Office of the Washington State Auditor
Pat McCarthy

State of Washington Single Audit Fiscal Year 2017

July 3, 2018

The Single Audit examines whether Washington's state agencies complied with federal grant requirements. In 2017, the state spent more than $17.5 billion in federal awards. This federal money, combined with significant state contributions, funded programs that include childcare, food and cash assistance, health insurance, unemployment benefits, transportation and education.

As a whole, the state materially complied with federal requirements. We issued a clean (or unmodified) opinion on most of the programs we audited.

We also issued 52 audit findings, reported $43 million in questioned costs, and estimated an additional $177.4 million in likely improper payments. We issued an adverse opinion on one program, which means that non-compliance was both material and pervasive. Depending on the conditions of the grant, the state might have to repay the federal share of inappropriately spent funds.

This report provides a summary of Washington's statewide single audit. The full, 1,111-page report is available online at the Washington State Office of Financial Management website at https://bit.ly/2tDw55r

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The mission of the Washington State Auditor's Office

To provide citizens with independent and transparent examinations of how state and local governments use public funds, and develop strategies that make government more efficient and effective.

The results of our work are widely distributed through a variety of reports, which are available on our web site and through our free, electronic subscription service.

We take our role as partners in accountability seriously. We provide training and technical assistance to governments and have an extensive quality assurance program.

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Background

Federal assistance can take many forms including grants, loans and non-cash awards such as supplies and equipment. Recipients of federal assistance must comply with requirements that govern the allowable uses of the funding as well as many administrative areas, such as cash management, matching, supplanting, procurement and reporting. When recipients of federal assistance spend $750,000 or more in federal awards in a year, they must prepare a Schedule of Expenditures of Federal Awards and arrange for an audit of their federal assistance under Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. This audit is known as a Single Audit.

The purpose of a Single Audit

The purpose of a Single Audit is to provide a format for non-federal entities to receive: (1) an audit of their federal award expenditures and (2) an audit of their financial statements. The audit of federal expenditures focuses on both compliance with federal requirements and internal controls over compliance. The auditing requirements, passed by Congress as part of the Single Audit Act of 1984 (as amended in 1996) and administered by the federal Office of Management and Budget (OMB), are recognized by federal agencies as the framework for monitoring the use of federal money.

The value of a Single Audit

As they are for local and state dollars, governments are responsible for overseeing the federal money they spend. These audits evaluate a government's ability to ensure it will follow federal guidelines and to demonstrate the extent to which it actually followed these guidelines when spending federal money.

What happens after a finding is issued?

State agencies must respond to audit findings by preparing a corrective action plan. This action plan is submitted to the grantor – the federal agency issuing the grant funds – with our audit report.

Grantors must issue a decision on audit findings within six months after they receive the audit report and action plan, and ensure the agency takes appropriate and timely corrective action. We have found this does not always occur. As the auditor, we must follow up on the status of that corrective action during the next audit and may again report any uncorrected issues as audit findings. Grantors also determine whether states must pay back questioned costs.

See **Appendix A** for a list of the programs audited for state fiscal year 2017, and **Appendix B** for a summary of all federal findings issued.

Some terms used in this report

Questioned costs – Costs are questioned in a finding (a) that resulted from a violation or possible violation of a provisions of a law or other requirement, (b) for which the costs, at the time of the audit, were not supported by adequate documentation or (c) for which the costs incurred appear unreasonable and do not reflect the actions a prudent person would take under the circumstances.

Likely improper payments – Likely improper payments are calculated by projecting questioned costs identified in an audit sample to the entire population from which the sample was drawn, generally in a statistically valid method.

Subrecipient – An entity that spends awards received from a pass-through entity to carry out a program. The agency passing along these funds is expected to monitor how the subrecipient manages the funds it receives.

Summary of the 2017 State of Washington Single Audit

In 2017, the state received more than $17.5 billion in federal money for more than 850 federal programs performing services that range from providing meals for school-age children and vaccines for at-risk or low-income people to interstate highway construction and environmental protection projects. About 94 percent of the money was administered by 10 state agencies, listed in **Exhibit 1**.

Exhibit 1 – 10 agencies spent about 94 percent of the federal money the state received

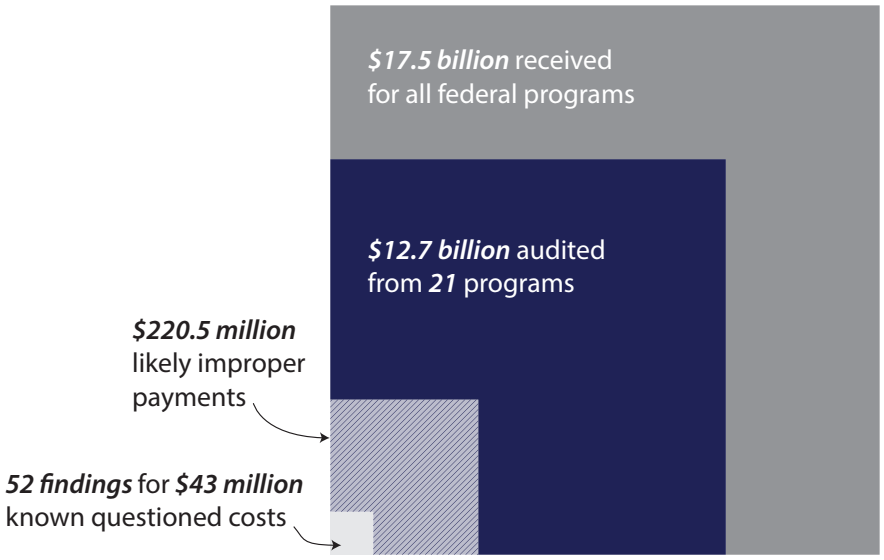
Fiscal year 2017

Agency	Total dollars
Health Care Authority	$5.7 billion
Social and Health Services	$5.2 billion
University of Washington	$1.4 billion
Employment Security	$1.2 billion
Superintendent of Public Instruction	$939 million
Transportation	$836 million
Community and Technical College System	$382 million
Washington State University	$369 million
Health	$353 million
Early Learning	$153 million
All others	$969 million
Total (rounded)	**$17.5 billion**

We audited 21 federal programs administered by 14 state agencies, and more than $12.7 billion in federal assistance (73 percent of the federal money the state received).

We reported 52 findings and identified $43 million in known federal questioned costs and $220 million in likely federal improper payments (shown in **Exhibit 2**). We also issued an adverse opinion for one program, the Child Care and Development Fund, managed by the departments of Early Learning and Social and Health Services.

Exhibit 2 – The value of known questioned costs increased in 2017, but likely improper payments decreased



Nine of the 21 programs audited complied with federal requirements

Of the 21 programs we audited, nine had established adequate internal controls over federal funds and complied with federal requirements. Exhibit 3 lists these nine programs.

Exhibit 3 – Nine programs, managed by 10 state agencies, met criteria

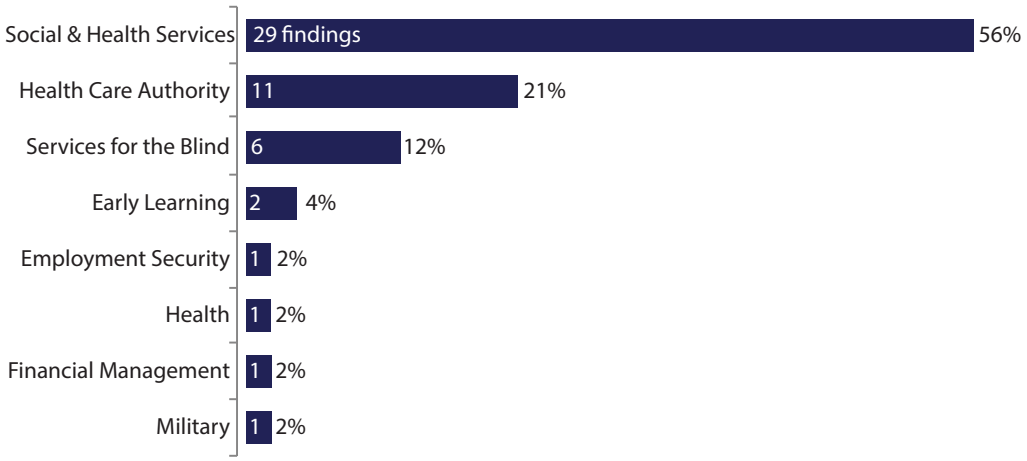
Agency	Program	Program dollars by agency
Clark College	Student Financial Aid Cluster	$22,316,000
Department of Health	Drinking Water State Revolving Fund Cluster	$22,601,000
Department of Social and Health Services	Social Services Block Grant	$41,086,000
Department of Transportation	High-Speed Rail Corridors and Intercity Passenger Rail Service – Capital Assistance Grants	$224,209,000
Department of Veterans' Affairs	Veterans State Nursing Home Care	$32,693,000
Health Care Authority	Children's Health Insurance Program	$115,683,000
Office of Superintendent of Public Instruction	Special Education Cluster	$233,278,000
	Title I, Grants to Local Education Agencies	$240,540,000
Spokane Community College	Student Financial Aid	$49,681,000
University of Washington	Health Systems Strengthening and HIV/AIDS Prevention, Care and Treatment under the President's Emergency Plan for AIDS Relief	$23,083,000
	Student Financial Aid Cluster	$397,103,000
Washington State University	Student Financial Aid Cluster	$230,380,000

Note: Numbers are rounded.

12 programs in eight state agencies received at least one finding

The remaining 12 programs in eight state agencies received at least one finding. **Exhibit 4** shows how many findings each of the eight agencies received. A summary of each finding is located in Appendix B, and the full text of each finding can be found on OFM's website at **https://bit.ly/2tDw55r**

Exhibit 4 - Number and percentage of findings by state agency



Questioned costs by state agency and program

We question costs when we find an agency did not follow grant regulations or does not have adequate documentation to support payments, or when the costs appear unreasonable. When using a statistically valid sample, we estimate the value of "likely improper payments" by extrapolating from the amount of expenditure we sampled. Agencies may be required to return this money to the federal agency that granted it. **Exhibit 5** shows the amounts of both known questioned costs and the extrapolation of likely improper payments.

Exhibit 5 – Known questioned costs and likely improper payments at four state agencies

State agency	Federal program	Known questioned costs	Likely improper payments	Total agency program dollars
Social and Health Services	Supplemental Nutrition Assistance Program (SNAP) Cluster	$2,515,277	$–	$1,487,209,029
	Vocational Rehabilitation Grants to States	$97,869	$4,428,499	$55,223,589
	Temporary Assistance for Needy Families (TANF)	$1,508,473	$6,242,250	$309,064,572
	Child Support Enforcement	$29,194	$–	$110,149,654
	Refugee and Entrant Assistance	$41,447	$–	$15,604,483
	Child Care and Development Fund Cluster	$7,386	$4,902,586	$120,228,015
	Foster Care – Title IV-E	$1,837	$214,819	$118,626,536
	Medicaid Cluster	$3,441,270	$115,486,672	$2,740,096,497
	Disability Insurance/Social Security Insurance Cluster	$557,743	$–	$51,786,506
Early Learning	Child Care and Development Fund Cluster	$10,669	$43,926,590	$127,821,325
Services for the Blind	Vocational Rehabilitation Grants to States	$2,479,527	$–	$9,584,408
Health Care Authority	Medicaid Cluster	$32,395,132	$45,284,386	$5,541,108,201
Total questioned costs		**$43,085,824**	**$220,485,802**	

Known questioned costs increased, but likely improper payments decreased in 2017

We reported 52 audit findings in 2017, two more than the 50 findings reported in 2016. While the known questioned costs increased from $17.9 million to $43.1 million, the likely improper payments decreased from $363.5 million to $220.5 million, as shown in Exhibit 6. The increase in known questioned costs can be attributed largely to the Medicaid program, which accounted for a total of $35.8 million in known questioned costs in 2017 compared to $3.2 million in 2016.

Exhibit 6 – Findings and questioned costs, 2012–2017

Audit year	Total federal assistance received	Number of programs audited	Number of audit findings	Known questioned costs	Likely improper payments
2012	$15,764,521,000	30	63	$3,950,901	$29,016,506
2013	$14,892,686,000	31	45	$4,275,906	$14,799,519
2014	$15,730,570,000	32	55	$3,625,781	$13,861,873
2015	$17,030,230,000	31	56	$28,674,366	$142,222,871
2016	$17,205,753,000	21	50	$17,929,847	$363,488,380
2017	**$17,543,553,000**	**21**	**52**	**$43,085,824**	**$220,485,802**

Note: Numbers for total federal assistance received are rounded.

Key Conclusions

We identified a number of significant issues in the 2017 Single Audit. In this section, we discuss problems at the Child Care Development Fund and Medicaid, the two programs that made up 95 percent of the reported likely improper payments, including problems with the agency controls that are meant to prevent such issues.

We continued to find significant internal control weaknesses in the Child Care and Development Fund program

Two state agencies – the Department of Early Learning (DEL) and the Department of Social and Health Services (DSHS) – manage Washington's Child Care and Development Fund program. The Department of Early Learning is the lead agency. Together, they spent $248 million in federal funds in 2017. The program supports low-income working families by providing access to affordable, high-quality early care and after-school programs.

We found DEL had inadequate internal controls in place to ensure payments to care providers were accurate and supported. We began reporting these weaknesses in 2005, when the program was administered by DSHS. In the 2017 audit, we found 26 percent of child care payments we examined using a statistically valid sample were partially or completely unallowable, resulting in $43.7 million in likely improper payments made with federal funds, with an additional $15 million in likely improper payments made using state money. The number of improper payments identified was significantly lower in 2017. However, this was not because DEL made significant improvements in its internal controls. Instead, it was primarily due to a rule change that now allows providers to bill for an entire month of child care if a child attends at least one day that month.

We also found DEL did not have adequate internal controls to ensure the program met health and safety requirements. DEL must conduct on-site inspections of licensed providers and follow up on any violations noted. Of the inspections we examined, we found 34 percent included violations concerning the health, safety and well-being of children and lacked sufficient documentation to show follow-up was performed adequately or promptly. Some examples of these violations include inadequate supervision of children, lack of background check documentation, exceeding the allowed staff-to-child ratio, and general health and safety hazards to the children. In addition, 581 licensed providers (12 percent) were overdue for their yearly inspections.

DSHS lacked adequate internal controls to ensure only eligible clients were approved to receive services; these weaknesses have been reported in the Single Audit since 2012. For the 2017 audit, 29 percent of client records we examined, using a statistically valid sample, lacked proper eligibility determinations. This resulted in $4.9 million in likely improper payments made with federal money, and $1.7 million in likely improper payments of state funds. Although this exception rate is still very high, it is a significant improvement from 2016, when the error rate was 58 percent. We also determined, for the third consecutive year, that DSHS had significant weaknesses regarding fraud detection and repayment requirements.

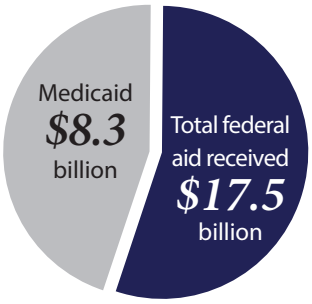
Although the results of the 2017 audit of the program demonstrated significant problems, both agencies have begun efforts to correct some of those problems identified in the 2015 and 2016 audits.

We continue to find internal control and compliance issues in the Medicaid program

Three state agencies manage Washington's Medicaid program: the Health Care Authority (Authority), the Department of Health (DOH) and DSHS. In addition, the Attorney General's Office oversees the Medicaid Fraud Control Unit, which is responsible for investigating and prosecuting fraud committed by health care providers. The Unit also monitors complaints of resident abuse or neglect in Medicaid-funded nursing homes, adult family homes and boarding homes. Most Medicaid expenditures are payments to providers of medical treatment, prescriptions, medical equipment, home health care and other services. Due to the program's size and complexity, and the risk of fraud and abuse, we focus much of our Single Audit effort on the Medicaid program.

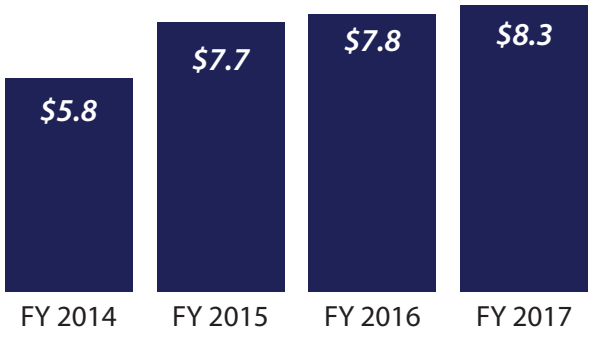
As shown in **Exhibit 7**, the state spent roughly 47 percent, or $8.3 billion, of all federal grant funds it received on Medicaid. The state spent another $4.2 billion through its required state match.

Exhibit 7 – Medicaid accounted for 47 percent of the state's overall federal spending



Spending on Medicaid continues to rise from earlier years. As **Exhibit 8** shows, over the past three state fiscal years, Medicaid spending has increased by nearly $2.5 billion in federal share dollars alone. Full implementation of the Affordable Care Act added about 330,000 people to the Medicaid rolls in Washington in 2015, increasing Medicaid expenditures in state fiscal year 2015 by about $1.9 billion. Medicaid's overall percentage of the state's federal expenditures increased from 37 percent to 47 percent from fiscal years 2014 to 2017.

Exhibit 8 – Federal share of Medicaid expenditures
(dollars in billions)



We audited 36 areas in the Medicaid program and issued 20 audit findings regarding unallowable expenditures, internal control deficiencies or noncompliance related to Medicaid rules and regulations. We identified $35.8 million in known questioned costs and $160.7 million in likely improper payments (compared to $8.2 million in known questioned costs and $112.3 million in likely improper payments in fiscal year 2106) related to:

- In-home services
- Services not provided
- Ineligible individuals
- Services provided by ineligible providers
- Overpayments to providers
- Uncollected drug rebates
- Incorrect payments made to managed-care organizations

We found significant weaknesses in five areas at the Health Care Authority

Additional action is needed to improve third-party liability efforts

The Authority did not ensure data exchanges with health insurers were performed as required by state law. Data exchanges help the agency and insurers determine whether clients have third-party medical insurance coverage, which could reduce the amount of their claim paid for by Medicaid. We have reported this issue since 2008.

Drug rebates

The Authority did not account for all claims eligible for managed care and fee-for-service outpatient drug rebates when preparing invoices. We found the Authority failed to claim $31,177,821 in known managed care and fee-for-service drug rebates from drug manufacturers; the federal share was $23,955,658 and the state share was $7,222,163. We estimate the Authority failed to collect about $56 million in likely unclaimed rebates. The federal share of these likely unclaimed rebates was about $43 million, and the state share was about $13 million.

We have issued findings over drug rebates since 2014. In the fiscal year 2016 audit, we found the Authority failed to account for $368,097 in known managed care outpatient drug claims. We estimated the value of those likely unclaimed rebates at about $15.6 million; the federal share of that amount was about $11.6 million.

Children's Health Insurance Program (CHIP)

The CHIP program provides health insurance for children whose family income meets Medicaid requirements. Additional CHIP funds are available for Medicaid children whose household income equals or exceeds 133 percent of the federal poverty level, but does not exceed 210 percent. The Authority did not have adequate internal controls to ensure and monitor that additional CHIP federal funds were claimed only for eligible Medicaid expenditures.

Although the Authority performs a post-eligibility review to ensure Medicaid eligibility has been adequately determined, the review is triggered only when data the Authority obtains shows the household income exceeds the Medicaid-applicable maximum level of 210 percent of the federal poverty level. If the verified income is below 133 percent, the Authority does not perform a post-eligibility review. For this reason, the Authority did not identify errors made in the eligibility determination that caused it to incorrectly claim additional CHIP funds.

We randomly sampled 86 Authority fee-for-service and managed care premium payments, as well as four judgmentally selected clients with paid amounts above $100,000, and identified $1,783 in known questioned costs in which clients were not eligible for additional CHIP federal funds. When we projected the results to the entire population of fee-for-service and managed care premium payments, we estimate the likely federal share of the improper payments to be about $2 million.

In addition, we randomly sampled 86 DSHS fee-for-service and managed care premium payments, as well as three judgmentally selected clients with paid amounts above $15,000, and identified $162 in known questioned costs in which clients were not eligible for additional CHIP federal funds. When we projected the results to the entire DSHS population of fee-for-service and managed care premium payments, we estimate the likely federal share of the improper payments to be about $365,080.

$31,177,821

drug rebates
HCA did not claim

$23,955,658

federal share

$7,222,163

state share

Stillaguamish Tribe payments for methadone

The Authority overpaid the Stillaguamish Tribe almost $6 million for Medicaid chemical dependency treatments. The Stillaguamish Tribe operates a chemical dependency facility that provides services to tribal and non-tribal clients. From January 2016 through December 2016, the Tribe was paid about $32 million for chemical dependency treatments.

To determine if the Tribe was reimbursed properly, we reconciled almost $7 million in claims to supporting documentation obtained from the Tribe. We found more than $6 million was paid improperly because the service provider was ineligible to claim at the reimbursed rate because he or she was not a specifically credentialed health care professional as named in the state plan.

Managed care payments

The Authority made improper payments to Medicaid managed care recipients with Medicare insurance coverage. We found 9,979 improper managed care premium payments were made on behalf of 4,065 clients who had Medicare coverage during the same month as their monthly, managed care premium payment. The Authority paid about $6.6 million to the managed care organizations serving these clients.

Duplicate payments or those made to an ineligible recipient are unallowable and cannot be claimed for federal reimbursement. The federal share of the improper premium payments total more than $4.3 million.

We also found significant weaknesses at the Department of Social and Health Services

We are highlighting five areas of concern regarding DSHS efforts to ensure it follows federal regulations governing payments to health care providers and background checks. We found weaknesses in the agency's internal controls pertaining to timesheet reconciliation for supported living provider caregivers, payments for care given to ineligible clients, and ensuring caregivers had current background checks in place. We also found DSHS overpaid a supported living agency because the agency did not provide all its contracted hours, was paid for those hours and did not submit supporting schedules for its final cost reports when DSHS requested them.

Payments to supported living providers: Reconciling paid hours to timesheets

The Developmental Disabilities Administration in DSHS manages the Home and Community Based Services program for people with developmental disabilities. Supported living is a core service offered through contracted providers who help clients living in their own homes with the social and adaptive skills necessary to live in the community and with daily living activities. Clients often share their homes with other supported living clients.

We found DSHS did not have adequate internal controls over and did not follow federal regulations to ensure payments to supported living providers were allowable. We selected a statistically valid sample of 86 monthly payments from a population of 48,232 monthly payments made for client support hours, and reconciled the payments to provider timesheets to verify if payments were adequately supported.

In 64 instances (74 percent), we could not determine that the provider delivered a client's planned level of hourly support. As **Exhibit 9** shows, this rate is a 15 percent increase from fiscal year 2016, when we identified 51 instances (59 percent) for which we could not determine that clients received their planned level of support hours.

Specifically, we identified 96,554 support hours that providers reported to DSHS they planned to provide to clients based on their residential staffing plans. Of those hours, we verified providers delivered 86,284 support hours. For 10,270 hours (11 percent) we could not determine if the hours were provided because employees were not scheduled to work or supporting documentation was lacking.

For four of the households in the sample, providers responded to our request for timesheets, but because of poor record-keeping we could not determine if sampled clients received any hours of support.

DSHS does not perform procedures to determine if a client received their assessed level of support hours, or reconcile the payments to provider timesheets. Rather, it relies on the cost settlement process to determine if a provider delivered the total number of contracted hours to all clients served by the supported living agency during the calendar year.

We found 64 payments, totaling $112,969, were not supported by payroll records; the federal share of the unsupported payments was $56,484. The estimated amount of likely improper payments was $63.3 million; the federal share of the likely improper payments was about $31.6 million. The state's share of known unsupported payments was $56,485, and its share of likely improper payments was about $31.6 million.

When reconciling household schedules to employee timesheets, we identified 1,317 days out of a total of 2,505 days when clients did not receive the number of support hours providers reported they planned to provide (shown in **Exhibit 10**). We also identified 198 days out of a total of 2,505 days when employee timesheets did not show that households designated to receive 24 hours of support received that amount of support.

In addition to the unsupported payments to providers, we found DSHS made unallowable duplicate payments totaling $21,169 because an edit in its payment system was not activated. The federal share of the unallowable duplicate payments was $10,584; the state's share was $10,585.

Supported living provider cost reporting

Supported living providers must prepare and submit a cost report at the end of each calendar year. DSHS uses the information to reconcile client support hours provided to clients and hours paid to providers. This is known as Settlement A. DSHS also uses the cost report to reconcile the amount it reimbursed providers to the costs providers incurred during the year. This is known as Settlement B. DSHS policy requires that providers refund the greater amount of Settlement A or B.

We reviewed copies of the cost reports submitted by 124 supported living providers for calendar year 2016. We found DSHS's internal controls over the cost report reconciliation process were ineffective to ensure Medicaid payments were allowable.

Exhibit 9 – Rise in instances when documentation showed clients did not receive planned hours of support
FY 2017 compared to FY 2016

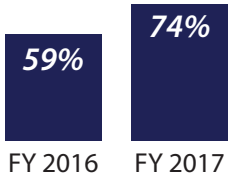


Exhibit 10 – Clients did not receive all hours planned for
From 2,505 total planned days of care

We requested payroll records from all providers to perform our own reconciliation. In 34 instances (27 percent), the payroll records providers submitted did not fully support the number of client support hours listed on the cost reports. In 75 instances (60 percent), providers did not properly categorize their employees as DSHS required.

DSHS said it did not dedicate resources to verify the accuracy of the information submitted by providers. Further, DSHS said it has never implemented a consistent process to request detailed payroll records from providers for reconciling to cost records. Also, DSHS said it did not monitor to confirm if providers comply with cost-report instructions.

One provider did not submit detailed payroll records. We questioned all $804,741 that DSHS paid for calendar year 2016 because of a lack of supporting documentation. The federal share of the costs totaled $402,370. We also questioned $2,906,998 that DSHS paid to the 34 providers whose detailed payroll records did not support the hours listed on their cost reports. The federal share of these questioned costs is $1,453,499.

In 48 instances (49 percent), providers were paid for more support hours than they listed on their cost reports. Before making this conclusion, we reviewed and considered the information DSHS forwarded to its collection arm, the Office of Financial Recovery.

During the audit period, DSHS issued guidance to providers to request an exception to credit the cost of overtime on their cost reports when calculating Settlement A (hours paid minus support hours provided.) This practice was not described in DSHS's CORE waiver with Centers for Medicare and Medicaid Services or its own policy. In effect, this process allowed providers to retain payment for support hours they did not provide.

We questioned $1,985,809 paid to the 48 providers that were paid for more support hours than they reported. The federal share of these questioned costs is $992,905.

We have reported findings over the supported living program since fiscal year 2012.

Payments to individual providers: Eligible clients

The Developmental Disabilities Administration and the Aging and Long-Term Support Administration, both part of DSHS, did not have adequate internal controls over and did not meet requirements to ensure Medicaid Community First Choice (CFC) client service plans were properly approved.

The Developmental Disabilities Administration and the Aging and Long-Term Support Administration offer personal-care and other services to support Medicaid clients in community settings through the CFC program. Clients may receive personal-care services, skills-acquisition training, assistive technology, personal emergency response systems and other services that help them remain in community settings. DSHS must ensure clients are eligible before authorizing services. A fully implemented person-centered service plan must be completed and signed before a client can be determined eligible for CFC. Federal Medicaid rules state that clients' person-centered service plans are incomplete until the clients or their representatives sign them; services should not be provided, or providers paid, without a completed agreement.

We found DSHS did not have adequate internal controls to monitor and ensure clients' person-centered service plans were completed before paying providers for client services.

Before August 2015, DSHS staff accepted a verbal "agreement of services" from clients rather than obtaining the needed signatures. In August 2015, DSHS trained staff to obtain necessary signatures on the person-centered service plan, but not all staff followed training guidelines. In addition, DSHS had a backlog of documents to scan into client records. DSHS believes this backlog and the process in getting documents to the Document Management System unit for scanning contributed to the number of client records without a signed service plan.

We used a statistically valid sampling method to randomly select a total of 172 CFC Developmental Disabilities Administration and Aging and Long-Term Support Administration clients who received services from an individual provider, from a total population of 58,892. We examined the client files and found 34 instances when DSHS did not monitor to ensure signed plans were received within 60 days, contained valid signatures or were scanned into its imaging system.

Specifically, we found:

- 16 instances when DSHS could not locate a signed plan
- 10 instances when the plans lacked required signatures of the client (5), the client's legal representative (2) or a DSHS representative (3)
- Six instances when DSHS did not receive all required signatures within 60 days of the plan's completion as state rule required
- Two instances when plans were signed by a client's legal guardian but DSHS did not have legal guardian paperwork in the file

We also performed follow-up testing on our 2016 audit finding that identified 18 instances when DSHS either did not monitor to ensure the plans were received within 60 days or that plans had valid signatures.

By not monitoring to ensure a fully implemented plan was in place, DSHS issued $583,396 in improper payments to providers. We questioned $326,389, which is the federal share of the improper payments.

When improper payments are identified, federal regulations suggest auditors consider if associated costs, such as benefits, were also paid. DSHS pays payroll-related benefits, which are considered associated costs, on behalf of CFC providers. Examples of these costs include health insurance, retirement, payroll taxes and training.

For the $583,396 in payments we determined were improper, we identified $136,102 in associated costs that are also considered improper. We questioned $75,242, which is the federal share of the improper associated payments. The state's share of known questioned costs including associated costs was $317,867.

Projecting the results of our statistically valid sample to the entire program, we estimated the amount of likely improper payments to be $98,429,897. The federal share of the unallowable payments was $55,013,776. The likely associated costs are $23,832,403. The federal share of these costs was $13,091,980. The state's share of likely improper payments to providers and associated costs was about $54.1 million.

Background checks

DSHS made payments on behalf of Medicaid clients to providers who did not renew their background checks in a timely manner or did not complete a required fingerprint check.

We selected a statistically valid sample of 216 providers and found three instances when DSHS did not perform a fingerprint background check of a provider and one instance when a background check was not renewed on time. Although the providers did have a Washington background check, state law requires a fingerprint check to also be completed. We identified $201,053 in questioned costs associated with care given by these providers. The federal share of the costs was $100,782; the state share was $100,271.

For the $201,053 in payments we determined were unallowable, we identified $1,297 in associated costs that we also considered to be unallowable. We questioned $727, which is the federal portion of the unallowable payments.

Projecting the results to the entire population of adult family home providers, we estimated the amount of improper payments to be $13,521,318. The federal share of the estimate is $7,409,719.

We reported these questioned costs in two findings.

We have reported findings regarding background checks at DSHS since 2011.

Appendix A: Programs Audited in Fiscal Year 2017

CFDA	Program
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
17.225	Unemployment Insurance (UI)
20.319	Highway Speed Rail Corridors and Intercity Passenger Rail Service – Capital Assistance Grants
64.015	Veterans State Nursing Home Care
66.468	Capitalization Grants for Drinking Water State Revolving Fund
	Student Financial Assistance Cluster
84.007	Federal Supplemental Educational Opportunity Grants (FSEOG)
84.033	Federal Work-Study Program
84.038	Federal Perkins Loan (FPL) – Federal Capital Contributions
84.063	Federal Pell Grant Program
84.268	Federal Direct Student Loans
84.379	Teacher Education Assistance for College and Higher Education Grants (TEACH Grants)
93.264	Nurse Faculty Loan Program (NFLP)
93.342	Health Professions Student Loans, Including Primary Care Loans and Loans for Disadvantaged Students (HPSL/PCL/LDS)
93.364	Nursing Student Loans (NSL)
84.010	Title I Grants to Local Educational Agencies (Title I, Part A of the ESEA)
	Special Education Cluster (IDEA)
84.027	Special Education – Grants to States (IDEA, Part B)
84.173	Special Education – Preschool Grants (IDEA Preschool)
84.126	Rehabilitation Services – Vocational Rehabilitation Grants to States
93.266	Health Systems Strengthening and HIV/AIDS Prevention
93.558	Temporary Assistance for Needy Families (TANF) State Programs
93.563	Child Support Enforcement
	Child Care and Development Fund Cluster
93.575	Child Care and Development Block Grant
93.596	Child Care Mandatory and Matching Funds of the Child Care and Development Fund
93.658	Foster Care – Title IV-E
93.659	Adoption Assistance – Title IV-E
93.667	Social Services Block Grant
93.767	Children's Health Insurance Program (CHIP)
	Medicaid Cluster
93.775	State Medicaid Fraud Control Units
93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare
93.778	Medical Assistance Program (Medicaid; Title XIX)
93.959	Block Grants for Prevention and Treatment of Substance Abuse
	Disability Insurance/SSI Cluster
96.001	Social Security – Disability Insurance (DI)
96.006	Supplemental Security Income (SSI)
97.036	Disaster Grants – Public Assistance

Appendix B: Summary of Federal Findings by State Agency

The full text of the findings can be found online in the 2017 Single Audit Report, starting on page E-17, at: **https://bit.ly/2tDw55r.**

Agency	Number	Finding
Social and Health Services	2017-002	The Department of Social and Health Services improperly charged about $4.1 million to multiple federal grants.
	2017-004	The Department of Social and Health Services did not have adequate internal controls over and did not comply with public assistance cost allocation plan requirements.
	2017-012	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.
	2017-013	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure client eligibility determinations were accurate and made within a reasonable period of time for the Vocational Rehabilitation program.
	2017-014	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure payments paid on behalf of clients for Vocational Rehabilitation were allowable.
	2017-015	The Department of Social and Health Services did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.
	2017-016	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of the Substance Abuse and Mental Health Services Projects of Regional and National Significance and Block Grants for Prevention and Treatment of Substance Abuse programs received required audits.
	2017-017	The Department of Social and Health Services did not have adequate internal controls over requirements to ensure payments to child care providers for the Temporary Assistance for Needy Families program were allowable.
	2017-018	The Department of Social and Health Services did not establish adequate internal controls over and did not comply with federal requirements to sanction Temporary Assistance for Needy Families program participants who were not cooperative with the Department regarding child support issues.
	2017-019	The Department of Social and Health Services did not have adequate internal controls in place over maintenance of effort requirements for the Temporary Assistance for Needy Families grant.
	2017-020	The Department of Social and Health Services did not have adequate internal controls in place for ensuring the accuracy of submitted quarterly reports for the Temporary Assistance for Needy Families Grant.
	2017-021	The Department of Social and Health Services did not have adequate internal controls in place for submitting quarterly and annual reports for the Temporary Assistance for Needy Families grant.
	2017-022	The Department of Social and Health Services did not report fraud affecting multiple federal programs to grantors.
	2017-023	The Department of Social and Health Services improperly charged payroll costs to the Child Support Enforcement Grant.

Agency	Number	Finding
Social and Health Services	2017-026	The Department of Social and Health Services did not have adequate internal controls over and did not comply with client eligibility requirements for the Child Care Development Fund.
	2017-027	The Department of Social and Health Services did not have adequate internal controls over and was not compliant with requirements to identify and detect fraud in the Child Care and Development Fund program.
	2017-028	The Department of Social and Health Services improperly charged $1,544 to the federal foster care grant.
	2017-029	The Department of Social and Health Services did not have adequate internal controls over and did not comply with payment rate setting and application requirements for the Foster Care program.
	2017-030	The Department of Social and Health Services did not have adequate internal controls over and did not comply with federal level of effort requirements for the Adoption Assistance program
	2017-042	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid intermediate care facilities.
	2017-043	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls to ensure compliance with survey requirements for Medicaid nursing home facilities.
	2017-044	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and was not compliant with requirements to ensure Medicaid payments to supported living providers were allowable.
	2017-045	The Department of Social and Health Services, Aging and Long- Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client support plans were properly approved.
	2017-046	The Department of Social and Health Services, Developmental Disabilities Administration, did not have adequate internal controls over and did not comply with requirements to ensure Medicaid Community First Choice client support plans were properly approved.
	2017-047	The Department of Social and Health Services, Aging and Long-Term Support Administration made improper Medicaid nursing facility fee-for-service payments for clients enrolled in managed care.
	2017-048	The Department of Social and Health Services, Aging and Long-Term Support Administration, did not have adequate internal controls over and did not comply with requirements to ensure Adult Family Home providers had proper background checks.
	2017-049	The Department of Social and Health Services, Aging and Long-Term Support Administration did not ensure all Medicaid Community First Choice individual providers had proper fingerprint background checks.
	2017-050	The Department of Social and Health Services, Aging and Long-Term Care Administration and Developmental Disabilities Administration, made improper overtime payments to Medicaid individual providers.
	2017-051	The Department of Social and Health Services charged payroll costs to the Disability Insurance/ SSI Cluster that were not adequately supported.

Agency	Number	Finding
Health Care Authority	2017-031	The Health Care Authority did not perform semi-annual data sharing with health insurers as required by state law.
	2017-032	The Health Care Authority overpaid a tribe for Medicaid chemical dependency treatments.
	2017-033	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid medical providers were revalidated every five years and screening requirements were met.
	2017-034	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid service verifications were performed for all eligible claims.
	2017-035	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure it sought reimbursement for all eligible Medicaid outpatient prescription drug rebate claims.
	2017-036	The Health Care Authority overpaid Medicaid hospitals for outpatient services.
	2017-037	The Health Care Authority did not have adequate internal controls over and did not comply with suspension and debarment requirements for Medicaid medical fee-for-service providers.
	2017-038	The Health Care Authority did not have adequate internal controls over and did not comply with requirements to ensure Medicaid expenditures were allowable to claim Children's Health Insurance Program funds.
	2017-039	The Health Care Authority made improper payments to Medicaid managed care recipients with Medicare insurance coverage.
	2017-040	The Health Care Authority made improper Medicaid pharmacy fee-for-service payments for clients enrolled in managed care.
	2017-041	The Health Care Authority made improper Medicaid payments to Federally Qualified Health Centers.
Services for the Blind	2017-006	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to establish timely individual plans of employment for Vocational Rehabilitation program clients.
	2017-007	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to determine client eligibility for the Vocational Rehabilitation program within a reasonable time period.
	2017-008	The Department of Services for the Blind did not have adequate internal controls to ensure cash draws were accurate and federal spending requirements were met for the Vocational Rehabilitation program.
	2017-009	The Department of Services for the Blind did not have adequate controls over, and was not compliant with, federal requirements for charging costs to the Vocational Rehabilitation program.
	2017-010	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, reporting requirements for the Vocational Rehabilitation Grant.
	2017-011	The Department of Services for the Blind did not have adequate internal controls over, and was not compliant with, federal requirements to ensure only eligible expenditures were earmarked as pre-employment transition services.

Agency	Number	Finding
Early Learning	2017-024	The Department of Early Learning did not have adequate internal controls over and was not compliant with requirements to ensure payments to child care providers for the Child Care and Development Fund program were allowable.
	2017-025	The Department of Early Learning did not have adequate internal controls over and did not comply with health and safety requirements for the Child Care and Development Fund program.
Health	2017-003	The Department of Health did not have adequate internal controls over and could not demonstrate it complied with requirements to perform risk assessments for all subrecipients of the Special Supplemental Nutrition Program for Woman, Infants and Children program.
Employment Security	2017-005	The Employment Security Department did not have adequate internal controls over and did not comply with requirements to ensure only eligible claimants of the Unemployment Insurance program received weekly benefits.
Military	2017-052	The Washington Military Department did not have adequate internal controls over and did not comply with federal requirements to ensure subrecipients of Disaster Grants-Public Assistance received required audits.
Financial Management	2017-001	The State should improve internal controls over specific areas of processing, recording, monitoring and reporting of financial activity included in the State's financial statements.