settlement that compares payment revenue to actual expenses.*

The Department cannot compare payment revenue to actual expenses when no documentation is received to verify the amount of actual expenses. In state fiscal year 2022, the Department completed audits for 66 out of 140 providers and, for the samples we tested, the Department requested and reviewed detailed level payroll expenditures. In the instances where the Department identified expenditures without adequate support there was no provider repayment. To determine if the provider is required to repay the self-attested expenditures that were not adequately supported, the Department adjusts the settlement calculation. There is a flaw in this process because the Department is relying on the provider's self-attested expenditure total in the settlement amount, which the Department just determined were not adequately supported, to determine if repayment is necessary. The Department has determined that the provider self-attested expenditures are not adequately supported yet they are still utilizing an unreliable self-attested amount to determine if repayment is required.

The Department cited a number of oversight and monitoring activities it performs related to Supported Living agencies. While these are useful processes and may help ensure clients receive proper services, they are not focused on ensuring payments made to providers are for allowable activities or meet cost principles.

In response to the finding 2019-054, CMS informed the Department that yearly review of the cost reports was not sufficient. Even if the cost reports covering the second half of the audit period were received within the audit period, the Department would be noncompliant with federal law.

During each audit, we evaluate the changes made by the Department to determine if supported living payments are allowable and adequately supported. We will continue to review the Department's asserted controls over allowable activities and cost principles to determine its adequacy.

We reaffirm our finding and will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 42 *U.S. Code of Federal Regulations* (CFR) Part 433, *State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers*, describes the requirements for identifying, reporting, collecting, and remitting Medicaid overpayments.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 CFR Part 200, Uniform Guidance, section 516, Audit findings, establishes reporting requirements for audit findings.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Home and Community-Based Services Waiver, states in part:

> Cost Reports:
>
> > Cost reports reconcile purchased support services with provided support services for the calendar year. Cost reports are desk audited to determine accuracy and the reasonableness of reported costs. Reported revenue received is reconciled to ProviderOne payment information to determine settlement amounts as described in DDA Policy 6.04.
> >
> > Settlements are calculated by the Department staff to determine settlements per contract(s) in cases where providers' contract(s) received more reimbursement for direct support costs than was paid out.

Developmental Disabilities Administration Policy 6.02 - Rates and Other Covered Costs for Supported Living, Group Training Homes, and Group Homes, issued 01/2020, states in part:

> C. Rates are payments for costs that are necessary, customary, and related to the provision of residential program instruction and support as described in chapters 388-101 and 388-lOlD WAC and the residential services contract.
>
> 24. Provision of Services

a. The service provider must provide residential services assigned to the service provider in the client's person-centered service plan.

c. The service provider must maintain a system that shows instruction and support service funds have been used to provide instruction and support services. All instruction and support services staff compensation, employer paid taxes, and benefits within each calendar year are annually reconciled to the ISS contracted rate through the cost reporting system. See DDA Policy 6.04.

Developmental Disabilities Administration Policy 6.04, Billing, Payment, and Cost Reporting for Supported Living, Group Training Homes, and Group Homes, issued 12/2019, states in part:

D. Cost Report Components

1. Instruction and Support Services

   a. If a provider reports ISS expenses beyond what is ordinary and necessary, the Department may ask the provider to explain the reported costs.

   c. Service providers must provide to DSHS upon request job descriptions for employees who are allocated in the cost report working both ISS and non-ISS duties. Payroll costs charged to ISS for cost reporting purposes must be verifiable in the service provider's records.

   e. Providers must report on their annual cost report the monthly or quarterly payroll expenses for staff that perform ISS duties (and non-ISS for those who perform both ISS & non-ISS duties). The employer must retain the detailed monthly or quarterly payroll and supporting records that support the monthly or quarterly amounts reported on the cost report as DDA may request these records.

   f. Allowable ISS Costs include:

      1. Compensation paid for ISS staff salaries, wages, stipends, training costs and other compensation for staff that are designated as ISS, and prorated for those staff whose time is split between ISS and administrative functions;

State of Washington
July 1, 2021 through June 30, 2022

2022-057 The Department of Social and Health Services' Aging and Long-Term Support Administration did not have adequate internal controls over and did not comply with requirements to ensure timely investigation of complaints of client abuse and neglect at Medicaid residential facilities.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Provider Health and Safety Standards
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership serving 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one third of the state's federal expenditures. The program spent more than $17.6 billion in federal and state funds during fiscal year 2022.

The Centers for Medicare and Medicaid Services (CMS), which administers the program at the federal level, allows states to provide long-term care services to Medicaid clients that require daily nursing services. Medicaid coverage for nursing homes and intermediate care facilities for intellectually disabled clients is only authorized when services are provided in a residential facility licensed and certified by the state survey agency. The state survey agency is also responsible for investigating complaints and allegations of abuse, neglect or misappropriation.

Residential Care Services, under the Department of Social and Health Services' Aging and Long-Term Support Administration (Department), is the state's long-term care facility survey agency. Residential Care Services manages the Complaint Resolution Unit (Unit), which is the frontline response system for providing the intake and assignment functions for complaints from staff, residents, families and the public.

The Unit receives two types of complaints, also known as reports: 1) complaints from Department staff, the public, government agencies, or law enforcement and 2) reports from facilities. People can submit complaints to the Unit by phone, mail, email, fax or online. The Unit responds to complaints received on holidays and after hours on the next business day. Until October 2021, the Department used the Tracking Incidents of Vulnerable Adults (TIVA) case management system to input, prioritize and track complaints. The Unit then began using the Secure Tracking and Reporting System (STARS) case management system for the rest of the audit period.

Unit intake staff perform an initial review of complaints before entering them into STARS. Clinical triage nurses determine the final priority assignment of all nursing home and intermediate care facility complaints. According to state law (RCW 74.34.063), a complaint of suspected abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult must be responded to no later than 24 hours after knowledge of the report.

The following table lists the five different priority levels for new complaints and the respective response times. During the COVID-19 pandemic, CMS guidance allowed states to work only on complaints with Immediate Jeopardy and Nonimmediate Jeopardy-High Priority levels.

Priority Levels	Required response times
Immediate Jeopardy	Initiate investigation within 2 working days of receipt
Nonimmediate Jeopardy-High	Initiate investigation within 10 working days of prioritization
Nonimmediate Jeopardy-Medium	Initiate investigation within 20 working days of prioritization
Nonimmediate Jeopardy-Low	Initiate investigation within 45 working days of prioritization
Quality Review	Field Manager Review

The CMS *State Operations Manual* requires each complaint to be triaged by someone who is professionally qualified to evaluate the nature of the problem based on their experience and knowledge of current clinical standards of practice and federal requirements. Unit intake staff review, research, and prioritize complaints to ensure the level of response corresponds to the severity of the allegation. If necessary, the Unit assigns complaints to the Department's field unit offices within two working days of knowledge of the complaint. Field staff investigate the complaints and follow up on them within the specified time frame as determined by the severity of the concerns noted.

In fiscal year 2022, the Department received 50,626 complaints. Of these, 15,408 were related to nursing homes and 958 were related to intermediate care facilities for intellectually disabled people. The following table shows the number of Immediate Jeopardy and Nonimmediate Jeopardy-High Priority complaints for both provider types:

Provider Type	**Immediate Jeopardy Complaints Received**	**Nonimmediate Jeopardy-High Complaints Received**
Nursing Home	212	2,525
Intermediate Care Facility for the Intellectually Disabled	5	59
Combined Total	**217**	**2,584**

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior audit we reported the Department did not have adequate internal controls over and did not comply with requirements to ensure timely investigation of complaints of client abuse and neglect at Medicaid residential facilities. The prior finding number was 2021-054.

Description of Condition

The Department did not have adequate internal controls over and did not comply with requirements to ensure timely investigation of complaints of client abuse and neglect at Medicaid residential facilities.

We evaluated all Immediate Jeopardy and Nonimmediate Jeopardy-High Priority complaints that occurred during fiscal year 2022 to ensure they met the required timelines for initiating an investigation. We found the Department did not initiate investigations timely for one of the Immediate Jeopardy complaints (0.5 percent) and 99 of the Nonimmediate Jeopardy-High Priority complaints (3.8 percent). For the Immediate Jeopardy complaint, the Department initiated an investigation four days after receipt. For the Nonimmediate Jeopardy-High Priority complaints, the Department initiated investigations between 11 to 83 days after receipt.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

The Department had limited staffing resources and received a large increase of COVID-19 related complaints. As a result, staff were unable to follow up on all complaints by the required response times. In addition, management did not effectively allocate sufficient resources to ensure all complaints were followed up on timely.

Effect of Condition

When the Department does not prioritize and investigate complaints timely, vulnerable residents at nursing homes and intermediate care facilities are at a higher risk of abuse, neglect and financial exploitation.

Recommendation

We recommend the Department strengthen its internal controls to ensure it responds to and investigates complaints timely, as federal and state regulations require.

Department's Response

The Department partially agrees with the finding.

We agree that not all complaint investigations were initiated within the required timeframes. However, we do not agree that it is due to inadequate internal controls. Residential Care Services (RCS) has effectively used our current internal controls since FY2017, when we received the SAO Stewardship Award related to this audit area.

Compliance with required timeframes declined due to an increase in complaints from the previous fiscal year that were assigned for investigation and the staff vacancy rate. The effects of the COVID-19 pandemic including exposure, illness, staff resignation due to vaccination mandates, and continued staff vacancy rate of 24% impacted our ability to complete complaint investigations in the required timeframes.

The 2021-054 Audit Corrective Action Plan (CAP) stated that we would be in compliance with Immediate Jeopardy intakes by 12/31/22, which is after the FY2022 audit period. In FY22 there was one late Immediate Jeopardy intake, which is a 97% improvement from the prior audit period. The CAP stated we would be in compliance with Non-Immediate Jeopardy intakes by 6/30/23. In FY22 there was a 48% improvement, proving that we are on pace to meet the 2021-054 CAP action item target date.

Residential Care Services will continue to use our current internal controls, in addition to condensing and streamlining surveyor training, and extending the contract with Health Care Management Solutions to assist with surveys. This will allow staff to focus on the complaint investigations and complaint investigation backlog and compliance with required investigation timeframes.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR Part 488 Subpart E, *Survey and Certification of Long-Term Care Facilities*, section 335, Action on complaints of resident neglect and abuse, and misappropriation of resident property, states in part:

(a) ***Investigation.***

(1) The State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in § 488.332.

(2) If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the State must investigate the allegation.

(3) The State must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property.

(b) ***Source of complaints.*** The State must review all allegations regardless of the source.

The Centers for Medicare and Medicaid Services, *State Operations Manual,* Chapter 5 – Complaint Procedures, states in part:

Section 5010 –General Intake Process

A complaint is an allegation of noncompliance with Federal and/or State requirements. If the SA determines that the allegation(s) falls within the authority of the SA, the SA determines the severity and urgency of the allegations, so that appropriate and timely action can be pursued. Each SA is expected to have written policies and procedures to ensure that the appropriate response is taken for all allegations and is consistent with Federal requirements as well as with procedures in the State Operations Manual. This structure needs to include response timelines and a process to document actions taken by the SA in response to allegations. If a State's time frames for the investigation of a complaint/incident are more stringent than the Federal time frames, the intake is prioritized using the State's time frames. The SA is expected to be able to share the logic and rationale that was utilized in prioritizing the complaint/incident for investigation. The SA response must be designed to protect the health and safety of all residents, patients and clients.

Section 5070 – Priority Assignment for Nursing Homes, Deemed and Non-Deemed Non-Long-Term Care Providers/Suppliers, and EMTALA

An assessment of each complaint or incident intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge of Federal requirements and his/her knowledge of current clinical standards of practice.

For non-long term care providers/suppliers, in situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to start the on-site investigation within two working days of receipt of the complaint or incident report in the case of a deemed provider or supplier, within two working days of RO authorization for investigation. For all non-immediate jeopardy situations, the complaint/incident is prioritized within two working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information.

The Department of Social and Health Services, Residential Care Services Division *Standard Operation Procedure: Complaint Resolution Unit,* Chapter 4A20, states in part:

<u>Procedure</u>

A. CRU staff will prioritize complaint intakes using the following guidelines:

1. **2 working days (Immediate Jeopardy)** – A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is

likely to cause, serious injury, harm, impairment, or death to a resident. Immediate corrective action is necessary.

2. **10 working days (Non Immediate Jeopardy-High**) – The alleged noncompliance may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well-being, the SA conducts a rapid response. Usually, specific rather than general information (such as, descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc.) factors into the assignment of this level of priority.

State of Washington
July 1, 2021 through June 30, 2022

2022-058 The Department of Social and Health Services did not have adequate internal controls over False Claims Act requirements.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Utilization Control and Program Integrity
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one-third of the state's federal expenditures. During fiscal year 2022, the program spent more than $17.6 billion in federal and state funds.

Federal law requires states to ensure providers and contractors receiving or making payments totaling at least $5 million annually under their Medicaid program have:

- Established written policies for all employees (including management) about the federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent state laws and rules
- Detailed provisions in their policies about detecting and preventing fraud, waste and abuse
- Included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent state laws and rules

The Department of Social and Health Services, Aging and Long-Term Support Administration (ALTSA), uses an SQL Server Reporting Services (SSRS) report to review prior federal fiscal year expenditures for both ALTSA and Development Disability Administration (DDA) providers and contractors. For the applicable providers and contractors identified as meeting or exceeding the $5 million threshold, the administrations send requests around March or April of each year to obtain support to ensure False Claims Act requirements are met. Providers and contractors appearing on the SSRS report for the first time are sent a letter requesting their policies and procedures, including information on the False Claims Act, whistleblower protections, detecting and preventing fraud, waste and abuse, and any existing employee handbook/policy manual if available. If a provider or contractor has sent this information in prior years, the templated letter requests that they send this information only if there have been significant changes to their policies or employee handbook. However, the Department requests that all providers and contractors in the report complete an Attestation of Compliance form detailing that they have complied with the False Claims Act requirements. The letters typically ask for documents to be returned within 45 days, and the status of each request is logged and monitored in tracking spreadsheets individually maintained by ALTSA and DDA.

In fiscal year 2022, the state Medicaid program paid more than $1 billion to 67 providers and contractors exceeding the False Claims Act threshold.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over False Claims Act requirements.

While independently confirming the completeness and accuracy of the SSRS report populations, we identified two providers paid nearly $30 million that were not included in the Department's SSRS report. The report did not show newer providers because it used and referenced an old provider table that had not been updated since 2015. Therefore, newer providers would not populate on the report. After the audit period ended, the Department identified and corrected the

issue. However, during the audit period, it did not request, obtain, or review these two providers for False Claims Act requirements.

Additionally, we found the Department had not established internal controls to ensure documentation from providers and contractors was obtained timely. The Department's request letters set a 45-day deadline for required items to be provided, however, it has not implemented procedures to enforce remedial actions for late submissions, such as payment suspension or contract termination. In our review of the tracking logs, we found that of the applicable 67 entities, 14 providers and contractors attributed to DDA returned their False Claims Act documents after our audit period—several as late as December 2022—which is 15 months after the end of the period the records pertain to.

We consider these internal control deficiencies to be a material weakness.

The issue was not reported as a finding in the prior audit.

Cause of Condition

Department management and staff did not know the SSRS report query was not capturing new providers and contractors. In addition, management did not think it necessary to enforce the deadline for providers and contractors to return False Claims Act documents, because their associated services are crucial to the Department's objectives.

Effect of Condition

By not establishing sufficient internal controls over False Claim Act requirements, the Department is unable to identify all providers and contractors that require monitoring. Furthermore, the Department did not meet federal requirements for the two entities that were not captured or monitored during our audit period.

Recommendations

We recommend the Department:

- Improve internal controls to ensure all providers and contractors exceeding the $5 million threshold are appropriately identified
- Monitor the two omitted providers to ensure their compliance with False Claims Act requirements
- Implement internal controls to ensure all provider and contractor responses are received timely, and define possible consequences and outcomes if timelines are not met

Department's Response

The Department agrees with the finding.

As of February 2023, a new report generated and tested through the Data Mart is being used that will include all Aging and Long-Term Support Administration/Developmental Disabilities Administration (ALTSA/DDA) Medicaid providers.

On April 1, 2023 the ALTSA Provider was mailed a letter requesting the False Claims Act attestation and policy/procedures. ALTSA will ensure that the FCA attestation and policy/procedures are returned to ensure compliance with the FCA requirement by 5/31/2023.

DDA provider's attestations were mailed in a timely manner and were received, although some were received after the due date. DDA will add to its process to follow up with their providers every month until the attestations are received.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

42 U.S. Code Section 1396a – *State plans for medical assistance,* states in part:

> A State plan for medical assistance must –
>
> > (68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—
> >
> > > (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through

3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

State of Washington
July 1, 2021 through June 30, 2022

2022-059 The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal provider eligibility requirements for the Medicaid Program.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U. S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Provider Eligibility
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one-third of the State's federal expenditures. During fiscal year 2022, the program spent about $17.6 billion in federal and state funds.

The Department of Social and Health Services (Department) is responsible for ensuring Medicaid social service providers are eligible to render services to recipients of the program. Providers are to remain in good standing with eligibility requirements in order to continue receiving payments under the program. The Department is responsible for performing measures appropriate for the provider type at application and initial enrollment. Federal regulations require state Medicaid agencies to revalidate the enrollment of all Medicaid providers at least every five years. Washington had over 81,000 active providers during fiscal year 2022. During that time, the Department paid nearly $4.6 billion to providers for direct client services.

The Department initiates and revalidates the enrollment of Medicaid providers through its contracting process. Individual providers contract terms are four years, and contracting requirements are screened by a contract specialist within the Department's Aging and Long-Term Support and Developmental Disabilities Administrations. Contracts are also screened by Area Agencies on Aging offices. A valid Washington state driver's license or other valid picture identification and either a Social Security card or proof of authorization to work in the United States must be checked during the initial contract or revalidation for individual providers (IPs). Nursing facility contract expiration dates are open ended, but the contract unit revalidates nursing facility enrollment every five years. Contracting requirements are screened by the Department's contract unit.

When a new provider is enrolled or a provider's contract is revalidated, contract staff review the application packet, including picture identification and proof of authorization to work in the United States for IPs, and a contract file is created in the Department's Agency Contracts Database (ACD). Once the application is marked approved in ACD, the Automated Provider Screening system automatically screens the provider through the following federal databases the following day:

- List of Excluded Individuals/Entities (LEIE)
- Excluded Parties List System (EPLS), now called System for Awards Management (SAM)
- SSA Limited Access Death Master File

Contract unit staff are notified by email if the screening resulted in a match and staff then manually verify if the match was legitimate. Federal law also requires that in between revalidation periods, state Medicaid agencies are to determine the exclusion status of providers, including any person with ownership, controlling interest, or acting as an agent or managing employee of the provider, no less frequently than monthly by performing checks of LEIE and SAM.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Department did not have adequate internal controls over and did not comply with federal provider eligibility requirements for the Medicaid Program.

During the audit period, the Department processed nine nursing facility revalidations and 13,352 new and revalidated individual provider enrollments. During this same period, the Department was required to perform ongoing eligibility determinations for 73,368 existing individual providers and 195 existing nursing facilities.

Federal law requires the Authority to check federal databases at least monthly to confirm the identity and exclusion status of providers. However, the automated system that performs these checks and notifies the Department of possible problems with providers was not operating correctly, and it frequently provided incorrect information. A management decision was made to instead only screen all providers on an annual basis. In September 2021, the Department manually screened all providers against the federal systems. For all other months, only newly populated providers from the automated systems check would receive screening for the month.

Additionally, we used a statistical sampling method to randomly select and examine 59 new and revalidated individual providers and five revalidated nursing facilities to determine if the Department had properly screened and enrolled providers in accordance with federal requirements. We found one individual provider in our sample for which the Department could not locate the enrollment documentation. Therefore, we could not confirm the Department's determination of the provider's eligibility status.

We consider these internal control deficiencies to be a material weakness which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

Because of issues with the automated system, the Department said they did not have the time or resources to manually perform database checks of all providers each month.

The Department could not locate the enrollment documentation for the one individual provider, because the provider never provided services to clients, and therefore was not associated with a region where the provider packets are typically filed and stored.

Effect of Condition

By not reviewing the exclusion status all providers in a timely and routine manner, the Department was non-compliant with federal requirements to check the LEIE and EPLS no less frequently than

monthly. As a result, the Department is at risk of not properly identifying any newly excluded or sanctioned providers.

By not retaining documentation for all enrollments, the Department could not demonstrate the individual provider was eligible to provide services to Medicaid beneficiaries.

Recommendations

We recommend the Department:

- Implement internal controls designed to bring it into compliance with monthly provider screening requirements
- Ensure provider documentation is retained to support the Department's screening and enrollment determinations

Department's Response

The Department agrees with the finding.

As of March 2023, DSHS is reviewing all providers on the monthly exclusion report.

On 6/1/2022 with the change to Consumer Direct of Washington (CDWA), Individual Providers are no longer contracted with DSHS. As a result, this type of error will not occur for this provider type moving forward.

It was verified that the ALTSA Provider that was missing enrollment documentation was never employed and did not receive any payments.

Auditor's Remarks

We thank the Department for its cooperation and assistance throughout the audit. We will review the status of the Department's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR section 455 Subpart E – Provider Screening and Enrollment, states in part:

Section 455.410 Enrollment and screening of providers

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:

(1) Medicare contractors.

(2) Medicaid agencies or Children's Health Insurance Programs of other States.

Section 455.414 Revalidation of enrollment

The State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

Section 455.436 Federal database checks

The State Medicaid agency must do all of the following:

(a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.

(b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.

(c)

(1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and

(2) Check the LEIE and EPLS no less frequently than monthly.

Section 455.450 Screening levels for Medicaid providers.

A State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of “limited,” “moderate,” or “high.” If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

(a) Screening for providers designated as limited categorical risk. When the State Medicaid agency designates a provider as a limited categorical risk, the State Medicaid agency must do all of the following:

(1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.

(2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with § 455.412.

(3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

(b) Screening for providers designated as moderate categorical risk. When the State Medicaid agency designates a provider as a “moderate” categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the “limited” screening requirements described in paragraph (a) of this section.

(2) Conduct on-site visits in accordance with § 455.432.

(c) Screening for providers designated as high categorical risk. When the State Medicaid agency designates a provider as a “high” categorical risk, a State Medicaid agency must do both of the following:

(1) Perform the “limited” and “moderate” screening requirements described in paragraphs (a) and (b) of this section.

(2)

(i) Conduct a criminal background check; and

(ii) Require the submission of a set of fingerprints in accordance with § 455.434.

(d) Denial or termination of enrollment. A provider, or any person with 5 percent or greater direct or indirect ownership in the provider, who is required by the State Medicaid agency or CMS to submit a set of fingerprints and fails to do so may have its –

(1) Application denied under § 455.434; or

(2) Enrollment terminated under § 455.416.

(e) Adjustment of risk level. The State agency must adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

(1) The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.

(2) The State Medicaid agency or CMS in the previous 6 months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within 6 months from the date the moratorium was lifted.

State of Washington
July 1, 2021 through June 30, 2022

2022-060 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it periodically audited cost report data for rate setting, hospital billings, and other financial and statistical records for inpatient hospital services.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Inpatient Hospital and Long-Term Care Facility Audits
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one third of the state's federal expenditures. During fiscal year 2022, the program spent more than

$17.6 billion in federal and state funds, including over $360 million paid to hospitals for inpatient services.

The Health Care Authority (Authority), the state Medicaid agency, pays for inpatient services to hospitals by using rates that are economic, efficient, and in accordance with the state plan. The federal grantor requires the Authority to periodically audit the financial and statistical records of participating providers, as established in the state plan.

The Medicaid State Plan, Attachment 4.19, lists the financial audit requirements for establishing payment rates for inpatient hospital services. Prior to October 1, 2021, the plan stated that cost report data used for rate setting, hospital billings, and other financial and statistical records will be periodically audited. Beginning October 1, 2021, the plan was amended and now states that cost report data used for rate setting may be periodically audited and hospital billings and other financial and statistical records will be periodically audited. Washington Administrative Code also states that the agency will periodically audit cost report data used for rate setting, hospital billings, and other financial and statistical records.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the most recent audits, we reported the Authority did not have adequate internal controls over and did not comply with requirements to ensure it periodically audited cost report data for rate setting, hospital billings, and other financial and statistical records for inpatient hospital services. The prior finding numbers were 2021-051 and 2020-049.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure it periodically audited cost report data for rate setting, hospital billings, and other financial and statistical records for inpatient hospital services.

Although the Authority did reconcile amounts paid to hospitals for inpatient services based on the amounts facilities reported, it did not periodically audit cost report data used for rate setting, hospital billings, or other financial and statistical records, which both state regulations and the state plan require.

Additionally, the Authority does not have documented methodology, policies or procedures for when and how the audits would be performed.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Authority did not establish policies and procedures to ensure it periodically audited cost report data, hospital billings, and other financial and statistical records for inpatient hospital services.

Effect of Condition

By not ensuring that it periodically audits cost report data, hospital billings, and other financial and statistical records, the Authority increases its risk of improperly paying for inpatient hospital services.

Recommendation

We recommend the Authority establish and implement adequate internal controls to ensure it meets federal inpatient hospital audit requirements.

Authority's Response

The State of Washington uses a prospective payment system that no longer uses cost reports for the reimbursement of almost all hospital providers, other than outlier payments, transplants, Critical Access Hospitals and Certified Public Expenditure Hospitals for inpatient fee for service.

The Authority is not aware of federal intention or directive for states to continue auditing cost reports if they are not used to establish reimbursement rates. In addition, a strict interpretation of this CFR is not consistent with the fact that CMS allows for states to rely on the Medicare audited cost reports even in cost-based reimbursement systems. 42 CFR 447.253(g) states "the Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers."

Washington does ensure there are reviews of hospital financial and statistical records, including the review of hospital Disproportionate Share Hospital (DSH) reimbursement through the DSH audit. The Agency will explore ways to review or audit the financial and statistical records of the components used in the ratio of cost to charges calculation.

Auditor's Remarks

The cost report requirement the Authority asserts was not relevant, was required for the first three months of the audit period by the state plan and for the entire audit period by Washington Administrative Code 182-550-5700. Additionally, the Authority may not use the audits of the Medicare cost reports to meet this requirement since those reports are for a different federal program.

The Medicaid state plan, Washington Administrative Code 182-550-5700, and 42 CFR 447.253(g) all require the Authority to periodically audit inpatient hospital billings and other financial and statistical records. The Authority asserted it performs reviews of hospital financial and statistical records. However, during the audit, we confirmed these reviews are informal, have no policies and procedures related to them, and do not meet this audit requirement. In addition, the DSH reimbursement audit referenced is a separate program requirement mandated by federal law (42 CFR 455.304).

We reaffirm our finding and will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR Part 447*, Payments for Services*, section 447.253, Other requirements, states in part:

(a) State assurances. In order to receive CMS approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to CMS that the requirements set forth in paragraphs (b) through (i) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(f) Uniform cost reporting. The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(g) Audit requirements. The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(i) Rates paid. The Medicaid agency must pay for inpatient hospital and long term care services using rates determined in accordance with methods and standards specified in an approved State plan.

Medicaid State Plan, Attachment 4.19-A Part I Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services, page 60 states in part:

3. Financial Audit Requirements

Cost report data used for rate setting may be periodically audited.

Hospital billings and other financial and statistical records will be periodically audited by the agency.

Washington Administrative Code (WAC) 182-550 – Hospital services specifies requirements for the Authority regarding hospitals providing Medicaid services.

WAC 182-550-5410 – CPE Medicaid cost report and settlements, states in part:

(4) The medicaid cost report schedules and supporting documentation are subject to audit by the agency or its designee to verify that claimed costs qualify under federal and state rules governing the CPE payment program. The documentation required includes, but is not limited to:

(a) The revenue codes assigned to specific cost centers on the medicaid cost report schedules.

(b) The inpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(c) The outpatient charges by revenue codes for uninsured patients and medicaid clients enrolled in an MCO plan.

(d) All payments received for the inpatient and outpatient charges in (b) and (c) of this subsection including, but not limited to, payments for third party liability, uninsured patients, and medicaid clients enrolled in an MCO plan.

WAC 182-550-5700 Hospital reports and audits, states in part:

(4) The agency will periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-061 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it performed procedures to safeguard against unnecessary utilization of care and services for the Medicaid program.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Utilization Control and Program Integrity
Known Questioned Cost Amount:	None

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one-third of the State's federal expenditures. During fiscal year 2022, the program spent about $17.6 billion in federal and state funds.

Under federal regulations, Medicaid state plans must include methods and procedures to safeguard against unnecessary utilization of care and services. The regulations require states to implement a statewide surveillance and utilization control program that:

- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
- Assesses the quality of those services;
- Provides for the control of the utilization of all services provided under the plan; and
- Provides for the control of the utilization of inpatient services.

Multiple state agencies in Washington manage aspects of the Medicaid program. The agencies include the Authority, Department of Social and Health Services, Department of Health, Office of the Attorney General, and Department of Children, Youth, and Families. The Centers for Medicare and Medicaid Services (CMS) considers the Authority to be Washington's official Medicaid agency. Federal regulations require the Medicaid agency:

(1) Monitor the statewide utilization control program;
(2) Take all necessary corrective action to ensure the effectiveness of the program;
(3) Establish methods and procedures to implement this section;
(4) Keep copies of these methods and procedures on file; and
(5) Give copies of these methods and procedures to all staff involved in carrying out the utilization control program.

Federal regulations also require the Medicaid agency have procedures for the ongoing evaluation, on a sample basis, of the need for, quality and timeliness of Medicaid services. These reviews must occur on a post-payment basis so that the State can review beneficiary utilization and provider service profiles, as well as identify exceptions so that the Authority can correct misutilization practices of beneficiaries and providers.

Furthermore, federal statute requires States to ensure providers and contractors receiving or making payments totaling at least $5 million annually under a state's Medicaid program have:

- Established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent state laws and rules
- Included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse
- Included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent state laws and rules.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the last four audits, we reported the Authority did not establish adequate internal controls over and did not comply with utilization control and program integrity requirements. The prior finding numbers were 2021-050, 2020-047, 2020-048, 2019-052, 2019-053 and 2018-047.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure it performed procedures to safeguard against unnecessary utilization of care and services for the Medicaid program.

Washington's Medicaid state plan does not include all methods and procedures to safeguard against unnecessary utilization of care and services. The Authority also did not implement and monitor a statewide surveillance and utilization control program.

We found that the Authority performs various types of program integrity and control utilization reviews, but in our judgment these efforts did not meet requirements of evaluating the appropriateness and quality of Medicaid services on a post-payment basis.

Additionally, our review of False Claims Act requirements for 130 applicable providers and contractors which exceeded the $5 million threshold found that the Authority did not appropriately monitor two contractors who were paid over $108 million.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

The Authority has a Program Integrity unit that is responsible for safeguarding against unnecessary utilization of care and services for the Medicaid program. However, they do not have policies and procedures to adequately ensure they met all compliance requirements that the Authority was responsible for. These requirements include implementing and monitoring the statewide utilization control program, which includes overseeing and monitoring the activities of other state agencies.

Program Integrity's scope of reviews do not include the topic of Medicaid service quality, and though other units at the Authority perform reviews to address quality, they are usually not performed on a post-payment basis.

The Authority and the Department of Social and Health Services (DSHS) are both responsible for ensuring the False Claims Act requirements are met. The noncompliance for the two contractors was due to confusion over whose responsibility it was to monitor them as these were DSHS contracts that were paid by the Authority and therefore each agency assumed it was the others' responsibility and no monitoring was performed.

Effect of Condition

By not establishing methods and procedures to safeguard against unnecessary utilization of care and services, there is an increased risk of unnecessary or inappropriate use of Medicaid services and payments.

Additionally, the current False Claims Act process in place for contractors outside of Managed Care Organizations (MCO) is not sufficient to prevent future noncompliance.

Furthermore, the Authority did not meet federal program integrity requirements and could be subject to federal sanctions because it has not established a statewide surveillance and utilization program and does not describe its safeguarding methods and procedures in the Medicaid state plan.

Recommendations

We recommend the Authority:

- Update the Medicaid state plan to include all the methods and procedures it uses to safeguard against unnecessary utilization of care and services
- Implement and monitor a statewide surveillance and utilization control program
- Implement adequate internal controls to ensure it complies with utilization control and program integrity requirements
- Improve internal controls for contractors subject to False Claims Act requirements to ensure all entities are properly monitored
- Perform monitoring of the two omitted contractors to ensure their compliance with False Claims Act requirements

Authority's Response

The Authority partially concurs with the finding.

The Authority has received guidance from CMS and will adjust the state plan based on CMS requirements. This will not include separately listing the methods and procedures it uses to safeguard against unnecessary utilization of care and services, per CMS guidance.

The Authority does not concur with the auditor's conclusion regarding its statewide surveillance and utilization control program. The program meets CMS standards and requirements and provides reasonable oversight.

The Authority concurs that two PACE providers were not monitored for their compliance with the FCA during the fiscal year. Our sister agency, DSHS, manages the contracts for the PACE program but payments to these providers are routed through ProviderOne. The process for PACE

provider monitoring has been clarified with DSHS and they will provide FCA oversight for these contracts going forward.

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR Subchapter C *Medical Assistance Programs* Part 456, Utilization Control, Subpart B, Utilization Control: All Medicaid Services states in part:

Section 456.1 Basis and purpose of part.

(a) This part prescribes requirements concerning control of the utilization of Medicaid services including –

(1) A statewide program of control of the utilization of all Medicaid services;

(b) The requirements in this part are based on the following sections of the Act. Table 1 shows the relationship between these sections of the Act and the requirements in this part.

(1) Methods and procedures to safeguard against unnecessary utilization of care and services. Section 1902(a)(30) requires that the State plan provide methods and procedures to safeguard against unnecessary utilization of care and services.

Section 456.2 State plan requirements.

(a) A State plan must provide that the requirements of this part are met.

(b) These requirements may be met by the agency by:

(1) Assuming direct responsibility for assuring that the requirements of this part are met; or

(2) Deeming of medical and utilization review requirements if the agency contracts with a QIO to perform that review, which in the case of inpatient acute care review will also serve as the initial determination for QIO medical necessity and appropriateness review for patients who are dually entitled to benefits under Medicare and Medicaid.

Section 456.3 Statewide surveillance and utilization control program.

The Medicaid agency must implement a statewide surveillance and utilization control program that –

(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

(b) Assesses the quality of those services;

(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and

(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

Section 456.4 Responsibility for monitoring the utilization control program.

(a) The agency must –

(1) Monitor the statewide utilization control program;

(2) Take all necessary corrective action to ensure the effectiveness of the program;

(3) Establish methods and procedures to implement this section;

(4) Keep copies of these methods and procedures on file; and

(5) Give copies of these methods and procedures to all staff involved in carrying out the utilization control program.

Section 456.5 Evaluation criteria.

The agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. This section does not apply to services in hospitals and mental hospitals. For these facilities, see the following sections: §§ 456.122 and 456.132 of subpart C; and § 456.232 of subpart D.

Title 42 CFR Subchapter C *Medical Assistance Programs* Part 456, Utilization Control, Subpart B, Utilization Control: All Medicaid Services states in part:

Section 456.21 Scope.

This subpart prescribes utilization control requirements applicable to all services provided under a State plan.

Section 456.22 Sample basis evaluation of services.

To promote the most effective and appropriate use of available services and facilities the Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Section 456.23 Post-payment review process.

The agency must have a post-payment review process that –

(a) Allows State personnel to develop and review –

(1) Beneficiary utilization profiles;

(2) Provider service profiles; and

(3) Exceptions criteria; and

(b) Identifies exceptions so that the agency can correct misutilization practices of beneficiaries and providers.

42 U.S. Code Section 1396a – *State plans for medical assistance,* states in part:

A State plan for medical assistance must –

(68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed

information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-062 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to report recoveries of fraudulent overpayments on the CMS-64 report.

Assistance Listing Number and Title:	93.775 State Medicaid Fraud Control Units 93.777 State Survey and Certification of Health Care Providers and Suppliers 93.777 COVID-19 State Survey and Certification of Health Care Providers and Suppliers 93.778 Medical Assistance Program 93.778 COVID-19 Medical Assistance Program
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	2105WAINCT; 2105WAIMPL; 2105WA5MAP; 2105WA5ADM; 2205WA5MAP; 2205WA5ADM
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Special Tests and Provisions: Medicaid Fraud Control Unit (MFCU)
Known Questioned Cost Amount:	$977,613

Background

Medicaid is a jointly funded state and federal partnership providing coverage for about 2.3 million eligible low-income Washington residents who otherwise might go without medical care. Medicaid is Washington's largest public assistance program and usually accounts for about one-third of the State's federal expenditures. During fiscal year 2022, the program spent about $17.6 billion in federal and state funds.

The Health Care Authority is required to refer suspected fraud or other criminal violations to the Medicaid Fraud Control Division (MFCD) for investigation and prosecution. The Authority reports any overpayment recoveries resulting from MFCD actions on the CMS-64 report.

The CMS-64 report is the quarterly statement of Medicaid Program expenditures that agencies use to report the actual program benefit costs and administrative expenses to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute the federal financial participation for the state's Medicaid Program costs.

When MFCD completes an investigation, it sends the final results over to the Authority for management review and signature. After a final judgment is made on an overpayment resulting from fraud, the State has 30 days to refund the entire federal share. Once the Authority receives the outcome, a Journal Voucher (JV) is created to move the federal portion of the overpayment over to state-only funding, which creates a credit on the CMS-64 report.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Authority did not have adequate internal controls over and did not comply with requirements to report MCFD overpayment recoveries on the CMS-64 report. The prior finding numbers were 2021-052 and 2020-050.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to report recoveries of fraudulent overpayments on the CMS-64 report.

Our audit found the Authority did not create JVs to move the entire federal portion of the two final judgments resulting from fraud over to state-only funding or report the entire overpayment on the CMS-64 report as a credit. Instead, the Authority only created JVs of the payments as they were made to the State. Additionally, the Authority did not have policies and procedures in place that described the process staff should follow for creating the JV or for reporting the MFCD overpayments on the CMS-64 report.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

Management did not implement sufficient internal controls to ensure the Authority returned recoveries of fraudulent overpayments to the grantor in a timely manner.

Additionally, the MFCD inadvertently did not notify the Authority at the time of final filing for one judgment resolution.

Effect of Condition and Questioned Costs

For fiscal year 2022, two final judgments were made totaling $2,792,013 in overpayments resulting from fraud. The Authority created JVs and reported $139,718 on the CMS-64 report dated June 30, 2022. JVs for the entire federal portion should have been processed and reported on the June 30, 2022 CMS-64 report. We are questioning the costs of $977,613 that the Authority did not report on the CMS-64 report or return to CMS, as federal regulations require.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Establish a formal process to ensure it properly reports recoveries of fraudulent overpayments on the quarterly CMS-64 report
- Consult with the federal grantor about whether or not the questioned costs identified in the finding should be repaid

Authority's Response

The Authority partially concurs with the finding. It has documented the processes and procedures staff will follow to acknowledge and comply with the applicable federal rules and regulations concerning the timely return of federal revenue associated with fraudulent overpayments.

The authority does not concur with repayment of $976,580 questioned costs related to one of the fraud referrals. The provider in this case was out of business and its business license expired May 2017, and then became inactive October 2017. The State pursued assets through available means and through the court. Final court rulings were made in June 2022, and in April 2023, within one year of the final rulings, the Attorney General's Office certified that the defaulted corporation had no identifiable assets. In accordance with 42 CFR 433.318 (d) the provider is out of business and the Authority is not required to refund overpayment to CMS.

The Authority will work with the Centers for Medicaid & Medicare Services to coordinate the return of the remaining $1,032 in identified questioned costs.

Auditor's Remarks

The Authority states that the $976,580 in questioned costs is not required to be returned due to the corporation having no identifiable assets. While this may be the case since the Attorney General's Office certified the corporation had no assets on April 13th, 2023, which was outside of our audit

scope, the summary judgement order for this case was issued on May 2, 2022, and the overpayments were required to be returned within 30 days of that ruling.

We reaffirm our finding and will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 42 *U.S. Code of Federal Regulations* (CFR) Part 433, *State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers*, describes the requirements for identifying, reporting, collecting, and remitting Medicaid overpayments.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 CFR Part 433, State Fiscal Administration, Subpart F – Refunding of Federal Share of Medicaid Overpayments to Providers states in part:

> Section 433.300 Basis.
>
> > This subpart implements -
> >
> > > (a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.
> > >
> > > (b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a

provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

(c) Section 1903(d)(3) of the Act, which provides that the Secretary will consider the pro rata Federal share of the net amount recovered by a State during any quarter to be an overpayment.

Section 433.312 Basic requirements for refunds.

(a) Basic rules.

(1) Except as provided in paragraph (b) of this section, the State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to CMS.

(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.

(b) Exception. The agency is not required to refund the Federal share of an overpayment made to a provider when the State is unable to recover the overpayment amount because the provider has been determined bankrupt or out of business in accordance with § 433.318.

Section 433.316 When discovery of overpayment occurs and its significance.

(a) General rule. The date on which an overpayment is discovered is the beginning date of the 1-year period allowed for a State to recover or seek to recover an overpayment before a refund of the Federal share of an overpayment must be made to CMS.

(b) Requirements for notification. Unless a State official or fiscal agent of the State chooses to initiate a formal recoupment action against a provider without first giving written notification of its intent, a State Medicaid agency official or other State official must notify the provider in writing of any overpayment it discovers in accordance with State agency policies and procedures and must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures.

(c) Overpayments resulting from situations other than fraud. An overpayment resulting from a situation other than fraud is discovered on the earliest of - - (1) The date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery;

(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or

(3) The date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

(d) Overpayments resulting from fraud.

(1) An overpayment that results from fraud is discovered on the date of the final written notice (as defined in § 433.304 of this subchapter) of the State's overpayment determination.

(2) When the State is unable to recover a debt which represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3) The Medicaid agency may treat an overpayment made to a Medicaid provider as resulting from fraud under subsection (d) of this section only if it has referred a provider's case to the Medicaid fraud control unit, or appropriate law enforcement agency in States with no certified Medicaid fraud control unit, as required by § 455.15, § 455.21, or § 455.23 of this chapter, and the Medicaid fraud control unit or appropriate law enforcement agency has provided the Medicaid agency with written notification of acceptance of the case; or if the Medicaid fraud control unit or appropriate law enforcement agency has filed a civil or criminal action against a

provider and has notified the State Medicaid agency.

(e) Overpayments identified through Federal reviews. If a Federal review at any time indicates that a State has failed to identify an overpayment or a State has identified an overpayment but has failed to either send written notice of the overpayment to the provider that specified a dollar amount subject to recovery or initiate a formal recoupment from the provider without having first notified the provider in writing, CMS will consider the overpayment as discovered on the date that the Federal official first notifies the State in writing of the overpayment and specifies a dollar amount subject to recovery.

(f) Effect of changes in overpayment amount. Any adjustment in the amount of an overpayment during the 1-year period following discovery (made in accordance with the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution process specified in State administrative policies and procedures) has the following effect on the 1-year recovery period:

(1) A downward adjustment in the amount of an overpayment subject to recovery that occurs after discovery does not change the original 1-year recovery period for the outstanding balance.

(2) An upward adjustment in the amount of an overpayment subject to recovery that occurs during the 1-year period following discovery does not change the 1-year recovery period for the original overpayment amount. A new 1-year period begins for the incremental amount only, beginning with the date of the State's written notification to the provider regarding the upward adjustment.

(g) Effect of partial collection by State. A partial collection of an overpayment amount by the State from a provider during the 1-year period following discovery does not change the 1-year recovery period for the balance of the original overpayment amount due to CMS.

(h) Effect of administrative or judicial appeals. Any appeal rights extended to a provider do not extend

Section 433.320 Procedures for Refunds to CMS.

(a) Basic requirements.

(1) The agency must refund the Federal share of overpayments that are subject to recovery to CMS through a credit on its Quarterly Statement of Expenditures (Form CMS-64).

(2) The agency must credit CMS with the Federal share of overpayments subject to recovery on the earlier of –

(i) The Form CMS-64 submission due to CMS for the quarter in which the State recovers the overpayment from the provider; or

(ii) The Form CMS-64 due to CMS for the quarter in which the 1-year period following discovery, established in accordance with § 433.316, ends.

(3) A credit on the Form CMS-64 must be made whether or not the overpayment has been recovered by the State from the provider.

(4) If the State does not refund the Federal share of such overpayment as indicated in paragraph (a)(2) of this section, the State will be liable for interest on the amount equal to the Federal share of the non-recovered, nonrefunded overpayment amount. Interest during this period will be at the Current Value of Funds Rate (CVFR), and will accrue beginning on the day after the end of the 1-year period following discovery until the last day of the quarter for which the State submits a CMS-64 report refunding the Federal share of the overpayment.

SCHEDULE OF FEDERAL AWARD FINDINGS AND QUESTIONED COSTS

State of Washington
July 1, 2021 through June 30, 2022

2022-063 The Health Care Authority did not have adequate controls over and did not comply with requirements to ensure payments to providers for the Block Grants for Community Mental Health Services were allowable and met period of performance requirements.

Assistance Listing Number and Title:	93.958 Block Grants for Community Mental Health Services 93.958 COVID-19 Block Grants for Community Mental Health Services
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B09SM082638-01; 6B09SM082638-01M001; 6N09SM082638-01M004; 6B09SM082638-01M002; 6B09SM082638-01M003; 6N09SM083829-01M001; 1B09SM083829-01; 1B09SM086035-01; 6B09SM086035-01M001; 6B09SM086035-01M002; 6B09SM086035-01M003; 1B09SM085384-01; 1B09SM085912-01; 1B09SM083998-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs / Cost Principles Period of Performance
Known Questioned Cost Amount:	$8,668,982

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grant for Community Mental Health Service (MHBG). The Authority subawards federal funds to counties, tribes, and nonprofit organizations to provide mental health treatment and crisis service to adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbances. In fiscal year 2022, the Authority spent about $31.7 million in federal program funds, $20.5 million of which it paid to subrecipients.

The Authority can use grant funds only for costs that are allowable and incurred during the period of performance, as specified in the grant's terms and conditions. At the beginning of each federal fiscal year and whenever the Authority receives a new federal grant, it establishes new cost objectives and allocation codes to ensure expenditures are charged to the proper grants. When the Authority receives reimbursement requests, program managers are responsible for reviewing supporting documentation to determine if the services billed meet the period of performance requirements under the grant. Fiscal managers are also responsible for ensuring that payments are coded to the correct period.

The Authority follows the accrual basis of accounting and uses the Agency Financial Reporting System (AFRS), which is the state's central accounting system, to record federal expenditures. At the end of the fiscal year, the Authority's federal financial reporting (FFR) unit estimates the amount of outstanding obligations to providers. These amounts are recorded in AFRS as an accrued expenditure for MHBG and subsequently reported to OFM for the compilation of the Schedule of Expenditures of Federal Awards.

FFR has written procedures for calculating its estimated accruals. The calculation begins by using a spreadsheet that tracks contractual obligations to MHBG subrecipients and vendors to determine the total state obligation amount through the end of the subaward or contract, which usually extend past the end of the current state fiscal year. This total is then reduced by the amount of actual payments made to the subrecipients and vendors, and is also reduced an additional 2 percent to account for anticipated underspending. The remaining total is then recorded as an estimated accrual for the fiscal year.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure payments to providers for the MHBG program were allowable and met period of performance requirements.

During the audit period, the FFR unit recorded two state fiscal year-end estimated accruals totaling $8,668,982. The Authority did not retain the obligation workbook used at the time of calculating these estimated accruals. Without this documentation, we were unable to assess the accuracy of the obligated amount. However, the Authority confirmed that the obligation amount used in the calculation included expenditures that were incurred after the state fiscal year. Any expenditures incurred after the state fiscal year has ended are not allowed to be included in an accrual.

Furthermore, provider payments liquidated after the state fiscal year are not assigned to the estimated accrual in the accounting system. Therefore, we could not determine if the estimated accrual amount was reasonable and accurately reflected expenditures that occurred within the state fiscal year.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

While the Authority has written procedures for the year-end estimated accruals, management did not ensure that only obligations within the state fiscal year were included. Furthermore, the Authority does not have a process in place to review estimated year-end accruals to verify the reasonableness of the accrual calculation.

Effect of Condition and Questioned Costs

Without retaining adequate support for the estimated year-end accruals and having a process to verify the reasonableness of the estimated calculation, the Authority cannot reasonably ensure that its MHBG expenditures are for allowable activities and within the period of performance. We identified $8,668,982 in known questioned costs related to the estimated year-end accruals.

Without establishing adequate internal controls, the Authority cannot reasonably ensure it is using federal funds for allowable purposes and that spending occurs within the allowed period of performance.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Improve its internal controls to ensure estimated accruals are reasonable and supported

- Improve its internal controls to ensure payments are within the award's period of performance
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Authority's Response

HCA concurs in part. HCA acknowledges that the version of the document used to determine year-end accruals was not retained as a supporting document. We also acknowledge that some portion of the accrued amount could have included obligations beyond state fiscal year 2022.

HCA does not agree that we cannot reasonably ensure that MHBG expenditures are for allowable activities and within the period of performance. Expenditures reported on MHBG are prepared based on cash and liquidations and all costs are reviewed to ensure they meet the period of performance. While the year-end accruals may included some amounts beyond the state fiscal year, the amounts accrued were based on four quarters of activity. This would not result in errors in federal reporting or federal cash draws. To question the year-end accruals in their entirety is an overstatement of any potential error that was made. The year-end accruals were solely recorded as estimate, and were not used to make any program payments or draw funds from the grantor. HCA only makes program payments to subrecipients and contractors after receiving invoices which are reviewed by staff, including review that the expenditures are within the grant period of performance. HCA does not agree with repayment of the $8,668,982 questioned costs associated with year-end accruals.

HCA notes that the $8,668,982 questioned costs, do not meet the definition of Improper Payments as defined in Uniform Guidance 2 CFR 200.1. Based on preliminary discussions with the grantor, HCA should expect that repayment of questioned costs related to the accruals will not be requested as no funds were drawn. This information was shared with the auditor.

Auditor's Remarks

In its response, the Authority acknowledged it did not retain supporting documentation to verify the year-end estimated accrual expenditures were incurred during the state fiscal year. Furthermore, the Authority acknowledged that the year-end estimated accruals likely included expenditures incurred after the state fiscal year.

The Authority reports cash and accrued expenditures on the Schedule of Expenditures of Federal Awards and, as such, the accruals are required to be audited. In our judgment, the Authority does not have sufficient processes in place to verify the reasonableness of the year-end estimated accrual calculations.

We reaffirm our finding and will review the status of the Authority's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments, which states impart: (2) Where the costs, at the time of the audit are not supported by adequate documentation. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 502, Basis for determining Federal awards expended, states in part:

> (a) *Determining Federal awards expended*. The determination of when a Federal award is expended must be based on when the activity related to the Federal award occurs. Generally, the activity pertains to events that require the non-Federal entity to comply with Federal statutes, regulations, and the terms and conditions of Federal awards, such as: expenditure/expense transactions associated with awards including grants, cost-reimbursement contracts under FAR, compacts with Indian Tribes, cooperative agreements, and direct appropriations; the disbursement of funds to subrecipients, the use of loan proceeds under loan and loan guarantee programs; the receipt of property; the receipt of surplus property; the receipt or use of program income' the distribution or use of food commodities; the disbursement of amounts entitling the non-Federal entity to an interest subsidy; and the period when insurance is in force.

Title 2 CFR Part 200, Uniform Guidance, section 510, Financial statements, states in part:

> (b) *Schedule of expenditures of Federal awards*. The auditee must also prepare a schedule of expenditures of Federal awards for the period covered by the auditee's financial statements which must include the total Federal awards expended as determined in accordance with 200.52.

Behavioral Health Grant Unit Procedures, state in part:

WHAT IS ACCRUAL: Fiscal year end and end of biennium contract subsequent payments.

PURPOSE: To prepare contact accruals for the end of the fiscal year or biennium and the subsequent payment of those invoices by the Behavioral Health Grant Unit.

BACKGROUND: Accruals and liquidations are looked at a high-level by program, fund, and fund sources (GF-S/GF-F), to see if the agency has over liquidated our authority. Some accruals are based on actual billings/claims, but a good chunk is based on estimates, because of the lag in billings, as well as the amount of contracts per grant; mainly block and SOR.

BLOCK GRANT AND SOR PROCESS

1. Create a SFYXX Accrual workbook using a JV workbook template.
2. Pull grant direct expenditure data to date including GL 0159 (liquidations), cash expenditures (6510), and accruals (6505), using your grant Webi criteria.
    a. We pull in accruals (GL6505), because we want to see accruals that have already been booked by AP, so we don't double book them.
    b. Expenditures paid in the new SFY will automatically need to be accrued since they weren't paid in by the end of the SFY.
    c. Filter out/do not accrue on any interagency transactions including state universities. Those are processed outside of our unit.
3. Take total SFY of year processing obligation from grant spreadsheet.
    - **NOTE:** For auditing purposes, if one was to reproduce the obligation amount it could change if you refer to the original document later than the date that we established the original obligation amount. Please always refer to the accrual spreadsheet for the obligation amount pulled at the time for the purpose of accruals.
4. Reduce the obligation amount by 2% so that we don't over accrue (The percentage was recommended…due to not spending everything that is obligated.).
5. First pivot to run is to identify total expenditures and accruals for SFY being processed. Use the expenditure amount for the second pivot table.
6. Second pivot to run is to figure out the split out the expenditure between ER and NB, because they are the most common. Calculate the left to accrue amount by taking the

obligations with 2% reduction subtracting the expenditures as well as the previous accrual amount. To see what you need to accrue.

7. Third and Fourth pivot tables find the most common PI for each of the subobjects.

8. Fifth pivot table identifies most common org index.

9. Calculate percentages to spread the accrual across ER and /or NB in allocations, per grant.

10. Complete the rest of the workbook following our JV process with obtaining the JV log number, filling out the JV log, adding the explanation and backup data for the upload and release tab. On the JV tab complete the TC to be 736 and include GL 5111. If we need to complete a reversal the TC would be 736R.

11. Upload and email the JV to Supervisor and Lead.

12. Supervisor and Lead review, approve, and release the JV.

State of Washington
July 1, 2021 through June 30, 2022

2022-064 The Health Care Authority did not have adequate internal controls over level of effort requirements for the Block Grants for Community Mental Health Services program.

Assistance Listing Number and Title:	93.958 Block Grants for Community Mental Health Services 93.958 COVID-19 Block Grants for Community Mental Health Services
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B09SM082638-01; 6B09SM082638-01M001; 6B09SM082638-01M004; 6B09SM082638-01M002; 6B09SM082638-01M003; 6B09SM083829-01M001; 1B09SM083829-01; 1B09SM086035-01; 6B09SM086035-01M001; 6B09SM086035-01M002; 6B09SM086035-01M003; 1B09SM085384-01; 1B09SM085912-01; 1B09SM083998-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Level of Effort
Known Questioned Cost Amount:	None

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Community Mental Health Services. The Authority subawards federal funds to counties, tribes and nonprofit organizations to provide mental health treatment and crisis services to adults diagnosed with serious mental illness and children diagnosed with serious emotional

disturbances. In fiscal year 2022, the Authority spent approximately $31.7 million in federal program funds, $20.5 million of which it paid to subrecipients.

Federal regulations require the Authority to maintain state spending at certain levels to meet federal grant requirements. Specifically, the Authority must maintain state spending at a level that is no less than the average of the previous two years of spending for the program.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Authority did not have adequate internal controls over level of effort requirements for the Block Grants for Community Mental Health Services program.

To monitor state funding levels, the Authority generates reports from its accounting system each quarter to determine if current expenditures are on track to meet level of effort requirements for all open grant awards. Upon closing each grant, the Authority also generates a final report to ensure the requirements were met. Throughout the year, fiscal staff generated the reports using incorrect expenditure criteria and, therefore, tracked the wrong expenditure amounts.

We consider these internal control deficiencies to be a material weakness.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The written procedures Authority staff used to prepare the reports contained wrong instructions with incorrect expenditure criteria for generating the report. Furthermore, the Authority did not require documented management review of the quarterly tracking workbooks to ensure they were accurate.

Effect of Condition

As a result of the Authority using incorrect expenditure criteria during the audit period, tracking workbooks for three of the four quarters contained incorrect expenditures amounts that were used to calculate the two-year average. Therefore, the Authority calculated the two-year average incorrectly.

Furthermore, the Authority was required to maintain state expenditures at no less than the average of the prior two fiscal year spending levels, or $472,042,275. The Authority reported $527,952,071 in state expenditures for state fiscal year 2022. However, due to the incorrect expenditure criteria being used, it was determined the Authority actually spent $557,351,803, resulting in an

underreporting of $29,399,732. While the Authority met the level of effort requirement, three of the four quarterly tracking workbooks contained incorrect state expenditure totals, and this internal control weakness could lead to noncompliance if not corrected.

By not establishing adequate internal controls, the Authority cannot ensure it meets the level of effort requirement.

Recommendations

We recommend the Authority:

- Ensure the written procedures for completing the quarterly level of effort tracking workbooks are accurate and complete
- Ensure correct information is used to monitor spending levels
- Improve internal controls to ensure sufficient monitoring of level of effort requirements

Authority's Response

We concur with the finding and recommendations. HCA has updated its procedures to include a greater level of review and approval to ensure information prepared is complete and accurate.

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 42 U.S. Code 300x-4, *Additional provisions*, states in part:

(b) Maintenance of effort regarding State expenditures for mental health

(2) In general

A funding agreement for a grant under section 300x of this title is that the State involved will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

State of Washington
July 1, 2021 through June 30, 2022

2022-065 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it filed accurate and timely reports required by the Federal Funding Accountability and Transparency Act for the Block Grants for Community Mental Health Services.

Assistance Listing Number and Title:	93.958 Block Grants for Community Mental Health Services 93.958 COVID-19 Block Grants for Community Mental Health Services
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B09SM082638-01; 6B09SM082638-01M001; 6B09SM082638-01M004; 6B09SM082638-01M002; 6B09SM082638-01M003; 6B09SM083829-01M001; 1B09SM083829-01; 1B09SM086035-01; 6B09SM086035-01M001; 6B09SM086035-01M002; 6B09SM086035-01M003; 1B09SM085384-01; 1B09SM085912-01; 1B09SM083998-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Community Mental Health Services. The Authority subawards federal funds to

counties, tribes and nonprofit organizations to provide mental health treatment and crisis services to adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbances. In fiscal year 2022, the Authority spent approximately $31.7 million in federal program funds, $20.5 million of which it paid to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Act), the Authority is required to collect and report information on each subaward of federal funds more than $25,000 in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS). For federal awards issued on or after November 12, 2020, the monetary threshold for reporting increased to $30,000. The Authority must report subawards by the end of the month following the month in which it made the subaward (or subaward amendment). The intent of the Act is to empower citizens with the ability to hold the federal government accountable for spending decisions and, as a result, reduce wasteful government spending.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure it filed accurate and timely reports required by the Act.

During the audit period, the Authority was required to report approximately $10.3 million of program funds that it awarded to 12 subrecipients through 21 new and amended subawards. We found the Authority did not report any of these subawards in FSRS as required.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Authority has multiple divisions that subaward program funds, and it did not have a process in place to gather subaward information from each division so it could submit these required reports to the federal government.

Effect of Condition

Failing to submit the required reports diminishes the federal government’s ability to ensure accountability and transparency of federal spending.

Recommendations

We recommend the Authority:

- Establish effective internal controls to ensure it submits required reports
- Establish policies and procedures for filing required reports
- Provide training for employees who oversee reporting and who verify the submission and accuracy of the reports
- Ensure management monitors reporting of this information so future reports are submitted completely and timely

Authority's Response

We concur with the finding and recommendations. HCA has developed a procedure coordinating between responsible divisions to ensure FFATA reports are submitted. This procedure was in place for SFY 2023.

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 170, *Reporting Subaward and Executive Compensation Information*, states in part:

Appendix A to Part 170 – Award Term

I. Reporting Subawards and Executive Compensation

1. Reporting of first-tier subawards.

1. *Applicability*. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that equals or exceeds $30,000 in Federal funds for a subaward to a non-Federal entity or Federal agency (see definitions in paragraph e. of this award term).

2. *Where and when to report.*

   i. The non-Federal entity or Federal agency must report each obligating action described in paragraph a.1. of this award term to https://www.fsrs.gov.

   ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2020.

3. *What to report.* You must report the information about each obligating action that the submission instructions posted at https://www.fsrs.gov specify.

Notice of Block Grants for Community Mental Health Federal Grant Award, Grant Number 1B09SM082638-01, states in part:

MHBG 2020 Standard Terms and Conditions

9) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

a. Reporting of first-tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity.

State of Washington
July 1, 2021 through June 30, 2022

2022-066 The Health Care Authority did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Block Grants for Community Mental Health Services program and the Block Grants for Prevention and Treatment of Substance Abuse program received required single audits, and that it appropriately followed up on findings and issued management decisions.

Assistance Listing Number and Title:

93.958 Block Grants for Community Mental Health Services

93.958 COVID-19 Block Grants for Community Mental Health Services

93.959 Block Grants for Prevention and Treatment of Substance Abuse

93.959 COVID-19 Block Grants for Prevention and Treatment of Substance Abuse

Federal Grantor Name: U.S. Department of Health and Human Services

Federal Award Number: 1B09SM082638-01; 6B09SM082638-01M001; 6N09SM082638-01M004; 6B09SM082638-01M002; 6B09SM082638-01M003; 6N09SM083829-01M001; 1B09SM083829-01; 1B09SM086035-01; 6B09SM086035-01M001; 6B09SM086035-01M002; 6B09SM086035-01M003; 1B09SM085384-01; 1B09SM085912-01; 1B09SM083998-01; 1B08TI083138-01; 6B08TI083138-01M003; 6B08TI083138-01M004; 6B08TI083486-01M001; 6B08TI083486-01M002; 6B08TI083486-01M004; 1B08TI83519-01; 1B08TI084681-01; 1B08TI083977-01

Pass-through Entity: None

Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Community Mental Health Services (MHBG) and the Block Grants for Prevention and Treatment of Substance Abuse (SABG) programs. The Authority subawards federal funds to counties, tribes, and nonprofit organizations to provide mental health treatment and crisis services to adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbances, as well as develop substance abuse prevention programs and provide treatment and support services. In fiscal year 2022, the Authority spent about $31.7 million in federal program funds for MHBG and about $67.3 million in federal program funds for SABG. Of these amounts, the Authority passed about $20.5 million to MHBG subrecipients and $52 million to SABG subrecipients.

Federal regulations require the Authority to monitor its subrecipients' activities. This includes verifying that its subrecipients that spend $750,000 or more in federal awards during a fiscal year obtain a single audit. The audit must be completed and submitted to the Federal Audit Clearinghouse within 30 days after receiving the auditor's report or nine months after the end of the subrecipient's audit period, whichever is earlier.

Additionally, for the awards it passes onto its subrecipients, the Authority must follow up and ensure the subrecipients take timely and appropriate corrective action on all deficiencies identified through audits. When a subrecipient receives an audit finding for an Authority-funded program, federal law requires the Authority to issue a management decision to the subrecipient within six months of the audit report's acceptance by the Federal Audit Clearinghouse. The management decision must clearly state whether the audit finding is sustained, the reason for the decision, and the actions the subrecipient is expected to take, such as repaying unallowable costs or making financial adjustments. These requirements help ensure subrecipients use federal program funds for authorized purposes and within the provisions of contracts or grant agreements.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure subrecipients of the MHBG and SABG programs received required single audits, and that it appropriately followed up on findings and issued management decisions.

We found the Authority did not have adequate internal controls in place to verify whether:

- Subrecipients received required audits, if necessary, and appropriate remedies were taken if audits were not filed
- Follow up occurred on findings and management decisions were issued when due

We used a nonstatistical sampling method to randomly select and examine 17 out of a total population of 129 subrecipients. We found the Authority did not monitor one subrecipient (6 percent) to ensure it received a single audit when required.

Additionally, we identified one subrecipient that received a single audit finding for which the Authority was required to issue a management decision. We found the Authority did not issue a management decision for this subrecipient.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

This issue was not reported as a finding in the prior audit.

Cause of Condition

The Authority did not have written policies or procedures to ensure all subrecipients received an audit when required and management decisions were issued. In addition, staff used a tracking sheet to monitor the subrecipient audit requirements but did not detect the identified noncompliance.

Effect of Condition

Without establishing adequate internal controls, the Authority cannot ensure all subrecipients that required a single audit received one. Furthermore, the Authority cannot ensure it is following up on subrecipient single audit findings and communicating required management decisions to subrecipients. By failing to ensure subrecipients establish corrective actions and management monitors them for effectiveness, the Authority cannot determine whether subrecipients have sufficiently corrected issues identified in audit findings.

Recommendations

We recommend the Authority:

- Establish and follow policies and procedures to ensure subrecipients obtain required single audits
- Establish and follow effective internal controls to ensure it issues management decisions by the due date and follows up on all subrecipient audit findings related to the programs
- Ensure subrecipients develop and perform acceptable corrective actions to adequately address all audit recommendations

Authority's Response

HCA concurs with the finding.

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200, Uniform Guidance, establishes the following applicable requirements:

> Section 200.332 Requirements for pass-through entities, states in part:
>
> > All pass-through entities must:
> >
> > (d) Monitor the activities of the subrecipient as necessary to ensure that the subaward is used for authorized purposes, in compliance with Federal statutes, regulations, and the terms and conditions of the subaward; and that subaward performance goals are achieved. Pass-through entity monitoring of the subrecipient must include:
> >
> > (5) Following-up and ensuring that the subrecipient takes timely and appropriate action on all deficiencies pertaining to the Federal award provided to the subrecipient from the pass-through entity detected through audits, on-site reviews, and written confirmation from the subrecipient, highlighting the status of actions planned or taken to address Single Audit findings related to the particular subaward.
> >
> > (6) Issuing a management decision for applicable audit findings pertaining only to the Federal award provided to the subrecipient from the pass-through entity as required by § 200.521.

(7) The pass-through entity is responsible for resolving audit findings specifically related to the subaward and not responsible for resolving crosscutting findings. If a subrecipient has a current Single Audit report posted in the Federal Audit Clearinghouse and has not otherwise been excluded from receipt of Federal funding (e.g., has been debarred or suspended), the pass-through entity may rely on the subrecipient's cognizant audit agency or cognizant oversight agency to perform audit follow-up and make management decisions related to cross-cutting findings in accordance with section § 200.513(a)(3)(vii). Such reliance does not eliminate the responsibility of the pass-through entity to issue subawards that conform to agency and award-specific requirements, to manage risk through ongoing subaward monitoring, and to monitor the status of the findings that are specifically related to the subaward.

(g) Verify that every subrecipient is audited as required by Subpart F of this part when it is expected that the subrecipient's Federal awards expended during the respective fiscal year equaled or exceeded the threshold set for the in §200.501 Audit requirements.

Section 200.339 Remedies for noncompliance, states:

If a non-Federal entity fails to comply with the U.S. Constitution, Federal statutes, regulations or the terms and conditions of a Federal award, the Federal awarding agency or pass-through entity may impose additional conditions, as described in § 200.208. If the Federal awarding agency or pass-through entity determines that noncompliance cannot be remedied by imposing additional conditions, the Federal awarding agency or pass-through entity may take one or more of the following actions, as appropriate in the circumstances:

(g) Temporarily withhold cash payments pending correction of the deficiency by the non-Federal entity or more severe enforcement action by the Federal awarding agency or pass-through entity.

(h) Disallow (that is, deny both use of funds and any applicable matching credit for) all or part of the cost of the activity or action not in compliance.

(i) Wholly or partly suspend or terminate the Federal award.

(j) Initiate suspension or debarment proceedings as authorized under 2 CFR part 180 and Federal awarding agency regulations (or in the case of a pass-through entity, recommend such a proceeding be initiated by a Federal awarding agency).

(k) Withhold further Federal awards for the project or program.

(l) Take other remedies that may be legally available.

Section 200.501 Audit requirements, states in part:

(c) Audit required. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single or program-specific audit conducted for that year in accordance with the provisions of this part.

(d) Single audit. A non-Federal entity that expends $750,000 or more during the non-Federal entity's fiscal year in Federal awards must have a single audit conducted in accordance with § 200.514 except when it elects to have a program-specific audit conducted in accordance with paragraph (c) of this section.

Section 200.521 Management decision, states in part:

(c) General. The management decision must clearly state whether or not the audit finding is sustained, the reasons for the decision, and the expected auditee action to repay disallowed costs, make financial adjustments, or take other action. If the auditee has not completed corrective action, a timetable for follow-up should be given. Prior to issuing the management decision, the Federal agency or pass-through entity may request additional information or documentation from the auditee, including a request for auditor assurance related to the documentation, as a way of mitigating disallowed costs. The management decision should describe any appeal process available to the auditee. While not required, the Federal agency or pass-through entity may also issue a management decision on findings relating to the financial statements which are required to be reported in accordance with GAGAS.

(f) Pass-through entity. As provided in § 200.332(d), the pass-through entity must be responsible for issuing a management decision for audit findings that relate to Federal awards it makes to subrecipients.

(g) Time requirements. The Federal awarding agency or pass-through entity responsible for issuing a management decision must do so within six months of acceptance of the audit report by the FAC. The auditee must initiate and proceed with corrective action as rapidly as possible and corrective action should begin no later than upon receipt of the audit report.

(h) Reference numbers. Management decisions must include the reference numbers the auditor assigned to each audit finding in accordance with § 200.516(c).

State of Washington
July 1, 2021 through June 30, 2022

2022-067 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure payments to providers for the Block Grants for Prevention and Treatment of Substance Abuse program were allowable and met period of performance requirements.

Assistance Listing Number and Title:	93.959 Block Grants for Prevention and Treatment of Substance Abuse 93.959 COVID-19 Block Grants for Prevention and Substance Abuse
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B08TI083138-01; 6B08TI083138-01M003; 6B08TI083138-01M004; 6B08TI083486-01M001; 6B08TI083486-01M002; 6B08TI083486-01M004; 1B08TI83519-01; 1B08TI084681-01; 1B08TI083977-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Activities Allowed or Unallowed Allowable Costs/Cost Principles Period of Performance
Known Questioned Cost Amount:	$19,959,714

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse (SABG). The Authority subawards federal funds to counties, tribes, and nonprofit organizations to develop prevention programs and provide treatment and support services. In fiscal year 2022, the Authority spent about $67.3 million in federal program funds, $52 million of which it paid to subrecipients.

The Authority can use grant funds only for costs that are allowable and incurred during the period of performance, as specified in the grant's terms and conditions. At the beginning of each federal fiscal year, and whenever the Authority receives a new federal grant, it establishes new cost objectives and allocation codes to ensure expenditures are charged to the proper grants. When the Authority receives reimbursement requests, program managers are responsible for reviewing supporting documentation to determine if the services billed meet the period of performance requirements under the grant. Fiscal managers are also responsible for ensuring that payments are coded to the correct period.

The Authority follows the accrual basis of accounting and uses the Agency Financial Reporting System (AFRS), which is the state's central accounting system, to record federal expenditures. At the end of the fiscal year, the Authority's federal financial reporting (FFR) unit estimates the amount of outstanding obligations to providers. These amounts are recorded in AFRS as an accrued expenditure for SABG and subsequently reported to OFM for the compilation of the Schedule of Expenditures of Federal Awards.

FFR has written procedures for calculating its estimated accruals. The calculation begins by using a spreadsheet that tracks contractual obligations to SABG subrecipients and vendors to determine the total state obligation amount through the end of the subaward or contract, which usually extend past the end of the current state fiscal year. This total is then reduced by the number of actual payments made to the subrecipients and vendors and is also reduced an additional 2 percent to account for anticipated underspending. The remaining total is then recorded as an estimated accrual for the fiscal year.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In the prior two audits, we reported the Authority did not have adequate internal controls to ensure payments made under the SABG program met the period of performance requirements. The prior finding numbers were 2020-059 and 2021-057.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure payments to providers for the SABG program were allowable and met period of performance requirements.

Year-end Estimated Accruals

During the audit period, the FFR unit recorded two state fiscal year-end estimated accruals totaling $19,870,537. The Authority did not retain the obligation workbook used at the time of calculating these estimated accruals. Without this documentation, we were unable to assess the accuracy of

the obligated amount. However, the Authority confirmed that the obligation amount used in the calculation included expenditures that were incurred after the state fiscal year. Any expenditures incurred after the state fiscal year has ended are not allowed to be included in an accrual.

Furthermore, provider payments liquidated after the state fiscal year are not assigned to the estimated accrual in the accounting system. Therefore, we could not determine if the estimated accrual amount was reasonable and accurately reflected expenditures that occurred within the state fiscal year.

Transaction Testing

We judgmentally selected and examined two expenditures that were recorded in the accounting system with service months prior to the allowed period of performance for the SABG federal fiscal year 2022 award. We found one of the expenditures (50 percent) was an accrual made at the end of the year with no subsequent liquidation payment.

We also judgmentally selected and examined five out of a total population of 24 expenditures made during the SABG federal fiscal year 2020 award liquidation period. We found three expenditures (60 percent) were for indirect charges automatically applied to the award through the Authority's cost allocation system for activities that occurred after the allowed period of performance.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

While the Authority had written procedures for the year-end estimated accrual, management did not ensure that only obligations incurred within the state fiscal year were included. Furthermore, the Authority did not have a process in place to review estimated year-end accruals to verify the reasonableness of the accrual calculation.

Additionally, management did not ensure that the cost allocation system only allowed indirect payments occurring within an award's period of performance to be charged to the grant, and did not monitor sufficiently to detect the improper charges.

Effect of Condition and Questioned Costs

Without retaining adequate support for the estimated year-end accruals and having a process to verify the reasonableness of the estimated calculation, the Authority cannot reasonably ensure its SABG expenditures are for allowable activities and within the period of performance. We identified $19,870,537 in known questioned costs related to the estimated year-end accruals.

For the federal fiscal year 2022 award that opened during the audit period, we identified questioned costs totaling $85,492 for services performed outside the period of performance.

For the federal fiscal year 2020 award that closed during the audit period, we identified questioned costs totaling $3,685 for indirect expenditures that were unallowable.

In total, we identified $19,959,714 in known federal questioned costs.

Without establishing adequate internal controls, the Authority cannot reasonably ensure it is using federal funds for allowable purposes and that spending occurs within the allowed period of performance.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Improve its internal controls to ensure estimated accruals are reasonable and supported
- Improve its internal controls to ensure the cost allocation system only charges eligible costs to the grant
- Improve its internal controls to ensure payments are within the award's period of performance
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Authority's Response

HCA concurs in part. HCA acknowledges that the version of the document used to determine year-end accruals was not retained as a supporting document. We also acknowledge that some portion of the accrued amount could have included obligations beyond state fiscal year 2022.

HCA does not agree that we cannot reasonably ensure that SABG expenditures are for allowable activities and within the period of performance. Expenditures reported on SABG are prepared based on cash and liquidations and all costs are reviewed to ensure they meet the period of performance. While the year-end accruals may included some amounts beyond the state fiscal year, the amounts accrued were based on four quarters of activity. This would not result in errors in federal reporting or federal cash draws. To question the year-end accruals in their entirety is an overstatement of any potential error that was made. The year-end accruals were solely recorded as estimates, and were not used to make any program payments or draw funds from the grantor. HCA only makes program payments to subrecipients and contractors after receiving invoices which are reviewed by staff, including review that the expenditures are within the grant

period of performance. HCA does not agree with repayment of the $19,870,537 questioned costs associated with year-end accruals.

HCA also does not concur with repayment of the $85,492 questioned costs associated with an accrual transaction. An accrual was entered in the accounting system based on expected billing. No invoice for the transaction was received for FY 22 grant activity, and as noted in the finding no payment was made. HCA does not draw funds from the grantor until a payment is made, and as a result no funds were drawn for this accrual.

HCA concurs with the $3,685 for indirect expenditures that were unallowable for the grant award. An accounting cost center was not correctly updated at the end of the grant period, and as a result some termination leave indirect expenditures were charged to the grant after the period of performance ended. HCA will review processes to ensure cost centers are appropriately closed to prevent unallowable expenditures from being charged to grant awards and discuss repayment with the grantor.

HCA notes that of the total $19,959,714 questioned costs, only $3,685 meet the definition of Improper Payments as defined in Uniform Guidance 2 CFR 200.1. Based on preliminary discussions with the grantor, HCA should expect that repayment of questioned costs related to the accruals will not be requested as no funds were drawn. This information was shared with the auditor.

Auditor's Remarks

In its response, the Authority acknowledged it did not retain supporting documentation to verify the year-end estimated accrual expenditures were incurred during the state fiscal year. Furthermore, the Authority acknowledged that the year-end estimated accruals likely included expenditures incurred after the state fiscal year.

The Authority reports cash and accrued expenditures on the Schedule of Expenditures of Federal Awards and, as such, the accruals are required to be audited. In our judgment, the Authority does not have sufficient processes in place to verify the reasonableness of the year-end estimated accrual calculations.

We reaffirm our finding and will follow up on the status of the Authority's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance, establishes definitions for improper payments, which states in part: (2) Where the costs, at the time of the audit, are not supported by adequate documentation. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 502, Basis for determining Federal awards expended, states in part:

(a) *Determining Federal awards expended*. The determination of when a Federal award is expended must be based on when the activity related to the Federal award occurs. Generally, the activity pertains to events that require the non-Federal entity to comply with Federal statutes, regulations, and the terms and conditions of Federal awards, such as: expenditure/expense transactions associated with awards including grants, cost-reimbursement contracts under FAR, compacts with Indian Tribes, cooperative agreements, and direct appropriations; the disbursement of funds to subrecipients, the use of loan proceeds under loan and loan guarantee programs; the receipt of property; the receipt of surplus property; the receipt or use of program income; the distribution or use of food commodities; the disbursement of amounts entitling the non-Federal entity to an interest subsidy; and the period when insurance is in force.

Title 2 CFR Part 200, Uniform Guidance, section 510, Financial statements, states in part:

(b) *Schedule of expenditures of Federal awards*. The auditee must also prepare a schedule of expenditures of Federal awards for the period covered by the auditee's financial statements which must include the total Federal awards expended as determined in accordance with 200.502.

Behavioral Health Grant Unit Procedures, state in part:

WHAT IS ACCRUAL: Fiscal year end and end of biennium contract subsequent payments.

PURPOSE: To prepare contact accruals for the end of the fiscal year or biennium and the subsequent payment of those invoices by the Behavioral Health Grant Unit.

BACKGROUND: Accruals and liquidations are looked at a high-level by program, fund, and fund sources (GF-S/GF-F), to see if the agency has over liquidated our authority. Some accruals are based on actual billings/claims, but a good chunk is based on estimates, because of the lag in billings, as well as the amount of contracts per grant; mainly block and SOR.

BLOCK GRANT AND SOR PROCESS

13. Create a SFYXX Accrual workbook using a JV workbook template.

14. Pull grant direct expenditure data to date including GL 0159 (liquidations), cash expenditures (6510), and accruals (6505), using your grant Webi criteria.
    a. We pull in accruals (GL6505), because we want to see accruals that have already been booked by AP, so we don't double book them.
    b. Expenditures paid in the new SFY will automatically need to be accrued since they weren't paid in by the end of the SFY.
    c. Filter out/do not accrue on any interagency transactions including state universities. Those are processed outside of our unit.

15. Take total SFY of year processing obligation from grant spreadsheet.

- **NOTE:** For auditing purposes, if one was to reproduce the obligation amount it could change if you refer to the original document later than the date that we established the original obligation amount. Please always refer to the accrual spreadsheet for the obligation amount pulled at the time for the purpose of accruals.

16. Reduce the obligation amount by 2% so that we don't over accrue (The percentage was recommended…due to not spending everything that is obligated.).
17. First pivot to run is to identify total expenditures and accruals for SFY being processed. Use the expenditure amount for the second pivot table.
18. Second pivot to run is to figure out the split out the expenditure between ER and NB, because they are the most common. Calculate the left to accrue amount by taking the obligations with 2% reduction subtracting the expenditures as well as the previous accrual amount. To see what you need to accrue.
19. Third and Fourth pivot tables find the most common PI for each of the subobjects.
20. Fifth pivot table identifies most common org index.
21. Calculate percentages to spread the accrual across ER and /or NB in allocations, per grant.
22. Complete the rest of the workbook following our JV process with obtaining the JV log number, filling out the JV log, adding the explanation and backup data for the upload and release tab. On the JV tab complete the TC to be 736 and include GL 5111. If we need to complete a reversal the TC would be 736R.
23. Upload and email the JV to Supervisor and Lead.
24. Supervisor and Lead review, approve, and release the JV.

State of Washington
July 1, 2021 through June 30, 2022

2022-068 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it met the earmarking requirement for the Block Grants for Prevention and Treatment of Substance Abuse.

Assistance Listing Number and Title:	93.959 Block Grants for Prevention and Treatment of Substance Abuse 93.959 COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B08TI083138-01; 6B08TI083138-01M003; 6B08TI083138-01M004; 6B08TI083486-01M001; 6B08TI083486-01M002; 6B08TI083486-01M004; 1B08TI83519-01; 1B08TI084681-01; 1B08TI083977-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Earmarking
Known Questioned Cost Amount:	$661

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse. The Authority provides federal funds to counties, tribes, nonprofit organizations and other state agencies to develop prevention programs and provide treatment and support services. In fiscal year 2022, the Authority spent approximately $67.3 million in federal program funds.

Federal regulations require the Authority to spend no more than 5 percent of the federal program funds on administrative costs of the grant. Federal regulations also require recipients to establish

and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

To monitor the administrative earmarking requirement, the Authority has staff run monthly reports from its accounting system to determine if it is on track to meet the requirement at the time the grant closes. Upon closing a grant, the Authority also runs a final report to ensure it met the requirement.

In prior audits, we reported the Authority did not have adequate internal controls and did not comply with earmarking requirements for the program. The prior finding number was 2021-056.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure it met the earmarking requirement for the Block Grants for Prevention and Treatment of Substance Abuse.

During the audit period, the monthly tracking workbooks used to track the earmark requirement contained an erroneous calculation for determining the percentage of administrative costs. A $13,212 supplement to the technical assistance award was incorrectly added to the base grant award amount instead of the technical assistance amount in the tracking workbook. We found the Authority closed the federal fiscal year 2020 grant while having exceeded the 5 percent administrative maximum.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

Throughout the year, staff ran the required monthly reports using the expenditures to date to track the percentage of administrative costs to meet compliance. However, management did not review these workbooks to ensure they correctly calculated and monitored this requirement.

Effect of Condition and Questioned Costs

The Authority was awarded $37,786,705 for the federal fiscal year 2020 grant. Therefore, it was allowed to spend $1,889,335 on administrative expenditures. However, it spent $1,889,996, which exceeded the administrative cost maximum by $661. As a result, we are questioning the $661 in unallowable administrative costs.

By not establishing adequate internal controls, the Authority cannot ensure it meets the administrative earmarking requirement. By not complying with federal requirements, the Authority risks having to repay federal funds or having future federal funds withheld.

We question costs when we find an agency has not complied with grant regulations or when it does not have adequate documentation to support its expenditures.

Recommendations

We recommend the Authority:

- Improve internal controls to ensure it does not exceed the maximum allowable amount for administrative costs at the end of the award period
- Consult with the grantor to discuss whether the questioned costs identified in the audit should be repaid

Authority's Response

HCA concurs with the incorrect calculation of the administrative expenditure limit in the tracking workbooks and will implement formal review procedures for the tracking workbooks. However, HCA does not concur with the identified questioned costs. HCA processed subsequent adjustments reducing the final administrative expenditures charged to the grant award to $1,840,664, less than the allowed amount of $1,889,335. The auditor did not consider the adjustments during the audit.

Auditor's Remarks

At the time the Authority submitted its final SF-425 report, the administrative costs that were identified as charged to the grant exceeded the allowed maximum by $661. In addition, the expenditures in question were still charged to the grant in the accounting system at the time the final report was submitted to the grantor and were not reversed until four months later. As stated above, we recommend the Authority consult with the federal grantor to discuss whether the questioned cost reported in the finding need to be repaid.

We reaffirm our finding, and we will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 200.1, Uniform Guidance establishes definitions for improper payments. Part 200.410 establishes requirements for the collection of unallowable costs.

Title 2 CFR Part 200, Uniform Guidance, section 403, defines factors affecting Allowability of costs.

Title 45 CFR Part 96, Block Grants, section 135, Restrictions on expenditure of grant, states in part:

> (b) The State shall limit expenditures on the following:
>
> > (1) The State involved will not expend more than 5 percent of the grant to pay the costs of administering the grant

State of Washington
July 1, 2021 through June 30, 2022

2022-069 The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it filed accurate and timely reports required by the Federal Funding Accountability and Transparency Act for the Block Grants for Prevention and Treatment of Substance Abuse.

Assistance Listing Number and Title:	93.959 Block Grants for Prevention and Treatment of Substance Abuse 93.959 COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award/Contract Number:	1B08TI083138-01; 6B08TI083138-01M003; 6B08TI083138-01M004; 6B08TI083486-01M001; 6B08TI083486-01M002; 6B08TI083486-01M004; 1B08TI83519-01; 1B08TI084681-01; 1B08TI083977-01
Pass-through Entity Name:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Reporting
Known Questioned Cost Amount:	None

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse (SABG). The Authority subawards federal funds to counties, tribes and nonprofit organizations to develop prevention programs and provide treatment and support services. In fiscal year 2022, the Authority spent about $67.3 million in federal program funds, $52 million of which it paid to subrecipients.

Under the Federal Funding Accountability and Transparency Act (Act), the Authority is required to collect and report information on each subaward of federal funds more than $25,000 in the Federal Funding Accountability and Transparency Subaward Reporting System (FSRS). For federal awards issued on or after November 12, 2020, the monetary threshold for reporting increased to $30,000. The Authority must report subawards by the end of the month following the month in which it made the subaward (or subaward amendment). The intent of the Act is to empower citizens with the ability to hold the federal government accountable for spending decisions and, as a result, reduce wasteful government spending.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits, we reported the Authority did not have adequate internal controls over and did not comply with requirements to ensure it filed reports required by the Act. The prior finding number was 2021-058.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with requirements to ensure it filed accurate and timely reports required by the Act.

During the audit period, the Authority was required to report about $34.3 million of program funds that it awarded to 63 subrecipients through 84 new and amended subawards for the primary SABG awards. We found the Authority only reported one subaward amendment totaling $864,000 in FSRS as required.

Additionally, the Authority was required to report program funds that it subawarded to subrecipients for the SABG COVID-19 Emergency Funding and SABG American Rescue Plan Act awards. However, the Authority was unable to provide subaward details for these two awards. The Authority received about $66 million for the two COVID-19-related awards. During the audit period, the Authority passed through about $16.6 million of COVID-19 SABG funds to subrecipients. We found the Authority did not report any subawards for these additional COVID-19-related awards.

We consider this internal control deficiency to be a material weakness, which led to material noncompliance.

Cause of Condition

The Authority has multiple divisions that subaward programs funds, and it did not have a process in place to gather subaward information from each division so it could submit these required reports to the federal government.

Effect of Condition

Failing to submit the required reports diminishes the federal government's ability to ensure accountability and transparency of federal spending.

Recommendations

We recommend the Authority:

- Establish effective internal controls to ensure it submits required reports
- Establish policies and procedures for filing required reports
- Provide training for employees who oversee reporting and who verify the submission and accuracy of the reports
- Ensure management monitors reporting of this information so future reports are submitted completely and timely

Authority's Response

We concur with the finding and recommendations. HCA has developed a procedure coordinating between responsible divisions to ensure FFATA reports are submitted. This procedure was in place for SFY 2023.

Auditor's Remarks

We thank the Authority for its cooperation and assistance throughout the audit. We will review the status of the Authority's corrective action during our next audit.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 2 CFR Part 170, *Reporting Subaward and Executive Compensation Information*, states in part:

Appendix A to Part 170 – Award Term

I. Reporting Subawards and Executive Compensation

2. Reporting of first-tier subawards.

4. *Applicability*. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that equals or exceeds $30,000 in Federal funds for a subaward to a non-Federal entity or Federal agency (see definitions in paragraph e. of this award term).

5. *Where and when to report.*

i. The non-Federal entity or Federal agency must report each obligating action described in paragraph a.1. of this award term to https://www.fsrs.gov.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2020.

6. *What to report.* You must report the information about each obligating action that the submission instructions posted at https://www.fsrs.gov specify.

Notice of Substance Abuse Prevention and Treatment Block Grant Federal Award, Grant Number 1B08TI083138-01, states in part:

SABG 2020 Standard Terms and Conditions

7) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

a. Reporting of first-tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates $25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity.

State of Washington
July 1, 2021 through June 30, 2022

2022-070 The Health Care Authority did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Block Grants for Prevention and Treatment of Substance Abuse program received required risk assessments.

Assistance Listing Number and Title:	93.959 Block Grants for Prevention and Treatment of Substance Abuse 93.959 COVID-19 Block Grants for Prevention and Treatment of Substance Abuse
Federal Grantor Name:	U.S. Department of Health and Human Services
Federal Award Number:	1B08TI083138-01; 6B08TI083138-01M003; 6B08TI083138-01M004; 6B08TI083486-01M001; 6B08TI083486-01M002; 6B08TI083486-01M004; 1B08TI83519-01; 1B08TI084681-01; 1B08TI083977-01
Pass-through Entity:	None
Pass-through Award/Contract Number:	None
Applicable Compliance Component:	Subrecipient Monitoring
Known Questioned Cost Amount:	None

Background

The Health Care Authority, Division of Behavioral Health and Recovery, administers the Block Grants for Prevention and Treatment of Substance Abuse (SABG). The Authority subawards federal funds to counties, tribes, and nonprofit organizations to develop prevention programs and provide treatment and support services. In fiscal year 2022, the Authority spent about $67.3 million in federal program funds, $52 million of which it paid to subrecipients.

The Authority serves as a pass-through agency for SABG funding. Pass-through entities are required to monitor the activities of subrecipients to ensure they are properly using the funds. To determine the appropriate level of monitoring, federal regulations require the Authority to evaluate

each subrecipient's risk of noncompliance with federal statutes and regulations and the terms and conditions of the subaward.

Federal regulations require recipients to establish and follow internal controls to ensure compliance with program requirements. These controls include understanding grant requirements and monitoring the effectiveness of established controls.

In prior audits we reported the Authority did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the SABG program received required risk assessments. The prior finding numbers were 2021-060 and 2020-064.

Description of Condition

The Authority did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the SABG program received required risk assessments.

Five different units in the Authority are responsible for performing risk assessments for the program subrecipients: Prevention, Treatment, Recovery, Managed Care, and Tribal Affairs. The Authority did not have a uniform process to ensure all subrecipients received risk assessments.

The Tribal Affairs unit did not complete a risk assessment for the one new subaward it issued during the audit period. In addition, we used a non-statistical sampling method to randomly select and examine 11 out of a total population of 51 new subawards issued by the other units during the state fiscal year. We found one of 11 (9 percent) did not receive a risk assessment during the audit period.

We consider these internal control deficiencies to be a material weakness, which led to material noncompliance.

Cause of Condition

During the audit period, the Authority implemented a new risk assessment process, but it was not in place for all of the audit period. Prior to this new process, each unit was responsible for performing risk assessments for the subawards it monitors, but management did not provide sufficient oversight to ensure the Authority met this requirement. In addition, the Tribal Affairs unit did not have a risk assessment process in place.

Effect of Condition

Without performing risk assessments of its subrecipients for the SABG program, the Authority cannot determine the appropriate amount of monitoring required for each subrecipient. It also makes the Authority less likely to detect noncompliance with grant terms and conditions and federal regulations.

Recommendations

We recommend the Authority:

- Establish internal controls to ensure it performs risk assessments for each subaward it issues
- Ensure it uses the results of risk the risk assessments to determine how much and what type of subrecipient monitoring to perform, as required by federal law

Authority's Response

HCA concurs with the findings, but with remarks. We concur that the Tribal Affairs unit did not complete risk assessments during the audit period, however, implementing a new process that will impact our Tribal partners appropriately requires more robust collaboration than with other partners. HCA is currently in active collaboration with the Tribes to incorporate a Tribal-specific risk assessment process to be implemented by July 1, 2023.

Relating to the ***one*** *finding outside of Tribal Affairs, it should be noted that the SAO is well-aware that HCA had not finalized incorporating risk assessments into the contracting process until FY 2022. The contract in question was provided a risk assessment as soon as practicable after the process had been incorporated. It should also be noted that HCA is not out of compliance with the law. 2 CFR 200 requires only that a risk assessment be done at some point. HCA has chosen to establish a process wherein we conduct risk assessments prior to contract execution. We understand that a risk assessment may not have been done during the audit period, but HCA disagrees with an implication that we are not in compliance with the law, as that is not accurate.*

Auditor's Remarks

While the Authority is correct that 2 CFR 200 does not explicitly require a risk assessment to be done prior to a contract being awarded, it does require the risk assessment be used to determine the level of monitoring for the subrecipient. In order to meet this requirement, the risk assessments must be completed timely to ensure the Authority implements required monitoring procedures to prevent noncompliance by the subrecipient.

We reaffirm our finding and will follow up on the status of the Department's corrective action during our next audit period.

Applicable Laws and Regulations

Title 2 *U.S. Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), section 516, Audit findings, establishes reporting requirements for audit findings.

Title 2 CFR Part 200, Uniform Guidance, section 303, Internal controls, describes the requirements for auditees to maintain internal controls over federal programs and comply with federal program requirements.

The American Institute of Certified Public Accountants defines significant deficiencies and material weaknesses in its *Codification of Statements on Auditing Standards*, section 935, Compliance Audits, paragraph 11.

Title 45 CFR Part 75, Uniform Guidance for HHS Awards, establishes the following applicable requirements:

Section 75.352, Requirements for pass-through entities, states in part:

All pass-through entities must:

(b) Evaluate each subrecipient's risk of noncompliance with Federal statutes, regulations, and the terms and conditions of the subaward for purposes of determining the appropriate subrecipient monitoring described in paragraphs (d) and (e) of this section, which may include consideration of such factors as:

(1) The subrecipient's prior experience with the same or similar subawards;

(2) The results of the previous audits including whether or not the subrecipient receives a Single Audit in accordance with subpart F, and the extent to which the same or similar subaward has been audited as a major program;

(3) Whether the subrecipient has new personnel or new or substantially changed systems; and

(4) The extent and results of HHS awarding agency monitoring (e.g., if the subrecipient also receives Federal awards directly from a HHS awarding agency).