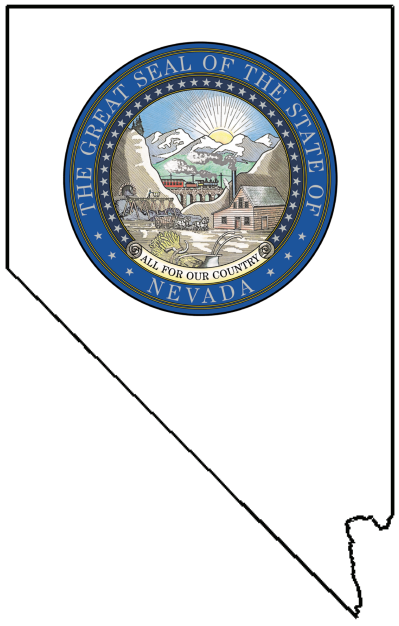
STATE OF NEVADA

Legislative Counsel Bureau
Audit Division

Audit Report Summaries
2021–2022



Eighty-Second
Nevada Legislature

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MEMORANDUM

TO: Members of the Senate Committee on Finance
Members of the Assembly Committee on Ways and Means

FROM: Daniel L. Crossman, Legislative Auditor, Audit Division,
Legislative Counsel Bureau

DATE: February 8, 2023

SUBJECT: **Audit Report Summaries**

This document contains summaries of audits issued during the past biennium. The table of contents references the audit's summary page. The executive budget reference guide lists the agency's corresponding page in the Executive Budget. Each section contains one-page highlights of the audits performed, followed by additional information regarding agency action on recommendations. The complete audit reports are available on the Audit Division's website at www.leg.state.nv.us/audit/. After an audit report has been issued, the following steps help ensure our audit recommendations are adequately implemented:

- Agencies are required to prepare a plan of corrective action 60 days after an audit report is issued detailing the anticipated steps to implement the audit recommendations.
- A status report is prepared by the Governor's Finance Office, Internal Audit Division, after it reviews the status of the audit recommendations 6 months after the 60-day plan of corrective action.
- The Audit Subcommittee of the Legislative Commission may also require agencies to attend meetings of the Subcommittee to discuss progress towards successful implementation of recommendations.

The involvement of the Legislature is an important part of the audit follow-up process that helps ensure corrective action is taken. Consequently, this involvement has contributed to continuing financial benefits. The audit report summaries in this document identify over $19 million in monetary benefits, cost savings, and revenue enhancements. Including measurable financial benefits from prior years' recommendations that impact the current biennium, we estimate financial benefits totaling more than $68 million were realized over the past biennium. These savings would not have been possible without the support and involvement of the Legislature.

LEGISLATIVE COUNSEL BUREAU
AUDIT DIVISION
AUDIT REPORT SUMMARIES

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LEGISLATIVE COUNSEL BUREAU
AUDIT DIVISION
AUDIT REPORT SUMMARIES

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EXECUTIVE BUDGET REFERENCE GUIDE

EXECUTIVE BUDGET REFERENCE GUIDE
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Education

Audit Highlights

Highlights of performance audit report on the Nevada System of Higher Education, Capital Construction Projects issued on January 12, 2023.

Legislative Auditor report # LA24-04.

Background

The Nevada System of Higher Education (NSHE) oversees all state-sponsored higher education in the state of Nevada. The mission of NSHE is to provide higher education to the citizens of the State at an excellent level of quality consistent with the State's resources. Sections 4 and 7 of the Nevada Constitution vest governance and administration of NSHE in the Board of Regents (Board). The Chancellor is appointed by the Board, and is responsible for NSHE administration and financial management, and implements Board policies and directives.

The net value of capital assets for NSHE was approximately $2.2 billion according to the fiscal year 2021 audited financial statements. NSHE capitalizes all expenditures for constructing a new building, including major improvements, additions, or major building alterations that involve an expenditure of at least $250,000. Funding for capital construction comes through a variety of sources including state, federal, institution, and private funds.

Purpose of Audit

The purpose of the audit was to determine if the University of Nevada, Las Vegas and the University of Nevada, Reno managed capital construction projects in accordance with laws, policies, and appropriate management standards. Our audit included a review of capital construction projects that were solicited, in progress, or completed between fiscal years 2019 and 2021.

Audit Recommendations

This audit report contains four recommendations to improve compliance with state laws and sound budgeting practices regarding capital construction financing and management, nine recommendations to help control change orders and strengthen project close out practices, and five recommendations to strengthen procurement practices.

NSHE accepted the 18 recommendations.

Recommendation Status

NSHE's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Capital Construction Projects

Nevada System of Higher Education

Summary

The Nevada System of Higher Education needs to enhance its policies and procedures to ensure institutions' capital construction project funding and management practices comply with state laws, NSHE policies, and contract terms. Funding of some capital construction projects used state-appropriated operating funds, and institutions did not have authority to manage some state-funded projects. In addition, change order documentation was not always adequate to ensure contractors' billed amounts complied with contract terms, and some unallowed amounts were billed. Furthermore, better project planning is needed to limit unnecessary modifications to construction contracts' scopes of work. Proper controls over construction project management are critical for ensuring compliance with applicable state laws and NSHE policies, and to safeguard financial resources.

Better controls over project solicitation and procurement practices are needed to ensure compliance with state law and NSHE practices. Specifically, some project solicitations did not comply with state law regarding the disclosure of selection criteria weights. In addition, delays in evaluating contractor proposals and reviewing contract documents added $1.8 million to a project contract. Furthermore, institutions used some nontraditional procurement methods for capital construction projects. Current practices associated with the use of these methods may limit institution control over project construction when compared to more traditional methods.

Key Findings

The University of Nevada, Las Vegas (UNLV) and the University of Nevada, Reno (UNR) used almost $5 million in state operating funds to help pay for capital construction. For 10 of 27 (37%) projects tested, UNLV and UNR used state operating funds. The Appropriations Act designates these funds for instructional and operating costs, and not capital construction. Institutions use of these funds was often done so they would not revert to the State. (page 7)

UNLV and UNR's management of capital construction projects using state operating funds did not always comply with state laws and NSHE policy. State law requires that contracts for the construction of NSHE projects with 25% or more state appropriations use the construction management services of the Department of Administration, State Public Works Division (SPWD). For 3 of 27 (11%) projects tested, the use of state funds represented more than 25% of the total project funding. Neither the institutions nor NSHE requested authority from SPWD to manage these projects. (page 11)

Change order documentation was often not adequate to determine compliance with contract terms. When a change to a project is needed, involving contract amount or timing, change orders are required to amend construction contracts. We tested 49 change orders worth $8.3 million related to 27 capital projects. For almost $3.1 million (37%), supporting documentation did not include detailed labor, material, equipment, or overhead and profit markup fees. In addition, unallowed costs or incorrect markup fees were charged. For change order items with adequate documentation, we found 38 of 49 (78%) change orders included unallowed costs or incorrect markup fees. This resulted in over $200,000 in inappropriate payments to contractors. (page 17)

Scope modifications to the original construction contract increased project costs by $5.5 million and resulted in additional overhead and profit markup fees of more than $800,000. These changes to the projects' scopes could have been included in the original solicitation process with better project planning. When a project's scope is modified through change orders, noncompetitive pricing and overhead and profit markup fees drive up the cost of these changes. (page 22)

Institutions' project closeout processes did not ensure compliance with state law regarding reporting requirements or ensure important documentation was received prior to the final project payment. In addition, excess project funding was not transferred timely. (page 25)

Institutions are using nontraditional procurement methods to complete capital construction projects. For one project, a public-private partnership was used for the construction of a new $125 million medical education building, at a cost of $25 million to the State. However, it is unclear whether institutions have statutory authority to use this method. In addition, the use of nontraditional methods compared to traditional methods resulted in less control and oversight over construction project management and financial activities. (pages 29)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Audit Highlights

Highlights of performance audit report on the Nevada System of Higher Education, Institution Foundations issued on January 12, 2023.

Legislative Auditor report # LA24-05.

Background

The Nevada System of Higher Education (NSHE) includes eight institutions which accept privately donated money through each institution's foundation(s). The foundations serve as the primary fundraising, community relations, and gift management agency for their respective institutions. These efforts typically include managing annual giving programs, scholarship giving programs, facilities support, and estate planning services on behalf of and to benefit each institution. Each foundation is a non-profit corporation established for charitable and educational purposes and is a tax-exempt entity in accordance with Section 501(c)(3) of the Internal Revenue Code.

Donations received by foundations are recorded as either unrestricted, restricted, or endowed support depending on the existence or nature of any donor restrictions.

The foundations' financial statements are provided to the NSHE Board of Regents each year and are made available publicly on the Board of Regents' website.

Purpose of Audit

This audit was required by Assembly Bill 416 (Chapter 467, Statutes of Nevada 2021). The scope of our audit included an examination and analysis of the sources and uses of money privately donated to certain NSHE institutions in fiscal year 2018 through fiscal year 2021. We also tested select transactions from fiscal year 2022 as deemed necessary. The purpose of the audit was to determine if privately donated money was appropriately recorded and spent in accordance with donors' intended purposes.

Audit Recommendations

This audit report contains three recommendations to ensure adequate policies are in place related to documenting acknowledgment letters or donation receipts, verifying key control processes are occurring, and reviewing inactive gift accounts.

NSHE accepted the three recommendations.

Recommendation Status

NSHE's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Institution Foundations

Nevada System of Higher Education

Summary

We found almost all gift donations were assigned to the appropriate foundation gift account in accordance with the donors' intent. However, there were instances in our sample where this did not occur consistently at a couple institutions' foundations. Additionally, while most donations were properly recorded, there were some differences in how certain related processes were performed. Specifically, records were not always maintained to demonstrate gift acknowledgement letters or receipts were issued to donors for every gift. Improved recordkeeping will help ensure donors receive adequate documentation to serve as support for tax deductible donations.

We found institutions generally expended gift funds in accordance with donor intent. However, some institutions carried forward unspent gift funds for multiple years that possibly could be utilized through related active accounts or be repurposed for other uses if agreed upon by donors. Additionally, in a few instances, gift funds were expended in a manner that did not appear to align with donors' intent. During the scope of our audit, changes to one institution's practices appear to have corrected this issue. In other cases, documentation supporting expenditures lacked some supporting details.

Key Findings

Overall, our testing found 763 of 774 (99%) sampled donations at 7 institutions were properly recorded by the foundations in appropriate gift fund accounts at the institutions. This sample included $116 million in donations received between July 1, 2017, and June 30, 2021. We confirmed the dollar value of the donation and the categorization in an appropriate gift fund aligned with the donation. (page 8)

Adequate documentation associated with donations and accompanying donor wishes were generally retained to support transactions. However, in certain instances, foundations could not provide evidence that all donation acknowledgment letters were sent to donors. For 65 of 774 (8%) donations tested, letters or donation receipts were not available at 5 of 7 foundations. (page 9)

During testing at College of Southern Nevada (CSN) Foundation, we found for 7 of 110 (6%) samples there were errors between the donation information recorded in CSN Foundation's donor management software and the CSN Foundation's financial software. These errors were not seen at other institutions' foundations. (page 11)

At Great Basin College (GBC) Foundation, we identified one instance where donated money was not applied to the correct gift fund in accordance with donor intent. In 2018, a donation of almost $94,000 designated by the donor for a memorial scholarship endowment was assigned to an unrestricted GBC Foundation account. We verified the money was transferred to the correct gift fund in October 2022. (page 11)

Our testing found 686 of 690 (99%) gift fund expenditures tested were appropriately spent in accordance with the intended purpose of the gift fund. This sample included expenditures totaling $23 million spent between July 1, 2017, and June 30, 2021. Additionally, adequate documentation associated with the expenditures was retained to support the transactions for 680 (99%) of the expenditures in our sample. (page 13)

At six institutions, we found that privately donated money went unutilized in certain accounts for multiple years. While some of these accounts may be saving funds for a future purpose, many did not have donation or expenditure activity for at least 5 years. Some institutions' gift funds would benefit from a routine review of stale accounts to identify opportunities to repurpose funds to other actively utilized accounts consistent with the donations' intended purpose. (page 14)

While 99% of donor funds were used in accordance with donor intent, we did find instances where this was not the case. At some institutions, we found a few instances where gift expenditures did not have sufficient supporting documentation or evidence the expenditure was in alignment with the intended purpose of the gift funds. In our assessment, these were not egregious deviations but warranted the attention of the institutions. (page 16)

Audit Highlights

Highlights of performance audit report on the Nevada System of Higher Education, Self-Supporting and Reserve Accounts issued on January 12, 2023.

Legislative Auditor report # LA24-03.

Background

NSHE is a state-supported land grant institution established by the Constitution of the State of Nevada in 1864. NSHE is a consolidation of eight institutions of public higher education in Nevada with an administration function.

NSHE is governed by the 13 elected member Board of Regents who are responsible for executive and administrative control of NSHE. The Chancellor is responsible for developing systemwide strategies and implementing policy.

More than 105,000 individuals utilized NSHE educational services for the Fall 2021 semester. However, student enrollment has declined overall the last 2 years.

NSHE institutions utilize self-supporting revenues to help pay for institution activities. Revenues consist mainly of student fees, investment income, indirect cost recoveries, and sales and service income. Student fees are allocated between state-supported and self-supporting accounts. At the end of fiscal year 2022, about $629 million remained in self-supporting program accounts.

Purpose of Audit

This audit was required by Assembly Bill 416 (Chapter 467, Statutes of Nevada 2021). The purpose of the audit was to analyze financial activity related to self-supporting funds and reserve accounts for fiscal years 2018 to 2021. When necessary, we included fiscal year 2022 data.

Audit Recommendations

This audit report contains 13 recommendations to ensure self-supporting funds are utilized appropriately and to improve accountability of NSHE resources.

NSHE accepted the 13 recommendations.

Recommendation Status

NSHE's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Self-Supporting and Reserve Accounts

Nevada System of Higher Education

Summary

Minimal systemwide oversight and variations in internal control systems and operations at institutions of the Nevada System of Higher Education (NSHE) contributed to inappropriate or questionable financial activity. This occurred because the Board of Regents (Board) has provided institutions with latitude for operations, but policies and related guidelines are often vague or insufficient, which contributes to variation amongst institutions. Our review of self-supporting accounts found some inappropriate activity. For example, institutions moved expenditures to state-supported accounts without ensuring consistency in the type of activity. In addition, state funds were not reverted in accordance with state law. We also found questionable uses of student fees when compared to Board policies. Furthermore, institutions commingled restricted and unrestricted revenues, and reports to the Board did not always provide useful, accurate, or complete information. Increased oversight of institutions will help ensure funds are used appropriately and NSHE is accountable to the Legislature, its students, and the public.

Reserve and contingency accounts are not adequately overseen by the Board. As a result, there is little consistency amongst institutions in how accounts are created, structured, and used. For instance, some institutions utilized reserve accounts for routine operational expenditures such as payroll. We also found some self-supporting programs had a significant amount of idle funds relative to total uses. These programs had about $200 million in reserves at the end of fiscal year 2021. Excess reserves can indicate programs are overfunded and fees should be reduced, or funding should be redirected for more immediate purposes.

Key Findings

Institutions make a concerted effort to utilize all state appropriations before other types of funding. Accounting transactions are created near year end to ensure state appropriations are fully utilized. All NSHE institutions recorded transactions to move expenditures from self-supporting to state-supported accounts in fiscal years 2018 to 2021. Of 90 transactions reviewed, 59 were related to moving expenditures near or at year end to ensure state appropriations were fully utilized. Of these 59 transactions, 9 moved expenditures between unrelated accounts or activities and 16 moved amounts across different functional categories of expenditures. (page 10)

About $270,000 in state appropriations were not reverted and state funds were reallocated to a different institution without obtaining authorization from the Legislature. The Appropriations Act requires the return of unused state appropriations after a specified date and approval from the Interim Finance Committee for changes to the distribution of appropriations. (page 13)

We tested 250 transactions in self-supporting accounts for all institutions and found 6 (2%) in which general improvement or other restricted student fees were not used consistent with Board policy. Specifically, two institutions used a total of nearly $6.7 million in general improvement and other restricted student fees to support athletics and band programs over several years. (page 15)

Differential and technology fees funded costs for centralized services against Board policy. One institution assessed a 3.5% administrative overhead charge to self-supporting programs. From fiscal year 2018 to 2022, nearly $1.5 million in differential and technology fees were used to pay for centralized services. (page 15)

Target amounts were not set for reserve or contingency accounts, so institutions have little assurance accounts are funded properly at any given time. Additionally, limited oversight or monitoring of reserve activities occurs systemwide. Variation occurred because the Board has not established policies regarding these activities. (page 23)

We found 5 of 50 (10%) transactions tested totaling over $2 million where reserve accounts were funded from sources that included student fees. We also found institutions paid normal operating costs from reserve accounts. Ten of 50 (20%) transactions reviewed included payments for payroll, printing, computer, and office equipment purchases. Paying for normal operating costs from reserve funds does not align with best practices. (page 26)

Institutions violated Board policy by not utilizing student fees on those students who paid them. Of 189 programs reviewed, 44 (23%) retained more than 1 year of revenue in reserve for at least 3 consecutive years. On average, these programs retained about two times average annual revenues at the end of fiscal year 2021. (page 26)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Commerce/Industry

Audit Highlights

Highlights of performance audit report on the Division of Insurance issued on May 13, 2021.

Legislative Auditor report # LA22-06.

Background

The Division of Insurance (Division) protects Nevada consumers in their interactions with the insurance industry and verifies the financial solvency of insurers. To carry out this mission, the Division oversees financial and market regulation of the state's $15 billion insurance industry. There are currently over 2,000 insurance companies licensed to engage in the business of insurance in Nevada.

The Division regulates and licenses insurance agents, brokers, and other professionals; sets ethical and financial standards for insurance companies; reviews programs operated by self-insured employers for worker's compensation; and provides a means for resolving issues between consumers and insurance entities.

The Division's main office is in Carson City, with a secondary office in Las Vegas. In fiscal year 2020, the Division recorded $55 million in revenues, and expenditures totaled over $13 million.

Purpose of Audit

The purpose of the audit was to determine if controls over revenue were adequate. We also reviewed certain Division activities over market conduct regulation. This audit included a review of financial and administrative activities during calendar years 2018 and 2019.

Audit Recommendations

This audit report contains four recommendations to improve controls over revenue collection, one recommendation to protect personally identifiable information (PII), and two recommendations to protect Nevada citizens interacting with bail agencies.

The Division accepted the seven recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on August 9, 2021. In addition, the 6-month report on the status of audit recommendations is due on February 9, 2022.

Division of Insurance

Department of Business and Industry

Summary

Controls over financial assets can be improved to ensure revenue is adequately monitored and fines are equitably enforced. Specifically, the Division does not reconcile revenue with database records to ensure amounts received are ultimately deposited and properly recorded. For calendar year 2019, we identified $11.5 million in revenues recorded in the state accounting system, but not in the Division's database. The Division does not record all revenue in the database due to limitations with the system. Further, the Division did not maintain a check receipt log and system controls allowed staff to alter financial records without oversight. The Division also does not have an adequate process for equitably assessing late fees. With proper controls, we estimate the Division can collect at least an additional $152,000 per year. Finally, the Division also lacks adequate controls to safeguard personally identifiable information (PII) from unauthorized access. In calendar year 2019, there were over 160,000 unmasked instances of PII in the Division's database.

The Division did not complete activities to ensure bail agencies corrected identified issues of noncompliance. The Division began a more comprehensive program to audit bail agencies in August 2018. This program, with full implementation, has the potential to strengthen confidence in the practices and services provided by the industry. However, the Division did not follow up with agencies to ensure corrective action, nor does it have a program to impose fines for continued noncompliance. Without an ongoing program of follow-up and continuation of the audit process, issues with the industry may again become problematic.

Key Findings

Even though some financial activities are bifurcated between the Division and the Department of Business and Industry, neither entity performs a comprehensive reconciliation of payments received. A reconciliation is important because the Division processes a large volume of transactions from different sources recorded to varying budget accounts and revenue types that total more than $50 million in any given year. As part of our audit, we compared fiscal year 2019 totals and found a variance of over $11.5 million between Division and state accounting system records. This occurred because the Division does not record all transactions in its licensing database due to database limitations that prevent certain transactions from being automatically recorded. (page 6)

The Division lacks a process to ensure checks received are properly accounted for. During calendar year 2019, the Division received over 9,000 checks totaling $10.8 million; however, the checks were not adequately controlled upon receipt. Specifically, the Division did not log the checks when opened and initially processed. Logging checks is critical to ensuring all funds received are deposited. In addition, a check receipt log provides those responsible for completing monthly reconciliations with critical supporting documentation. (page 6)

Accounting staff have greater user rights than necessary for accounting system controls to function as intended. For example, accounting staff are able to make edits, such as voiding payments, to financial records without managerial oversight or approval. During March 2019, we identified more than 50 records totaling $112,000 that were voided or edited without supervisory review. These capabilities along with the lack of check receipt logs make it possible for staff to alter financial records and divert checks for personal use. (page 7)

The Division does not consistently assess fines for late payments. There were nearly 2,500 late payments during calendar year 2018; however, only some licensees were assessed fines even though authority exists, in many instances, to fine entities for late payment. The Division did not correctly assess fines on 15 (47%) of the 32 late payments included in our testing. On average, for our sample, payments were received 47 days late, but one payment was received almost 6 months after the due date. (page 7)

Our review identified the following instances of vulnerability for the Division regarding PII; over 160,000 unmasked PII on Division databases; generating over 200 accounting reports with PII each year; the policy and procedures manual was available to all employees and contained unmasked PII; and, applications not requiring a secure method of transmission when sending documents containing PII. These issues resulted from the Division using PII as a primary identifier for the majority of individual licensees. (page 9)

The Division completed the last bail agency audit in February 2019; however, no other routine follow-up has been conducted on any of the entities audited. As a result, the Division may be allowing some issues to persist in an industry serving a vulnerable population. While the Division sent notifications of violations, it did not ensure corrective action was taken. Furthermore, the audit process has not been standardized as routine by the Division. (page 11)

Steve Sisolak

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Director

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Administrator

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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: February 9, 2022

Subject: Legislative Audit of the Department of Business and Industry, Division of Insurance

On May 13, 2021, your office released an audit report (LA22-06) on the Department of Business and Industry, Division of Insurance. The Division of Insurance (DOI) subsequently filed a corrective action plan on August 9, 2021. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DOI to comply with audit findings.

There were seven recommendations contained in the report. The extent of DOI's compliance with the audit recommendations is as follows:

Recommendation 1

Develop comprehensive policies and procedures to perform monthly reconciliations between the state accounting system and the Division bank account, database, and receipt logs.

Status – Partially Implemented

Agency Actions – DOI has taken action to develop comprehensive policies and procedures to perform monthly reconciliations between the state accounting system and the Division bank account, database, and receipt logs. DOI revised its existing Accounting Policy and Procedure Manual on December 15, 2021 and its Revenue Management Desk Procedure on September 20, 2021 to incorporate changes made to the division's revenues and accounts receivable process. DOI reports it conducts a daily reconciliation of all revenues received between the following systems and documentation: DOI's bank

accounts; daily check log; vendor transaction reports; DOI's licensing database, Sircon for States (SFS); and the state's accounting system.

DOI uses the daily check log to: record all paper payments received; verify receipting and depositing; and support DOI's internal deposit report. The internal deposit report is reviewed daily by a person not involved in the receipting and depositing process.

The Department of Business and Industry's (B&I) Fiscal Services Unit (FSU) is responsible for entering the receipt into the state's accounting system. After the transaction is recorded to the state's accounting system, DOI staff reconciles the deposit to the state's accounting system to ensure all funds received have been properly coded and entered.

Auditor Comment – DOI's processes do not provide for adequate segregation of duties in the revenue and accounts receivable process and do not document elements required to determine individuals performing key controls. To determine the implementation status of Recommendations 1 and 2, the Division of Internal Audits (DIA) reviewed the following documentation:

- DOI's revised Accounting Policy and Procedure Manual, Revenue Management Desk Procedure, Invoicing Procedure Manual, and Check Log Process (P&P);
- SFS Revenue Billing and Revenue Management user security roles;
- Five deposits made December 13, 2021 through December 17, 2021 and supporting documentation as evidence of implementation of DOI P&P.[1]

Review revealed that although DOI P&P segregate billing and receiving revenues between two positions, these positions act as back-up to each other and have the same SFS user access roles allowing them to perform invoicing, receiving payments, and recording payments to accounts in SFS. The position responsible for reviewing deposit documentation prior to submitting to B&I FSU may act as back-up to these two positions. Additionally, the position responsible for tracking receipt of payments in DOI's check log is also responsible for making and reconciling deposits.

Deposit support does not include evidence of the individual who made the deposit, only that the deposit was reviewed. Because the two positions and the reviewer may act as back-up to each other in the billing and receipts processes, DIA could not determine if these deposits were also prepared by the reviewer.

Full implementation of both recommendations is dependent upon segregation of duties between: billing, receiving, recording, depositing, and approving revenue transactions. These duties must also be segregated between user roles in the SFS system.

[1] Each deposit included: DOI's internal report generated at the division-level that included all information necessary to adequately account for the funds received; DOI's external report submitted to B&I's FSU with sensitive information removed or redacted; and screen-shots of transaction detail from DAWN.

Recommendation 2

Establish a process to ensure staff maintain logs for all payments mailed to the Division. Include receipt logs in reconciliations.

Status – Partially Implemented

Agency Actions – DOI has taken action to establish a process to ensure staff maintain logs for all payments mailed to the Division, including receipt logs in reconciliations. DOI revised its existing Accounting Policy and Procedure Manual on December 15, 2021 and its Revenue Management Desk Procedure on September 20, 2021 to incorporate changes made to the division's revenues and accounts receivable process. DOI reports it conducts a daily reconciliation of all revenues received between the following systems and documentation: DOI's bank accounts; daily check log; vendor transaction reports; DOI's licensing database, Sircon for States (SFS); and the state's accounting system.

DOI uses the daily check log to: record all paper payments received; verify receipting and depositing; and support DOI's internal deposit report. The internal deposit report is reviewed daily by a person not involved in the receipting and depositing process.

The Department of Business and Industry's (B&I) Fiscal Services Unit (FSU) is responsible for entering the receipt into the state's accounting system. After the transaction is recorded to the state's accounting system, DOI staff reconciles the deposit to the state's accounting system to ensure all funds received have been properly coded and entered.

Auditor Comment – DOI's processes do not provide for adequate segregation of duties in the revenue and accounts receivable process and do not document elements required to determine individuals performing key controls. To determine the implementation status of Recommendations 1 and 2, the Division of Internal Audits (DIA) reviewed the following documentation:

- DOI's revised Accounting Policy and Procedure Manual, Revenue Management Desk Procedure, Invoicing Procedure Manual, and Check Log Process (P&P);
- SFS Revenue Billing and Revenue Management user security roles;
- Five deposits made December 13, 2021 through December 17, 2021 and supporting documentation as evidence of implementation of DOI P&P.[2]

Review revealed that although DOI P&P segregate billing and receiving revenues between two positions, these positions act as back-up to each other and have the same SFS user access roles allowing them to perform invoicing, receiving payments, and recording payments to accounts in SFS. The position responsible for reviewing deposit documentation prior to submitting to B&I FSU may act as back-up to these two positions.

[2] Each deposit included: DOI's internal report generated at the division-level that included all information necessary to adequately account for the funds received; DOI's external report submitted to B&I's FSU with sensitive information removed or redacted; and screen-shots of transaction detail from DAWN.

Additionally, the position responsible for tracking receipt of payments in DOI's check log is also responsible for making and reconciling deposits.

Deposit support does not include evidence of the individual who made the deposit, only that the deposit was reviewed. Because the two positions and the reviewer may act as back-up to each other in the billing and receipts processes, DIA could not determine if these deposits were also prepared by the reviewer.

Full implementation of both recommendations is dependent upon segregation of duties between: billing, receiving, recording, depositing, and approving revenue transactions. These duties must also be segregated between user roles in the SFS system.

Recommendation 3

Implement controls to include managerial approval and oversight of edits to financial records.

Status – Partially Implemented

Agency Actions – DOI has taken action to implement controls to include managerial approval and oversight of edits to financial records. DOI revised SFS system user security roles for revenue tracking to ensure only certain positions may modify an invoice following managerial approval by the Chief Deputy Commissioner.

Auditor Comment – DOI's Accounting Policy and Procedure Manual (manual) does not include adequate controls for managerial approval and oversight of edits to financial records. DIA reviewed: the DOI manual; duties assigned to SFS security roles for revenue billing and revenue management; and DOI staff and assigned SFS security roles.

DIA found the Chief Deputy Commissioner may act as both the approver and the position responsible for recording edits to financial records, as documented in manual, duties associated with SFS security roles, and roles associated with the Chief Deputy Commissioner. Full implementation is dependent upon segregating these duties between the approver and the individual recording the edits.

Recommendation 4

Revise policies and procedures regarding the assessment, collection, and tracking of late fees across all income sources to ensure consistent and timely application and adherence to statutes and regulations.

Status – No Action

Agency Actions – DOI has not revised policies and procedures regarding the assessment, collection, and tracking of late fees across all income sources to ensure consistent and timely application and adherence to statutes and regulations. DOI reported it has

procedures to monitor past due invoices and to assess late fees when permitted by law as detailed in a list provided to support implementation of the recommendation. Fees associated with late business license renewals are automatically assessed in SFS. DOI procedures address late fees for renewals, the Administration and Enforcement assessment, and the Fraud assessment.

Auditor Comment – Review of DOI policies and procedures show DOI has not revised policies and procedures regarding the assessment, collection, and tracking of late fees across all income sources. DOI policies and procedures do not address specific fees associated with revenue streams or how the fees are calculated, such as the producer reinstatement penalty assessed at twice all applicable renewal fees plus an additional $250 penalty. Full implementation is dependent upon revision of existing policies and procedures to include fees assessed for across all income sources.

Recommendation 5

Develop policies, procedures, and controls to ensure the safe handling and storage of all personally identifiable information including, but not limited to:

a. *Limiting staff access to personally identifiable information.*
b. *Ensuring electronic transmissions containing personally identifiable information are done by a secure method.*
c. *Ensuring personally identifiable information is properly secured in current and future information systems.*
d. *Not using a Social Security number as a primary identifier, whenever possible.*

Status – Partially Implemented

Agency Actions – DOI has taken action to develop policies, procedures, and controls to ensure the safe handling and storage of all personally identifiable information. Prior to the issuance of the audit report, DOI took steps to limit staff access to personally identifiable information (PII), such as: masking PII in the division database; redacting sensitive information in policies and procedures; and working with the database vendor to ensure PII is masked in accounting reports going forward. DOI took the following additional actions to implement the recommendation: adopted a policy regarding the use and protection of PII; limited access to social security numbers (SSN) in SFS using security roles; uses a secure email system when transmission of SSNs is required; limits access to electronic records through security roles assigned by the IT Professional; and avoids using an SSN as a primary identifier when possible.

Auditor Comments – DOI reports the accounting team uses PII if research is needed and no other identifiers are available, including SSNs to identify payors. SSNs are still visible in the SFS Vertafore batch reports included in internal deposit and account reconciliation records. DOI made a request to Sircon to revise the batch reports; however, Sircon indicated the requested revision is not scheduled in its current product road map.

Although batch reports included in internal deposit and account reconciliation records contained manually masked SSNs, review of documentation for Recommendations 1 and 2 indicates there is not adequate segregation of duties and a lack of documentation of the individuals performing the tasks. Inadequate segregation of duties and lack of review could lead to accidental disclosure of SSNs if information is not manually masked prior to report generation and electronic storage.

Because Sircon does not intend to mask SSNs in Vertafore batch reports, full implementation is dependent upon using compensating controls and implementing Recommendations 1 and 2 to ensure protection of PII in the reports.

Recommendation 6

Develop a program for continued oversight of bail agencies including updating policies, procedures, and timelines regarding follow-up activities.

Status – Partially Implemented

Agency Actions – DOI hast taken action to develop a program for continued oversight of bail agencies including updating policies, procedures, and timelines regarding follow-up activities. DOI reports it regulates the bail industry through the available regulatory avenues set forth in NRS Title 57. DOI states this recommendation pertains to a specific project it undertook to review its internal processes and to educate bail licensees regarding the statutes and regulations that apply to the industry (bail project). DOI reports it commenced promulgating amendments to the regulations governing bail agencies, which were submitted to Legislative Counsel in January 2020. These regulations have not yet been returned to DOI for adoption. In the meantime, DOI developed a timeline and narrative to continue the bail project.

Auditor Comments – DOI has not developed updated policies and procedures regarding follow-up activities for continued oversight of bail agencies. Full implementation is dependent on development of a program for continued oversight of bail agencies and revision of policies and procedures to document program activities.

Recommendation 7

Impose penalties in accordance with statute for continued noncompliance.

Status – No Action

Agency Actions – DOI has not imposed penalties in accordance with statues for continued noncompliance. DOI reports it continues to take administrative actions against bail licensees for violations of law, including violations where a consumer has been harmed. DOI states it will continue to proceed with such actions to the extent it has sufficient evidence and legal authority to proceed with administrative action and impose penalties.

Auditor Comments – Audit findings indicate DOI did not follow up with agencies to ensure corrective action, nor did it have a program to impose fines for continued noncompliance although it has authority to do so. Information reviewed for Recommendation 6 and DOI's response for Recommendation 7 indicate DOI has not taken action other than to rely on existing enforcement activities for imposing penalties for bail agencies' continued noncompliance. Full implementation requires development of a program for continued oversight of bail agencies and imposition of penalties in accordance with statute for continued noncompliance.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Yvanna Concela, Chief of Staff, Office of the Governor
Terry Reynolds, Director, Department of Business and Industry
Budd Milazzo, Deputy Director, Department of Business and Industry
Barbara D. Richardson, Insurance Commissioner, Division of Insurance
Stephanie B. McGee, Chief Deputy Commissioner, Division of Insurance
Warren Lowman, Administrator, Division of Internal Audits

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March 11, 2022

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In May 2021, we issued an audit report on the Division of Insurance (Division) of the Department of Business and Industry. The Division filed its plan for corrective action in August 2021. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the seven recommendations contained in the audit report. As of February 9, 2022, the Office of Finance indicated five recommendations were partially implemented and two recommendations had no action. The recommendations and status are shown below.

	Recommendation	Status
Recommendation No. 1	Develop comprehensive policies and procedures to perform monthly reconciliations between the state accounting system and the Division bank account, database, and receipt logs.	Partially Implemented
Recommendation No. 2	Establish a process to ensure staff maintain logs for all payments mailed to the Division. Include receipt logs in reconciliations.	Partially Implemented
Recommendation No. 3	Implement controls to include managerial approval and oversight of edits to financial records.	Partially Implemented
Recommendation No. 4	Revise policies and procedures regarding the assessment, collection, and tracking of late fees across all income sources to ensure consistent and timely application and adherence to statutes and regulations.	No Action
Recommendation No. 5	Develop policies and procedures, and controls to ensure the safe handling and storage of all personally identifiable information including, but not limited to: a. Limiting staff access to personally identifiable information. b. Ensuring electronic transmission containing personally identifiable information are done by a secure method. c. Ensuring personally identifiable information is properly secure in current and future information systems. d. Not using a Social Security number as a primary identifier, whenever possible.	Partially Implemented

Recommendation No. 6	Develop a program for continued oversight of bail agencies including updating policies, procedures, and timelines regarding follow-up activities.	Partially Implemented
Recommendation No. 7	Impose penalties in accordance with statute for continued noncompliance.	No Action

In February 2022, we discussed the status of the seven recommendations with Division management and reviewed relevant documentation. Our review indicated the Division has now fully implemented Recommendation No. 5 regarding the handling and storage of personally identifiable information. We have the following questions for the Division:

Questions

1. What progress have you made toward fully implementing the remaining six recommendations?

2. What is your timeline for full implementation?

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:smy
cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Susan Brown, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
Terry Reynolds, Director, Department of Business and Industry (B&I)
Budd Milazzo, Deputy Director, B&I
Barbara D. Richardson, Insurance Commissioner, Division of Insurance, B&I
Stephanie B. McGee, Chief Deputy Commissioner, Division of Insurance, B&I

Human Services

Audit Highlights

Highlights of performance audit report on the Employment Security Division released on March 29, 2021.

Legislative Auditor report # LA22-05.

Background

The Employment Security Division (Division) is a division of the Department of Employment, Training and Rehabilitation. The 1937 Nevada State Legislature enacted the Unemployment Compensation Law requiring the compulsory setting aside of financial reserves to provide temporary partial replacement of income to unemployed workers. The Division's mission is to empower a vibrant labor market in Nevada by creating business and worker connections with high-quality demand-driven services.

The Division is responsible for the administration of the Unemployment Insurance program and numerous state and federally funded workforce investment programs that seek to connect employers with a skilled and qualified workforce.

In fiscal year 2019, the Division had three budget accounts with revenues and expenditures of over $93 million. The Division is primarily funded through federal grants and allowances, which amounted to 69.5% of revenues in fiscal year 2019. The Division headquarters is located in Carson City, with a Southern Nevada office in Las Vegas and career centers located in Elko, Ely, Fallon, Henderson, North Las Vegas, Reno, Sparks, and Winnemucca.

Purpose of Audit

The purpose of this audit was to evaluate certain controls over the collection of unemployment taxes from employers. The scope of our audit included a review of tax overpayments and refunds during calendar years 2018 and 2019. We also reviewed past due state unemployment tax receivables as of November 30, 2018, and related collection activities during prior periods.

Audit Recommendations

This audit report contains 11 recommendations to improve administrative controls over overpayment activities and collection of delinquent state unemployment taxes.

The Division accepted the 11 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 22, 2021. In addition, the 6-month report on the status of audit recommendations is due on December 22, 2021.

Employment Security Division

Department of Employment, Training and Rehabilitation

Summary

The Employment Security Division (Division) did not effectively administer certain aspects of Nevada's state unemployment taxes (SUTA) from employers. Employer accounts with overpayments totaling over $25 million are being treated inconsistently, with some overpayments rolling forward and others being removed from accounts after 3 years. Additionally, the Division could improve collection of past due SUTA from employers. We found Division collection activities were often untimely and monthly collection reports were incomplete, incorrect, or not used effectively. Furthermore, the Division does not always document collection activities completed on accounts and does not use the Debt Offset Program to assist in the collection of delinquent SUTA. With over $26 million in outstanding SUTA as of November 2018, enhancements to the Division's collection process should be made.

Key Findings

The Division's refund practices result in inequitable refund conditions for Nevada employers. The UINV system expires some account overpayments after 3 years, consistent with statute and previous processes, while others roll forward each quarter. Active employer accounts are not subject to credit expiration and employers may be allowed to use or request a refund indefinitely, even though statute requires refunds be requested by employers no later than 3 years after the overpayment was made. The Division did not process overpayments in this manner until the UINV system was implemented. In October 2018, almost 17,000 employer accounts had over $25 million in overpayments. (page 6)

The Division can improve the effectiveness of its operations and administrative controls over the collection of accounts receivable. Collection activities on delinquent SUTA employer accounts were not always performed, and sometimes the Division did not perform any collection activities when employers failed to pay taxes due. As of November 2018, there were over $26 million in outstanding SUTA due from over 10,000 employer accounts. (page 7)

The Division has not established guidelines for the timing of collection activities, other than system generated employer billing statements. Standard collection activities include sending billing statements, conducting warning calls, issuing pre-demand and demand letters, entering into payment agreements, and generating judgements and notices to withhold. Inconsistent and inadequate collection processes lead to a wide variation between accounts as to when collection activities occur. Inconsistent collection activity persists because the Division has not determined which collection activities are most successful nor does it prioritize accounts based on payment history, industry, amount, age, or account type, to maximize limited resources. (page 9)

Reports used by the Division's collection unit are not always complete, which delays recoveries. System support staff were not aware of report deficiencies to correct the errors. Additionally, an accounts receivable aging report is not generated by the UINV system. If reports used by the Division are not accurate or reliable, employer accounts may not be detected, collection activities may not begin timely, and delinquent accounts may remain deficient indefinitely. (page 13)

Collection documents are not consistently scanned into UINV by the Division. UINV is the system of record and should be used to track completed collection activities. However, we found documents were often not in the system because policies and procedures have not been properly developed to ensure collections activities are completely documented. (page 14)

The Division is not using the statutorily authorized Debt Offset Program offered by the State Controller to assist in the collection of delinquent SUTA. Debts can be submitted to the Controller exclusively for the offset program. If the Division does not utilize all the collection tools available to it, the probability of collecting delinquent SUTA decreases. (page 15)

Employer accounts with returned billing statements that do not have forwarding addresses are not placed on account hold by the Division. The Division sends approximately 25,000 monthly statements to all employers with any non-zero balance on their account. Account holds suspend mail notifications including monthly statements. This would eliminate mailing of undeliverable statements and reduce some postage costs. (page 15)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: December 22, 2021

Subject: Legislative Audit of the Department of Employment, Training, and Rehabilitation – Employment Security Division.

On March 29, 2021, your office released an audit report (LA 22-05) on the Department of Employment, Training, and Rehabilitation (DETR), Employment Security Division (ESD). ESD subsequently filed a corrective action plan on June 16, 2021. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by ESD to comply with audit findings.

There were eleven recommendations contained in the report. The extent of ESD's compliance with the audit recommendations is as follows:

Recommendation 1

Consult with legal counsel regarding the perpetual roll forward of overpayments and clarify whether current practice complies with statute.

Status – Fully Implemented

Agency Actions – ESD consulted with legal counsel regarding the perpetual roll forward of overpayments and clarified whether current practice complies with statute. Senate Bill 75 was enacted during the 2021 legislative session to amend NRS 612.655 by removing the three-year limitation on refunds of overpayments. The legislation took effect July 1, 2021, thereby altering the legal criteria for rolling forward overpayments. Staff received training on the new refund process prior to the law taking effect. ESD updated its refund policy and procedure on October 15, 2021.

Recommendation 2

Ensure the UINV system administers overpayments consistently across employer account types in accordance with NRS 612.655.

Status – Fully Implemented

Agency Actions – ESD is ensuring the UINV system administers overpayments consistently across employer account types in accordance with NRS 612.655. Overpayment credit balances are no longer purged after three years for inactive accounts in accordance with changes to statute effective July 1, 2021, which removed the three-year limitation on refunds of overpayments. DETR's IT System Administrator disabled ESD's ability to purge overpayments on June 17, 2021, prior to the amended law taking effect.

Recommendation 3

Enhance the notification process of overpayments to employers on billing statements including actions required by employers to apply credits or request refunds.

Status – Fully Implemented

Agency Actions – ESD enhanced the notification process of overpayments to employers on billing statements including actions required by employers to apply credits or request refunds. ESD updated the billing statement to advise employers that overpayment credits may be applied to future balances or refunded. The billing statement lists the actions required for employers to request a refund for overpayment. Additionally, ESD created the Refund Request Form and made it available on ESD's website to help employers seek refunds entitled to them after amendments to NRS 612.655 removed the three-year refund limitation effective July 1, 2021.

Recommendation 4

Develop policies and procedures prioritizing debts and establish timelines for specific collection activities.

Status – Fully Implemented

Agency Actions – ESD developed policies and procedures prioritizing debts and established timelines for specific collection activities. ESD updated the procedure for initiating collection activities against debtors to include a three-day timeline for contacting debtors with balances exceeding $10,000 and a 30-day timeline for contacting all other debtors.

Recommendation 5

Establish written policies and procedures for payment agreements to specify which employers qualify for plans and the number of defaults allowed before initiating the next level of collection activity.

Status – Partially Implemented

Agency Actions – ESD has taken action to establish written policies and procedures for payment agreements to specify which employers qualify for plans and the number of defaults allowed before initiating the next level of collection activity. The updated policies and procedures for payment agreements include the negotiation of payment plans backed by the filing of summary judgments.

Auditor Comment – The updated policy and procedure for payment agreements does not specify the number of defaults allowed before initiating the next level of collection activity and the course of action to be taken when default occurs. The policy broadly addresses which employers qualify for payment agreements but does not specify when other collection tools must be employed to escalate collection activity.

Recommendation 6

Work with system support staff to correct erroneous collection reports.

Status – No Action

Agency Comments – ESD reports it identified the preliminary need to have collections processes functioning correctly within the operating system to eliminate erroneous collection reports. ESD reports it plans to work with IT staff to develop functional requirements for a Request for Proposal creating the new IT system. Anticipated implementation of the new IT system is unknown.

Recommendation 7

Create an aged account receivables report.

Status – No Action

Agency Comments – ESD reports deficiencies still exist within the aged accounts receivables report. ESD reports the current IT system is incapable of creating an aged accounts receivables report that accurately captures all receivables data the audit recommends and meets the requirements of the U.S. Department of Labor. ESD will work with IT staff to develop functional requirements for a Request for Proposal creating a new IT system to produce the necessary report. Anticipated implementation of the new IT system is unknown.

Recommendation 8

Utilize the non-filers report to assist in prioritizing accounts and collection activities.

Status – No Action

Agency Comments – ESD reports the state unemployment taxes non-filers report is not utilized to assist in prioritizing accounts and collection activities due to the absence of payment-related information. ESD reports it will instead implement an IT system-dependent solution to capture the necessary information to make the non-filers report useful. ESD will work with IT staff to develop functional requirements for a Request for Proposals creating a new IT system to produce the necessary information on the non-filers report. Anticipated implementation of the new IT system is unknown.

Auditor Comment – The state unemployment taxes non-filers report lists employers that did not file a return rather than employers that did not pay taxes. Tax liabilities still exist regardless of whether employers file tax returns. The audit recommends utilizing the non-filers report because delinquent employers who failed to file tax returns do not always show on accounts receivable reports because accounts do not show a balance due.

Recommendation 9

Establish formal policies and procedures for recording collection activities in the UINV system. Include procedures for documenting the collection process in system notes and scanning collection documents.

Status – Fully Implemented

Agency Actions – ESD established formal policies and procedures for recording collection activities in the UINV system. The procedures include documenting the collection process in system notes and scanning collection documents. ESD tax examiners use the Managed Notes screen to record collection activities in the UINV system. The notes are updated throughout the collection process to record information such as the issuance of a demand letter, filing of judgment, and Notice of Entry of Judgment. Additionally, the policy and procedure for scanning collection documents was updated July 1, 2021 to reflect the imaging and indexing processes performed by the Work Distribution Center and staff were trained on the new process.

Recommendation 10

Develop policies and procedures to identify employers with delinquent accounts who are current state vendors and use the Controller's Debt Offset Program for possible payment interception.

Status – Partially Implemented

Agency Comments – ESD has not developed policies and procedures to identify employers with delinquent accounts who are current state vendors and has not used the Controller's Debt Offset Program for possible payment interception. ESD requested a payment interception memorandum of understanding from the State Controller's Office to identify employers with delinquent accounts who are current state vendors. ESD reports policies and procedures for identifying employers with delinquent accounts will be updated upon execution of the agreement. Anticipated implementation of the recommendation is unknown.

Recommendation 11

Develop a process to identify and correct address errors, and establish account holds when otherwise applicable.

Status – Fully Implemented

Agency Comments – ESD developed a process to identify and correct address errors, and establish account holds when otherwise applicable. Returned billing statements are now used to place account holds on employers with erroneous addresses when an updated address cannot be obtained. Additionally, ESD instituted a policy of making billing statements available electronically and changed the frequency of mailing statements from monthly to quarterly to further reduce postage costs. The updated policy and new procedure were added to ESD's desk manual and staff were trained on the new process.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Elisa Cafferata, Director, Department of Employment, Training, and Rehabilitation
Lynda Parven, Administrator, Employment Security Division
Warren Lowman, Administrator, Division of Internal Audits

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March 11, 2022

Members of the Audit Subcommittee
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In March 2021, we issued an audit report on the Employment Security Division (Division) of the Department of Employment, Training and Rehabilitation. The Division filed its plan for corrective action in June 2021. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the 11 recommendations contained in the audit report. As of December 22, 2021, the Office of Finance indicated 6 recommendations were fully implemented, 2 recommendations were partially implemented, and 3 had no action taken. The partially implemented and no action recommendations are shown below.

	Recommendation	Status
Recommendation No. 5	Establish written policies and procedures for payment agreements to specify which employers qualify for plans and the number of defaults allowed before initiating the next level of collection activity.	Partially Implemented
Recommendation No. 6	Work with system support staff to correct erroneous collection reports.	No Action
Recommendation No. 7	Create an aged account receivables report.	No Action
Recommendation No. 8	Utilize the non-filers report to assist in prioritizing accounts and collection efforts.	No Action
Recommendation No. 10	Develop policies and procedures to identify employers with delinquent accounts who are current state vendors and use the Controller's Debt Offset Program for possible payment interception.	Partially Implemented

Payment Agreements

For Recommendation No. 5, the Office of Finance indicated the Division took some action to establish written policies for payment agreements, but policies did not specify the number of defaults allowed before initiating additional collection activity or the course of action to be taken when a default occurs. Our audit found nearly almost half of accounts with payment agreements showed multiple plans or significant contact and resources expended to contact employers who did not comply or were uncooperative.

Question

1. Why hasn't the Division developed and adopted policies over payment agreement defaults?

Utilizing the Controller's Debt Offset Program

For Recommendation No. 10, the Office of Finance indicated the Division has not developed policies and procedures to identify and intercept payments for employers with delinquent accounts who are also state vendors. Nevertheless, ESD has requested a memorandum of understanding with the State Controller's Office and is waiting until that agreement is executed prior to developing policies and procedures. Our audit found that some employers with past due accounts were also state vendors and offsets could be beneficial.

Questions

2. Has the Division contacted the Controller's Office and inquired about an estimated completion date for the memorandum of understanding?

3. When does the Division expect to modify policies and procedures for executing debt offsets?

Recommendations with No Action Taken

The Division stated no action was taken on Recommendation Nos. 6, 7, and 8 as it anticipates developing a new IT system in the future. These functions would be encapsulated in the Request for Proposal of the new system and therefore, no action has been, or would be taken on these recommendations until implementation of the system.

However, the Office of Finance questioned whether action on Recommendation No. 8 should be deferred for a new system as the Division could utilize the current non-filers report. Our audit indicated the non-filer report can be utilized to proactively engage in early collection efforts as tax liabilities typically exist regardless of whether employers file tax returns.

Currently, the non-filers report is not provided to the collections unit, but is generated by the current system.

Question

4. Why doesn't the Division utilize the current non-filers report as proactively as possible?

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:smy
cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Susan Brown, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
Elisa Cafferata, Director, Department of Employment, Training, and Rehabilitation (DETR)
Lynda Parven, Administrator, Employment Security Division, DETR

Audit Highlights

Highlights of performance audit report on the Department of Employment, Training and Rehabilitation, Rehabilitation Division issued on January 12, 2023.

Legislative Auditor report # LA24-02.

Background

The Rehabilitation Division's (Division) mission is to promote barrier-free communities in which individuals with disabilities have access to opportunities for competitive, integrated employment, and self-sufficiency. Services include assessments, training, treatment, and job placement.

Adult Vocational Rehabilitation (VR) enables individuals with disabilities the opportunity to obtain meaningful competitive integrated employment. In 2014, the Division began expanding services to assist youth with disabilities overcome barriers and facilitate a successful transition into the workforce or post-secondary education.

The Division is primarily funded by General Fund appropriations and federal grants. Total revenue for fiscal year 2022 amounted to nearly $43.3 million. Expenditures from the same time were approximately $39.7 million. The Division provides services from 13 locations throughout the State.

Purpose of Audit

The purpose of the audit was to analyze whether the Division is performing sufficient outreach for the Pre-Employment Transition Services youth program and to determine if certain activities related to the approval and oversight of adult Vocational Rehabilitation programs are adequately monitored and approved.

The audit focused on the Division's activities related to adult and youth services in fiscal years 2020 and 2021. We also reviewed prior years' documentation back to 2009 to understand the entirety of services rendered on specific cases.

Audit Recommendations

This audit report contains eight recommendations to improve program planning and communication and enhance managerial oversight.

The Rehabilitation Division accepted the eight recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Rehabilitation Division

Department of Employment, Training and Rehabilitation

Summary

The Division lacks the necessary processes to adequately implement the Pre-Employment Transition Services (Pre-ETS) youth program. For example, the Division fell short of meeting youth spending requirements by an average of 5% since 2018 which may result in fewer funds available for adult services. Insufficient planning also left the Division unable to ensure program and financial requirements were met. As a result, youth with disabilities in rural communities lacked equitable access to resources as students in three rural school districts did not receive any Pre-ETS services, and nine others had minimal access to services. Additionally, some school districts indicated communication and Division responsiveness has been lacking. Finally, the Division does not keep adequate records for youth services. Without adequate program planning, increased communication, and data tracking, the Division is not able to maximize funding available, and youth with disabilities are not receiving necessary services.

The Division does not have strong oversight and outreach controls over the administration of VR services. Counselors did not review an average of 41% of open cases in accordance with grant requirements in fiscal years 2020 and 2021. Additionally, Individualized Plans of Employment (IPE) costs exceeded plan amounts without adequate approval in 56% of cases reviewed. Weak controls also may allow for the misuse of services by elderly clients to obtain hearing aids without an intention to work. Finally, the Division should improve outreach to underserved populations.

Key Findings

The Division is out of compliance with grant spending requirements. To bring spending into compliance, the Division would need to spend an average of $814,000 more per year on Pre-ETS services or decrease adult services by an average of $5.4 million per year. (page 7)

The Division has not adequately developed a service plan for Pre-ETS program delivery. Additionally, a lack of adequate program planning has impacted the distribution and quality of services rendered among Nevada counties. (page 8)

Some rural communities have limited, if any, services for youth, while others have more established programs. Three rural counties with high schools did not receive any Pre-ETS services in either fiscal year 2020 or 2021. Although the remaining rural school districts had services, the primary service offered was a virtual job shadow. (page 9)

The Division can increase services through enhanced collaboration and communication. School district staff were not aware of the full range of services or funding, and many school district staff expressed challenges in working with the Division. (page 12)

The Division does not have policies and procedures over accurately tracking key data points for Pre-ETS program delivery. Invoices submitted by school districts totaled approximately $104,000 in fiscal year 2021; however, records in the Division's data management system totaled less than $37,000. (page 13)

Thirty-three of the 80 (41%) client cases tested did not contain documentation that the clients' employment plan was reviewed or updated annually. IPE costs also exceeded plan amounts without adequate approval. Nine of the 16 (56%) cases reviewed exceeded planned spending amounts, and cases reviewed did not obtain the required supervisory approval. These nine cases totaled $104,000 in additional spending over the level of supervisory approved amount. (page 15)

Division practices allowed elderly clients and vendors to potentially misuse services. Weak controls allowed elderly clients the opportunity to obtain hearing aids without providing documentation of employment. Further, the Division does not monitor vendors to prevent them from over referring clients to the Rehabilitation Division solely to receive services not covered by other means. (page 17)

Additional efforts are required to improve the equitability of services. Fewer Asian and Hispanic or Latino individuals obtained services when compared to the Nevada population. Additionally, Asian and Black or African American clients received less services when comparing the average cost per client. (page 17)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Audit Highlights

Highlights of performance audit report on the Division of Child and Family Services issued on May 4, 2022.

Legislative Auditor report # LA22-14.

Background

The Division of Child and Family Services' (Division) mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division provides or oversees a continuum of services to support children, parents, and caregivers. The continuum of services includes comprehensive case management, emergency shelter care, foster and relative care, group home care, respite care, residential treatment care, and independent living services.

When the Division identifies a child that is in need of protection due to abandonment or an unsafe home environment, the Division can remove the child from the home and place the child in licensed foster or unlicensed homes.

The Division is responsible for overseeing the home environment and care provided to children in state custody. The Division also provides supplemental payments to support additional needs regarding the care of children in licensed foster homes. Child welfare services are funded primarily by state and federal funds.

Purpose of Audit

The purpose of the audit was to determine if Division processes ensure foster care and other homes for children in state custody are adequate to ensure the safety and welfare of children. We also evaluated controls over certain payments supporting children and youth to ensure payments were accurate and appropriate. This audit included a review of the Division's activities for the 18-month period beginning July 1, 2020, through December 31, 2021. We also reviewed child and placement monitoring activities back to calendar year 2017.

Audit Recommendations

This audit report contains 10 recommendations to improve Division oversight of in-home providers who care for children in state custody.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on August 1, 2022. In addition, the 6-month report on the status of audit recommendations is due on February 1, 2023.

Assessment and Safety of Child Placements

Division of Child and Family Services

Summary

While overall we found the Division generally complied with requirements associated with child placements, some improvements can be made. Health, safety, and regulatory standards were not always followed for some providers that care for children in state custody. Additionally, there was no evidence that some required background checks and provider assessments were completed, and some inspections and subsequent corrective action of foster homes were not adequately documented. We also found unlicensed homes are not subjected to the same standards of licensed foster homes, but additional measures can help ensure the welfare of children placed in these homes. Improved oversight of child placement providers will assist the Division in ensuring the safety and welfare of children in state custody.

Foster care payments were accurately and appropriately administered by the Division. We reviewed a representative sample of foster care and specialized payments and found payments were made to verified youth placements at licensed facilities. Additionally, specialized payments were supported by corresponding documentation in the Division's records. Accurate and justified foster care payments support the financial health of the Division, the State, and foster care providers.

Key Findings

Child placement providers did not always comply with health, safety, and regulatory standards. Of 30 homes inspected, 10 or 33% of homes had health and/or safety deficiencies, and 79% of foster placements had at least 1 foster care regulatory violation. (page 7)

Four foster providers assessed did not comply with medication management requirements established in regulation. Foster care providers are required to maintain records detailing provided medication and the date and time administered. Homes evaluated included children on antipsychotic and anti-seizure medications. (page 10)

After conducting reviews of Division files for 11 unlicensed placements selected for inspection, we found the Division did not have evidence required background checks and home assessments were completed for some providers. There was no evidence of home inspection documentation for 27% and no evidence of background checks for 45% of unlicensed placement providers reviewed. In addition, some emergency placements lacked required Division safety assessments, including Emergency Placement Checklists (29%) and Confirming Safe Environment assessments (57%). (page 11)

We also found that the Division did not always complete home inspection documentation and ensure that all residents of foster homes received required health assessments. Fifty-eight percent (14 of 24) of foster home inspection documentation was incomplete, including 2 missing inspection checklists, 7 checklists with inspection criteria not completed, and 10 inspection checklists with missing or incomplete corrective action plans. Of the 24 foster homes, 5 homes (21%) did not have a tuberculosis test completed timely for all the adults in the home, and 1 foster home resident did not have any tuberculosis test on file. (page 12)

The Division has not established a written agreement with unlicensed providers who oversee children in state custody, and home inspection procedures for unlicensed providers are brief or poorly defined. Additionally, the Division does not provide documentation regarding expected home health and safety standards to unlicensed providers. The Division, children in state custody, and providers are at increased exposure to preventable risk due to inadequate oversight of unlicensed placements. (page 14)

Foster care payments were accurately and appropriately administered by the Division. We randomly selected 50 fiscal year 2021 foster care payments of 4,068 total claims and found payments were accurately calculated, payment records in Unified Nevada Information Technology for Youth (UNITY) agreed to the state accounting system, and special payments were supported by medical documentation. (page 18)

Joe Lombardo
Governor

Amy Stephenson
Director

Warren Lowman
Administrator

STATE OF NEVADA
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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Amy Stephenson, Director
Governor's Finance Office

Amy J. Stephenson

Date: February 1, 2023

Subject: Legislative Audit of the Department of Health and Human Services, Division of Child and Family Services

On May 4, 2022, your office released an audit report (LA 22-14) on the Department of Health and Human Services, Division of Child and Family Services (DCFS). The division subsequently filed a corrective action plan on August 1, 2022. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the division to comply with audit findings.

There were ten recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Communicate to licensed and unlicensed providers applicable health, safety, and regulatory deficiencies identified in this audit report. Periodically inform licensed and unlicensed providers of common deficiencies identified in Division home inspections.

Status – Partially Implemented

Agency Actions – DCFS is making progress to communicate to licensed and unlicensed providers applicable health, safety, and regulatory deficiencies identified, and periodically inform licensed and unlicensed providers of common deficiencies identified in Division home inspections. DCFS worked on developing a specific "Home Inspection Checklist" to be completed by DCFS staff and signed by the foster parent(s). The checklist would include the following: foster parent's household information; the type of inspection to be

completed (3-month, 6-month, 9-month, or 12-month); background check compliance; a listing of NRS and NAC home requirements; and, a notes section for DCFS to communicate with providers on deficiencies and any action plans with dates and a section to note actual dates of compliance.

DCFS also has a contract with Foster Kindship, approved by the Clerk of the Board of Examiners on 09/29/2022, to provide training for their foster parents. The scope of work for the contract is as follows: "...to provide the online five-week class series "Caring for Your Own" training to relative and fictive kin for the initial licensing process per NAC 424, requirements for licensure."

DCFS also reports it is in the process of developing an Unlicensed Packet, which will include a "Home Inspections Highlight Sheet" for a quick reference on NAC 424.360-Regulations for relative and fictive kin providers.

Full implementation is expected in March 2023.

Recommendation 2

Generate a list that is routinely updated of all unlicensed providers that care for children in state custody and their contact information.

Status – Partially Implemented

Agency Actions – DCFS is making progress to generate a list that is routinely updated of all unlicensed providers that care for children in state custody and their contact information. DCFS reports it is developing a formal procedure for the referral process for caseworkers to provide placements and enter the information into the licensing software.

Full implementation is expected in March 2023.

Recommendation 3

Enhance supervisory oversight to ensure staff routinely verify medication administration records are completed in accordance with Division policy and regulations.

Status – Partially Implemented

Agency Actions – DCFS is making progress to enhance supervisory oversight to ensure staff routinely verify medication administration records are completed in accordance with Division policy and regulations. DCFS reports it is developing and deploying brief training sessions for caseworkers, foster homes, and relative homes for placements. DCFS has identified the training program, Just in Time Training/USF, for caseworker and foster parents. Some of the trainings offered include: Record Keeping, Medication Management, and Prescription Information. Additionally, DCFS developed a Quality Child/Caregiver

Contact Field Guide checklist to provide a reference when conducting monthly child and caregiver contacts.

DCFS also reports they plan to provide training for foster homes to submit forms through the BINTI (licensing database); however, no action was taken.

Full implementation is expected in March 2023.

Recommendation 4

Improve the medication administration template for ease of use and understandability.

Status – Partially Implemented

Agency Comments – DCFS is making progress to improve the medication administration template for ease of use and understandability. DCFS reports it is reviewing and developing a simplified medication management form.

Full implementation is expected in March 2023.

Recommendation 5

Ensure supervisory oversight is performed and documented for unlicensed placements to ensure Emergency Placement Checklists, Confirming Safe Environment assessments, background checks, and home inspections are being completed timely.

Status – Partially Implemented

Agency Actions – DCFS is making progress to ensure supervisory oversight is performed and documented for unlicensed placements to ensure Emergency Placement Checklists, confirming Safe Environmental assessments, background checks, and home inspections are being completed timely. DCFS reports it is developing a standardized process for the Emergency Placements and "Confirming Safe Environment Present Danger" forms, as well as adding additional checks to the "Legal Unsafe Case Transfer Checklist."

Full implementation is expected in February 2023.

Recommendation 6

Ensure documented supervisory review routinely takes place of a sample of foster home inspection paperwork to verify completeness and confirm corrective action plans are issued and resolved.

Status – Fully Implemented

Agency Actions – DCFS ensured documented supervisory review routinely takes place of a sample of foster home inspection paperwork to verify completeness and confirm corrective action plans are issued and resolved. DCFS reports the BINTI system flags any missing information and the supervisor reviews all foster home inspections.

Auditor Comment – The auditor viewed the BINTI system and visually verified the flags for missing information; home inspection checklists were reviewed; and, e-mail documentation was reviewed showing supervisory review of the foster home documentation.

Recommendation 7

Comply with policy requiring tuberculosis testing completed timely and documented.

Status – Fully Implemented

Agency Actions – DCFS complied with policy requiring tuberculosis testing completed timely and documented. DCFS reports the BINTI system is able to track TB tests and send out notifications.

Auditor Comment – The auditor viewed the BINTI system and visually verified the TB tracking for the foster homes.

Recommendation 8

Establish a written agreement with unlicensed placement providers regarding rights and responsibilities for care of children in state custody. Ensure the agreement acknowledges the Division or its authorized representatives may perform home inspections.

Status – Partially Implemented

Agency Comments – DCFS is making progress to establish a written agreement with unlicensed placement providers regarding rights and responsibilities for care of children in state custody, and ensured the agreement acknowledges the Division or its authorized representatives may perform home inspections. DCFS reports that Rural Child Welfare will develop an acknowledgement of its agreement of placement for DCFS and its representatives to perform the necessary home visits and inspections.

Full implementation is expected in March 2023.

Recommendation 9

Create and implement an inspection checklist for unlicensed placements that is compared on a regular basis.

Status – Partially Implemented

Agency Actions – DCFS is making progress to create and implanted an inspection checklist for unlicensed placements that is compared on a regular basis. DCFS reports it is developing a "Home Inspection Checklist" to be completed by DCFS staff at initial contact, post transfer, and prior to any court proceeding for unlicensed placements. The checklist would be similar to the licensed placement checklist.

Full implementation is expected in March 2023.

Recommendation 10

Develop and provide documented health and safety standards to unlicensed providers upon child placement.

Status – Partially Implemented

Agency Actions – DCFS is making progress to develop and provide documented health and safety standards to unlicensed providers upon child placement. DCFS reports it is developing a "Relative/Fictive Kin" handbook which will include the following: ongoing responsibilities for providers, applicable contact information, safety standards for children, notification for access to their home by DCFS or its representatives, medical forms, and other pertinent information for the providers.

Full implementation is expected in March 2023.

The degree of ongoing compliance with these recommendations is the responsibility of the division.

cc: Ben Kieckhefer, Chief of Staff to Governor Sisolak
Richard Whitley, M.S., Director, Department of Health and Human Services (DHHS)
Cindy Pitlock, Administrator, Division of Child and Family Services
Kimberly Fahey, Audit Liaison, Director's Office, DHHS
Warren Lowman, Administrator, Division of Internal Audits

Audit Highlights

Highlights of performance audit report on the Division of Child and Family Services issued on March 22, 2022.

Legislative Auditor report # LA22-08.

Background

The Division of Child and Family Services (Division) was established in 1991. The Division's mission is to provide support and services to assist Nevada's children and families in reaching their full human potential. The Division recognizes that children, youth, and families thrive when they live in safe, permanent settings; experience a sense of sustainable emotional and physical wellbeing; and receive support to consistently make positive choices for family and the common good.

Child welfare and protective services functions in three regional services areas: northern, southern, and rural. The Division is responsible for Child Protective Services (CPS) activities and children in state custody in the rural service area, which includes all counties other than Washoe and Clark. Both the northern and southern service areas are state-supervised, county-administered child welfare delivery systems.

CPS receives reports from mandatory reporters and the public about alleged child maltreatment. Reports are assessed or screened for statements or allegations of child abuse and neglect. As part of its responsibilities to care for children in state custody, the Division supports the health of children by ensuring they receive necessary medical, dental, and mental health care.

Purpose of Audit

The purpose of the audit was to evaluate whether the Division adequately ensures the safety and welfare of children for certain Division activities, including maltreatment report response and the supervision of medical care of children in state custody. The audit included a review of the Division's activities for the 18-month period of January 1, 2019, to June 30, 2020, including previous years for case management activities.

Audit Recommendations

This audit report contains 11 recommendations to improve processing of maltreatment reports and oversight of health care services for children in state custody.

The Division accepted the 11 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 15, 2022. In addition, the 6-month report on the status of audit recommendations is due on December 15, 2022.

Management of Maltreatment Reports and Child Health

Division of Child and Family Services

Summary

The Division did not completely process certain maltreatment reports and was unaware that some reports lacked supervisory review. In addition, Division staff and management did not always employ adequate report recordkeeping practices and had the opportunity but did not complete necessary investigations in response to certain maltreatment reports. Furthermore, the Division does not assess comprehensive Medicaid claims of children in state custody to identify injuries or medical evaluations indicating potential abuse and neglect. Without effective management of maltreatment incidents and reports, children were exposed to increased risk of harm and neglect.

The Division was lacking in its monitoring of health care for children in state custody. For instance, the Division did not ensure children received required preventative health and dental care or that visits were properly documented in Unified Nevada Information Technology for Youth (UNITY). In addition, the Division's prescribed health care schedule for children in state custody was not updated to align with medical standards. When children do not receive required health care, they are at an increased risk of preventable illness. Maintaining complete records of health care for children in state custody facilitates continuity of care and supports the welfare of children.

Key Findings

Division management was unaware that certain maltreatment reports lacked complete supervisory review and were not processed according to statute and policy. Of over 4,800 rural reports received in calendar year 2019, 107 indicated a lack of supervisory review, which means the report was not completely processed. Unprocessed reports included serious allegations such as physical abuse, parental drug abuse, domestic violence, and child self-harm. Out of the 107 reports, 35 reports identifying alleged victims, perpetrators, and/or maltreatment incidents did not receive complete or timely supervisory review until we notified the Division of the oversight. We assessed all 107 reports and identified 18 in which the welfare of the children was potentially at immediate risk. We promptly notified the Division of these 18 reports. The Division confirmed these reports had not received proper oversight and assessed the safety of the children involved. (page 7)

The case histories associated with 11 of 107 maltreatment reports showed that children were exposed to additional risk of abuse and neglect because of inadequate or untimely report processing by the Division. The Division also delayed reporting alleged crimes of sexual abuse against children to law enforcement. (page 8)

The Division did not have adequate recordkeeping and record retention practices for certain maltreatment reports. Of 133 reports, 11 reports had inadequate report documentation. Examples of inadequate report documentation included insufficient or inaccurate documentation of alleged incidents, alleged perpetrators, alleged victims, or Division actions in response to reports. (page 8)

Some reports were deleted from UNITY even though those contained important incident-related information regarding alleged victims or instances of abuse and neglect. (page 9)

The Division had the opportunity but did not complete necessary investigations in response to allegations of abuse and neglect for 7 of 133 reports we assessed that were received in 2019. Reports not investigated by the Division included allegations of neglect, child abuse, inadequate shelter, failure to protect, threatened violence against a child, potential self-harm, and domestic violence. (page 10)

The Division does not analyze Medicaid claims of children in state custody for injuries or medical assessments indicative of abuse and neglect. Both state and federal entities have evidenced the child welfare benefits of utilizing Medicaid claims to identify potential incidents of child abuse and neglect. The Division was not aware of this best practice. (page 11)

Many children in state custody in 2019 did not receive required preventative health and dental care. A total of 29% of children did not receive annual preventative health care and 28% did not receive any dental care. (page 13)

For 159 of 198 (80%) children in state custody for all of 2019, the Division did not maintain complete health records in UNITY. Division policies are inadequate to ensure all health care records are obtained and entered into UNITY. (page 14)

The Division did not update timely its preventative health care schedule in policy for children in state custody to align with American Academy of Pediatrics recommendations. (page 15)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Steve Sisolak
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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Amy Stephenson, Director
Governor's Finance Office

Date: December 15, 2022

Subject: Legislative Audit of the Department of Health and Human Services, Division of Child and Family Services

On March 22, 2022, your office released an audit report (LA 22-08) on the Department of Health and Human Services, Division of Child and Family Services (DCFS). DCFS subsequently filed a corrective action plan on June 1, 2022. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DCFS to comply with audit findings.

There were eleven recommendations contained in the report. The extent of DCFS's compliance with the audit recommendations is as follows:

Recommendation 1

Implement staff training when changes to the UNITY system occur to ensure proper processing of maltreatment reports.

Status – Fully Implemented

Agency Actions – DCFS implemented staff training when changes to the UNITY system occured to ensure proper processing of maltreatment reports. The UNITY team now utilizes online training options as new and updated features are introduced. Staff are notified when impacted by UNITY rollouts. DIA reviewed the UNITY Referral to Report Disposition informing staff of upcoming UNITY changes and the impacts of the changes. DIA examined the UNITY Bulletin from January 2021 through October 2022 to ensure

that instructional guides were distributed to all DCFS employees and the contracted staff at the Crisis Call Center.

Recommendation 2

Develop and review a management report to ensure all maltreatment reports are timely and properly processed.

Status – Fully Implemented

Agency Actions – DCFS developed and reviews management reports to ensure all maltreatment reports are timely and properly processed. The reports are distributed monthly to the Rural Regional managers and supervisors. DCFS provided monthly reports since April 2022 that capture incomplete maltreatment data. DIA reviewed the reports and the report notifications sent to the intake supervisor for November 2022. DIA verified incomplete reports were flagged in the system and dispositioned to ensure maltreatment data was timely reported and properly processed.

Recommendation 3

Improve policies and management oversight controls to ensure critical information is documented in UNITY related to maltreatment reports.

Status – Fully Implemented

Agency Actions – DCFS improved policies and management oversight controls to ensure critical information is documented in UNITY related to maltreatment reports. Rural Regional managers are now required to review a random sample of referrals quarterly for compliance with updated policies and procedures. Intake Unit supervisors are required to review intake reports daily for minimum standards and timeliness and to instruct staff to follow-up for additional information. The Intake Policy was updated in May 2022 to identify the critical information that must be gathered and entered into UNITY at the time of intake for reports of maltreatment. The Intake Policy includes instructions for the Intake Unit to create a new case profile in UNITY and to search for participants that may also have history in other cases. Intake Procedures were distributed to staff in May 2022. DIA confirmed the quarterly review of referrals was completed for the first three calendar quarters of 2022.

Recommendation 4

Improve controls to prevent deletion of necessary maltreatment reports.

Status – Fully Implemented

Agency Actions – DCFS has improved controls to prevent deletion of necessary maltreatment reports. DCFS changed its IT process to preclude deletion of maltreatment

reports without two levels of approval. Reports may still be deleted with proper authorization and by submitting a DCFS Help Desk request. By default, maltreatment reports are marked as incomplete rather than being deleted from the system. DIA confirmed the Intake Procedures revised in September 2021 preclude maltreatment reports from being deleted from the UNITY system without authorization. DIA confirmed that incomplete reports in the system are now being flagged and captured on a system generated report that is reviewed by staff monthly.

Recommendation 5

Comply with policy and investigate maltreatment reports that meet established criteria.

Status – Fully Implemented

Agency Actions – DCFS has complied with policy and investigated maltreatment reports that meet established criteria. DCFS implemented a centralized intake hotline to improve consistency in the way reports are dispositioned across rural regions. Additionally, a random sample is taken, by region, of 'Information Only' intake referrals which are then reviewed by management for compliance with the established policy and procedure. Maltreatment reports that meet established criteria are investigated. DIA confirmed the quarterly review of 'Information Only' intake referrals was completed for the first three calendar quarters of 2022.

Recommendation 6

Implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Perform follow-up activities to ensure the welfare of children as necessary.

Status – No Action

Agency Actions – DCFS has not taken action to implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Follow-up activities have not been performed to ensure the welfare of children as necessary.

Auditor Comment – DCFS reports it plans to work with Medicaid, the Family Programs Office, and the Office of Analytics to identify ways to establish a link between Medicaid and UNITY to identify possible abuse and neglect for children in state custody. DCFS asserts that this recommendation is a high priority and will be implemented after Recommendation 10 is completed.

Recommendation 7

Provide training to ensure staff understand health care documentation requirements and the necessary health care for children in state custody.

Status – Fully Implemented

Agency Actions – DCFS provided training to ensure staff understand health care documentation requirements and the necessary health care for children in state custody. The training program was developed by the Rural Region Quality Assurance and Training Unit and includes virtual training for new employees and periodical refresher training for permanent employees, including managers and supervisors, to ensure staff understand health care documentation requirements. DCFS updated the statewide Health Services Policy in August 2021 to include the requirements. DIA reviewed the webinar developed to train employees on entering health care data and documentation into the UNITY system and examined the meeting schedule and list of attendees to ensure training was provided.

Recommendation 8

Improve policies by requiring a consistent frequency in which caseworkers and supervisors perform activities to monitor and obtain documentation regarding health care.

Status – Fully Implemented

Agency Actions – DCFS improved policies by requiring a consistent frequency in which caseworkers and supervisors perform activities to monitor and obtain documentation regarding health care. As of May 2021, supervisors are required to monitor compliance monthly using the Cognos report and follow up at the next consultation. DIA verified that Work Performance Standards for supervisors were updated in April 2022 to include monitoring health care data as part of case-specific consultations.

Recommendation 9

Ensure health care for children in state custody is documented in UNITY.

Status – Fully Implemented

Agency Actions – DCFS has ensured health care for children in state custody is documented in UNITY. The Health Services Policy established a process to track statewide compliance using a data collection report and notification system. Caseworkers now receive weekly notifications for due dates to identify, schedule, and attend an Early Periodic Screening Diagnostic and Treatment (EPSDT) appointment. Training to improve wellness and data outcomes for children in foster care was provided to staff. The training is designed to help staff independently run reports and accurately enter and monitor EPSDT appointments. DIA examined the report that tracks statewide compliance with the

Health Services Policy. The report indicates health care services for children in state custody have been documented in UNITY.

Recommendation 10

Complete a feasibility assessment of linking the Medicaid claims database to UNITY.

Status – No action

Agency Actions – DCFS has not taken action to complete a feasibility assessment of linking the Medicaid claims database to UNITY. DCFS reports the Family Program Office is in the process of locating funding and a vendor for a wide-scale feasibility study of all UNITY functions. DCFS asserts that providing improved linking functions between Medicaid and UNITY will allow Information Services to populate Medicaid health care information into the UNITY Health Passport.

Auditor Comment – DCFS reports it plans to work with Medicaid, the Family Programs Office, and the Office of Analytics to identify ways to locate grant funding to establish a link between Medicaid and UNITY. DCFS reports it will initiate an RFP to contract with a vendor to complete the project once funding is secured.

Recommendation 11

Revise Division policies and procedures to incorporate current American Academy of Pediatrics recommendations.

Status – Fully Implemented

Agency Actions – DCFS revised its policies and procedures to incorporate current American Academy of Pediatrics (AAP) recommendations. DCFS added a link to AAP's recommendations to the Health Services Policy. Processes are now in place for Family Programs Office specialists to timely review the AAP Periodicity schedule, exam reports, and DCFS case reports. DIA confirmed the policies and procedures include the expectations that youth will have an exam every year and staff will enter the exam into UNITY.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Cindy Pitlock, Administrator, Division of Child and Family Services
Warren Lowman, Administrator, Division of Internal Audits

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January 3, 2023

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In March 2022, we issued an audit report on the Division of Child and Family Services (Division) of the Department of Health and Human Services, Management of Maltreatment Reports and Child Health. The Division filed its plan for corrective action in June 2022. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the 11 recommendations contained in the audit report. As of December 15, 2022, the Office of Finance indicated nine recommendations were fully implemented and no action was taken on two recommendations. The recommendations with no action are shown below.

	Recommendation	Status
Recommendation No. 6	Implement a process to identify and assess Medicaid claims that indicate possible abuse and neglect for children in state custody. Perform follow-up activities to ensure the welfare of children as necessary.	No Action
Recommendation No. 10	Complete a feasibility assessment of linking the Medicaid claims database to UNITY.	No Action

For Recommendation No. 6, the Office of Finance indicated the Division plans to work with Medicaid, the Family Programs Office, and the Office of Analytics to identify ways to establish a link between Medicaid and Unified Nevada Information Technology for Youth (UNITY) to identify possible abuse and neglect for children in state custody. The Division asserted this recommendation is a high priority and will be implemented after Recommendation No. 10 is completed.

For Recommendation No. 10, the Office of Finance also indicated the Division plans to work with Medicaid, the Family Programs Office, and the Office of Analytics to identify ways to locate grant funding to establish a link between Medicaid and UNITY. The Division stated it will contract with a vendor to complete the project once funding is secured.

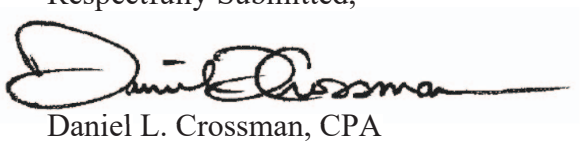
While a link between these two systems would be useful, we found it is not necessary in order to review medical claims for evidence of possible abuse and neglect. We obtained and reviewed claim data directly from Medicaid to complete our audit testing. Both state and federal entities have evidenced the child welfare benefits of utilizing Medicaid claims to identify potential incidents of child abuse and neglect.

Questions

1. Has the Division identified a source to fund programming changes to create a link between Medicaid and UNITY?

2. If funding is not identified, does the Division intend to obtain and review claim data of children in state custody to identify possible abuse or neglect?

Respectfully Submitted,



Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
cc: Ben Kieckhefer, Chief of Staff, Office of the Governor
Amy Stephenson, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services (DHHS)
Kimberly Fahey, Director's Office – Audit Liaison, DHHS
Cindy Pitlock, Administrator, Division of Child and Family Services, DHHS

Audit Highlights

Highlights of performance audit report on the Division of Health Care Financing and Policy issued on January 12, 2023.

Legislative Auditor report # LA24-01.

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada; 3) restrain the growth of health care costs; and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division administers both Nevada Medicaid and Check Up programs.

Managed Care Organizations (MCOs) are contracted with the Division to provide covered medical services to recipients currently living in urban Clark County and Washoe County. In calendar year 2021, the State had three MCOs that provided medical benefits and one dental benefit administrator. MCOs are paid a monthly risk-based capitated rate for each enrolled recipient. Approximately 75% of the state's Medicaid and Check Up population receive medical benefits through an MCO.

In fiscal year 2021, the Division was primarily funded with federal grants totaling $3.7 billion and state appropriations of about $873 million. As of May 25, 2022, the Division had 314 positions authorized of which 273 positions were filled, for a vacancy rate of 13%. The Division has offices located in Carson City, Elko, Las Vegas, and Reno.

Purpose of Audit

The purpose of the audit was to determine if the Division of Health Care Financing and Policy monitored certain activities related to Managed Care Organizations' enrolled participants and drug rebate payments.

Audit Recommendations

This audit report contains 10 recommendations to reduce improper MCO capitation payments and improve the collection of MCO supplemental drug rebates.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 10, 2023. In addition, the 6-month report on the status of audit recommendations is due on October 10, 2023.

Dual Enrollments and Supplemental Drug Rebates

Division of Health Care Financing and Policy

Summary

The Division does not have adequate processes in place to monitor certain MCO activities, which resulted in over $34 million in improper payments and uncollected funds. Specifically, the Division does not identify individuals concurrently enrolled in other states' Medicaid programs. Consequently, the Division made improper monthly capitation payments to MCOs because federal law does not allow an individual to be enrolled in more than one state. We conservatively estimate over $22.9 million in improper capitation payments were made during calendar years 2020 and 2021. In addition, the Division's lack of oversight related to MCOs' supplemental drug rebate payments resulted in $6.9 million dollars going uncollected for almost 2 years. Additionally, $4.2 million in rebates were invoiced to drug manufacturers by MCOs but not remitted to the State. Without action and effective oversight activities, improper capitation payments will continue and supplemental drug rebates will go uncollected.

Key Findings

The Division does not utilize available information to identify recipients enrolled in Medicaid in another state and to end related MCO capitation payments. Because payments are automatic and made each month regardless of actual medical services rendered, significant improper payments accrue when out-of-state recipients are not identified timely, and action is not taken to disenroll them from the MCO. We identified 7,092 individuals who were enrolled in a Nevada Medicaid MCO during calendar year 2020, and also enrolled in another state's Medicaid program. For 44 of 50 (88%) recipients randomly selected and tested from the population, we observed capitation payments continued an average of 12 months after the individual enrolled in another state's Medicaid program. As a result, we conservatively estimate MCOs received over $22.9 million in improper payments during calendar years 2020 and 2021. (page 6)

The Division's oversight of the supplemental drug rebate program is inadequate. During the 2019 Legislative Session, Senate Bill 378 was passed and included a provision that MCOs remit supplemental drug rebates to the State, less an administrative fee. This requirement went into effect on January 1, 2020. The Division issued a memorandum on March 27, 2019, to MCOs detailing the requirement to submit rebates less a 1% administrative fee at the end of each quarter. Despite issuing the memorandum, we found the Division took no additional action to collect or verify millions of dollars in supplemental drug rebates. While two MCOs remitted rebate payments to the State, one did not. After our inquiry to the Division on November 30, 2021, the MCO made a payment for $6.9 million in supplemental drug rebates owed. Neither the Division nor the MCO could explain why payment was not remitted, even though two other MCOs submitted supplemental drug rebate payments to the Division totaling over $7.4 million as of March 31, 2021. (page 10)

In addition, the Division did not obtain supporting documentation to ensure supplemental drug rebate payments made were accurate or timely. We requested supporting documentation and determined another $900,000 in drug rebates was collected by MCOs, but not remitted to the State. Furthermore, another $3.3 million in rebates was invoiced to drug manufactures by MCOs, but remains uncollected by the MCOs. The Division has not established formal policies and procedures over the collection and review of supplemental drug rebates, and the reconciliation of supplemental drug rebates invoiced, collected, and received by MCOs. (page 10)

The Division has not complied with requirements to audit certain MCO activities related to supplemental drug rebates. State law requires the Division perform an annual audit of each MCO, including an analysis of all claims processed to evaluate supplemental drug rebate compliance. Furthermore, MCOs are required to obtain an annual audit of internal controls to ensure the integrity of financial transactions and claims processing. The results of these audits must be posted on the Division's website. According to the Division, staff turnover impacted the Division's ability to perform and obtain audits. In addition, the Division does not have policies and procedures related to the auditing of supplemental drug rebates or internal controls. Without policies and procedures, Division staff will lack adequate guidance to ensure compliance with laws and contract provisions. (page 11)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Audit Highlights

Highlights of performance audit report on the Division of Health Care Financing and Policy, Information Security issued on March 22, 2022.

Legislative Auditor report # LA22-12.

Background

The mission of the Division of Health Care Financing and Policy (Division) is to: 1) purchase and provide quality health care services to low-income Nevadans in the most efficient manner, 2) promote equal access to health care at an affordable cost to the taxpayers of Nevada, 3) restrain the growth of health care costs, and 4) review Medicaid and other state health care programs to maximize potential federal revenue. The Division administers both Nevada Medicaid and Check Up programs.

The Medicaid Management Information System (MMIS) is a computerized claims processing and information retrieval system the Nevada Medicaid program must have to be eligible for federal funding.

In fiscal year 2021, the Division was primarily funded with federal grants totaling $3.7 billion and state appropriations of about $873 million. As of June 2021, the Division had 261 filled positions located in its Carson City, Elko, Las Vegas, and Reno offices. Eighteen of these positions are dedicated to information technology (IT) activities. One position leads the Business Process Management Unit; three support the Information Security Office; six support the Project Management Office; and eight provide support for the Division's systems, network, and help desk.

Purpose of Audit

The purpose of the audit was to determine if the Division of Health Care Financing and Policy has adequate controls to ensure user access controls protect its sensitive information and to monitor its MMIS change management process. The audit included the systems and practices in place during fiscal year 2021, and fiscal year 2020 for enhancement projects.

Audit Recommendations

This audit report includes six recommendations to improve information security access controls to users of the Medicaid Management Information System.

The Division accepted the six recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 15, 2022. In addition, the 6-month report on the status of audit recommendations is due on December 15, 2022.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Information Security

Division of Health Care Financing and Policy

Summary

The background investigation process at the Division can be strengthened. Specifically, non-Division state employees and Division IT contractors were given access to the Medicaid Management Information System without verifying or documenting a background check was completed. In addition, some fiscal agent employees' user accounts were enabled before the Division received background investigation information and authorized access. Finally, newly hired Division employees did not receive a preliminary background investigation or submit their background investigation packet before they were given access to MMIS. Background investigations help reduce the risk sensitive data will be accessed by disreputable individuals.

The Division does not actively manage MMIS user accounts. Specifically, the Division does not ensure MMIS access is still needed for non-Division state employees. In addition, the Division does not ensure that user accounts of former state employees and its fiscal agent are disabled timely. Finally, the Division does not ensure documentation used to authorize user MMIS access is complete or reviewed periodically. Accounts still valid after a user leaves an enterprise make it easier for an external or internal threat actor to gain unauthorized access to enterprise data using valid user credentials.

Key Findings

The Division did not verify or document background investigations were performed for non-Division state employees and Division IT contractors that were granted access to MMIS. For 84 non-Division employees, the Division did not verify background checks were performed. In addition, we randomly selected 7 of the Division's 13 IT contractors for testing. For four of seven (57%) contractors tested, the Division had no record a background investigation was conducted. (page 3)

Fiscal agent staff were given MMIS access before proper authorization. We identified 2 of 10 (20%) fiscal agent user accounts that were enabled in the system prior to the background investigation process being initiated and authorized by the Division. (page 4)

For all newly hired Division employees in fiscal year 2021, access was granted to MMIS prior to completing a preliminary or fingerprint background investigation. A preliminary background investigation consists of a national records check that provides detailed background information based on someone's name and Social Security number and can be performed before a more thorough fingerprint background check. (page 5)

The Division does not have a process to actively manage non-Division state employee user accounts and ensure system access is still needed. For 11 of 79 (14%) non-Division state employee MMIS user accounts tested, the employee had never logged into MMIS since being given access. Three accounts have remained enabled for over 2 years without any login activity. In addition, nine other employees have not logged into MMIS since before June 2021. One employee has not logged into the system for over 2.5 years. Instead of actively managing user accounts, the Division relies on other state agencies and the fiscal agent to notify them when access is no longer needed. (page 7)

During our testing of user accounts, we identified four non-Division state employees that ended state employment before June 30, 2021, while their user accounts remained active for months after they terminated employment with the State. In addition to state employees, we tested accounts of all seven fiscal agent users who were identified as terminated. One account was disabled the same day of termination while six remained enabled for several days to several months. (page 7)

The Division did not properly document system access authorization or documentation was inaccurate on the MMIS security access request forms. For 23 non-fiscal agent system access forms tested, we observed for some forms supervisor or information security officer approval was not documented, user roles were not documented, or approved user roles did not agree to user roles assigned in the system. In addition, the Division could not provide system access request forms for three users. (page 9)

The Division's MMIS enhancement process is effective in ensuring changes to the system are prioritized and completed. A documented change management plan is utilized and monitored. In addition, the Division monitors hours charged to individual projects. Proper management of this process helps ensure changes to the MMIS meet the needs of stakeholders and align with available resources. (page 11)

Audit Division
Legislative Counsel Bureau

Steve Sisolak
Governor

Amy Stephenson
Director

Warren Lowman
Administrator

STATE OF NEVADA
GOVERNOR'S FINANCE OFFICE
Division of Internal Audits

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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Amy Stephenson, Director
Governor's Finance Office

Date: December 15, 2022

Subject: Legislative Audit of the Department of Health and Human Services, Division of Health Care Financing and Policy

On March 22, 2022, your office released an audit report (LA 22-12) on the Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP). DHCFP subsequently filed a corrective action plan on June 15, 2022. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DHCFP to comply with audit findings.

There were six recommendations contained in the report. The extent of DHCFP's compliance with the audit recommendations is as follows:

Recommendation 1

Improve policies and procedures to ensure background investigations are performed and documented for Division IT contractors and employees of other state agencies prior to granting users access to MMIS.

Status – Fully Implemented

Agency Actions – DHCFP improved policies and procedures to ensure background investigations are performed and documented for IT contractors and employees of other state agencies prior to granting users access to MMIS. Effective July 1, 2022, the DHCFP security procedure for background investigations was updated to ensure background checks are completed prior to granting system access to contractors or other State

agencies. DIA reviewed the list of new hires and verified a sample for compliance with the revised policy.

Recommendation 2

Work with the fiscal agent to develop a process that will ensure background investigation packets and Division approval are received prior to creating user accounts in MMIS.

Status – Fully Implemented

Agency Actions – DHCFP worked with the fiscal agent to develop a process that will ensure background investigation packets and approval are received prior to creating user accounts in MMIS. DHCFP updated security procedures for background investigations of the fiscal agent's employees. Effective July 1, 2022, the updated procedures require background investigations to be completed for all fiscal agent employees prior to creating user accounts in MMIS. DHCFP required the fiscal agent to revise its security procedures to align with DHCFP's procedures. DIA reviewed the revised DHCFP and fiscal agent's policies and procedures. DIA obtained a list of all new fiscal agent employees and verified a sample for compliance with the revised policies and procedures.

Recommendation 3

Revise Division new hire policies and procedures to ensure a national records check is completed, or background investigation results are received prior to granting users access to MMIS.

Status – Fully Implemented

Agency Action – DHCFP revised new hire policies and procedures to ensure a national records check is completed, or background investigation results are received prior to granting users access to MMIS. Effective July 1, 2022, the DHCFP security procedure for background investigations was updated to ensure background checks are completed prior to granting system access to contractors or other state agencies. DHCFP revised new hire policies and procedures to include a national records check, no later than the first date of employment, to cover the period between the employee's first day of work and completion of federal and state investigations by the Department of Public Safety. DIA reviewed DHCFP's revised policies and examined a list of new hires to verify compliance with the updated policies.

Recommendation 4

Develop a policy and procedure requiring timely notification, by all entities with MMIS user accounts, of changes to user employment status or access needs.

Status – Fully Implemented

Agency Actions – DHCFP developed a policy and procedure requiring timely notification, by all entities with MMIS user accounts, of changes to user employment status or access needs. The updated policy and procedure requires that changes must be documented to the MMIS user accounts within 24 hours of a change in a user's employment status. DIA reviewed the revised policy and procedure, obtained a list of all terminated employees, and reviewed a sample for compliance with the revised policy.

Recommendation 5

Establish a process to review quarterly the status of all user accounts in MMIS, verify authorized roles, and to coordinate with other entities to identify unneeded accounts and disable access when no longer required.

Status – Fully Implemented

Agency Actions - DHCFP established a process to review quarterly the status of all user accounts in MMIS, verify authorized roles, and to coordinate with other entities to identify unneeded accounts and disable access when no longer required. DHCFP's quarterly review process is documented in policy. DIA verified the quarterly review was completed for the first quarter of fiscal year 2023.

Recommendation 6

Follow established procedures for MMIS account reconciliation with the properly completed SAR form on file and routinely review all user roles.

Status –Fully Implemented

Agency's action - DHCFP has followed established procedures for MMIS account reconciliation with the properly completed System Access Request (SAR) form on file and routinely reviews all user roles. The established procedures for MMIS account reconciliation have been updated and incorporated into DHCFP's Personnel Procedure. Human Resources staff or the employee's supervisor must initiate and approve the SAR then forward the SAR to IT for implementation. The procedures require both the IT supervisor and the initiating HR staff or the employee's supervisor to review and reconcile the user profile. DIA reviewed one recently completed SAR for compliance with the established procedures.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Suzanne Bierman, Administrator, Division of Health Care Financing and Policy
Warren Lowman, Administrator, Division of Internal Audits

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January 3, 2023

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In March 2022, we issued an audit report on the Division of Health Care Financing and Policy, Information Security (Division) of the Department of Health and Human Services. The Division filed its plan for corrective action in June 2022. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the six recommendations contained in the audit report. As of December 15, 2022, the Office of Finance indicated all recommendations were fully implemented. Therefore, we have no questions for agency officials.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
cc: Ben Kieckhefer, Chief of Staff, Office of the Governor
Amy Stephenson, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services (DHHS)
Kimberly Fahey, Director's Office – Audit Liaison, DHHS
Dr. Antonina Capurro, Deputy Administrator, Division of Health Care Financing and Policy (DHCFP), DHHS
Sandie Ruybalid, Deputy Administrator, DCHFP, DHHS
Stacie Weeks, Deputy Administrator, DHCFP, DHHS

Report Highlights

Highlights of Legislative Auditor report on the Governmental and Private Facilities for Children – Surveys, Observations, and Inspections issued on March 22, 2022.

Legislative Auditor Report # LA22-10.

Background

Nevada Revised Statutes (NRS) 218G.570 through 218G.595 authorize the Legislative Auditor to conduct audits of governmental facilities for children and reviews, inspections, and surveys of governmental and private facilities for children.

As of June 30, 2021, we had identified 59 governmental and private facilities that met the requirements of NRS 218G: 19 governmental and 40 private facilities. In addition, 57 Nevada children were placed in 10 different out-of-state facilities across 4 different states as of June 30, 2021.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2020, through June 30, 2021, we received 629 complaints from 28 facilities in Nevada. Thirty-one Nevada facilities reported that no complaints were filed during this time.

Purpose

Surveys, observations, and inspections were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our surveys and observations of 16 children's facilities and an inspection of 4 children's facilities. As surveys, observations, and inspections are not audits; these were not conducted in accordance with generally accepted government auditing standards, as outlined in *Government Auditing Standards* issued by the Comptroller General of the United States, or in accordance with the *Statements on Standards for Accounting and Review Services* issued by the American Institute of Certified Public Accountants.

The purpose of our surveys, observations, and inspections was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities, and whether the facilities respect the civil and other rights of the children in their care.

Surveys and inspections included discussions of select policies, procedures, and related issues with facility management. In addition, we reviewed youth and personnel files. Inspections also included observations of all areas accessible to children in the facility.

Governmental and Private Facilities for Children – Surveys, Observations, and Inspections

December 2021

Summary

In 15 of the 20 children's facilities surveyed, observed, and inspected, we did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at the five facilities listed below we observed conditions that caused us to question whether the facility adequately protected the children in its care. Based on our observations, we contacted the facilities' licensing agencies and communicated our concerns.

P6 Family Services, LLC

We noted health, safety, and welfare issues at two foster homes operated by P6 Family Services, LLC. Health issues included unsecured, incomplete, and inaccurate medication records. Safety issues included unsecured cleaning chemicals and fire escape routes were not posted. Welfare issues included: human feces in a child's bedding and on bedroom walls; mold in a children's bathroom; carpets were heavily stained; walls, baseboards, and children's bedrooms were in need of deep cleaning; and an occupied child's bedroom did not contain a bed. After our visit, Washoe County Human Services Agency closed one of P6's two homes. (page 6)

Tahoe House Family Services

We noted health, safety, and welfare issues at the Tahoe House Family Services' home. Health issues included incomplete and inaccurate medication records, and required medical documentation was missing. Safety issues included: unsecured tools and chemicals; fire escape routes were not posted; and an employee's file lacked required records. Welfare issues included a child's file did not contain evidence to support whether treatment services were provided, and a bed did not have clean sheets or coverings. Other issues included no evidence to support whether significant events, including alcohol consumed by a child in the home, were communicated to the facility's licensing agency; and policies and procedures were weak and not consistent with management's understanding. After our visit, the Division of Child and Family Services revoked the license it issued to facility management. (page 8)

3 Angels Care

We noted health, safety, and welfare issues at three foster homes operated by 3 Angels Care. Health issues included unsecured and incomplete medication records, and two unsecured prescription pills on the carpet of a child's bedroom. Safety issues included unsecured tools and laundry supplies. Welfare issues included: worn and stained carpets; children's bathrooms were dirty; and children's bedrooms contained partially eaten food, garbage, pillows without pillowcases, and disorganized piles of clothing. After our visit, the agency's licensing agency issued a corrective action plan to one of three homes observed. (page 10)

Eagle Quest

At three of four Eagle Quest homes, we noted health, safety, and welfare issues. Health issues included incomplete medication records. Safety issues included unsecured tools, cleaning chemicals, and alcohol. Welfare issues included: unsecured and incomplete records; walls, baseboards, and children's bathrooms in need of cleaning; worn carpets; and doors and cabinets in need of repair and replacement. After our visit, the agency's licensing agency and facility management confirmed our concerns were addressed immediately. (page 12)

180 Community Wellness Centers, LLC

We noted health, safety, and welfare issues at one home operated by 180 Community Wellness Centers, LLC. Health issues included: unsecured and incomplete medication records, unsecured medication, and incomplete medication policies. Safety issues included unsecured tools and cleaning chemicals. Welfare issues included the children's bathroom was dirty and in need of deep cleaning. After our visit, the agency's licensing agency confirmed our concerns were addressed. (page 13)

Conclusion:

Facility and agency management at all five facilities listed above did not ensure their foster parents met one or more of the following minimum foster care standards outlined in Nevada Administrative Code 424: reasonable housekeeping standards; clean living spaces, bedrooms, and bathrooms free from trash and hazards; maintaining medical records, treatment planning, and personnel records; securing medications, medical records, tools, chemicals, laundry products, and alcohol; providing beds, sheets, and coverings; plans for responding to disasters and other emergencies; maintaining laundry equipment; care and treatment of children; notifying and reporting to the licensing agency; and reviewing and updating policies and procedures.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Report Highlights

Highlights of Legislative Auditor report on the Governmental and Private Facilities for Children – Inspections issued on January 12, 2023.

Legislative Auditor Report # LA24-06.

Background

Nevada Revised Statutes (NRS) 218G.570 through 218G.595 authorize the Legislative Auditor to conduct audits of governmental facilities for children and reviews, inspections, and surveys of governmental and private facilities for children.

As of June 30, 2022, we had identified 57 governmental and private facilities that met the requirements of NRS 218G. In addition, 105 Nevada children were placed in 14 different out-of-state facilities across 6 different states as of June 30, 2022.

NRS 218G requires facilities to forward to the Legislative Auditor copies of any complaint filed by a child under their custody or by any other person on behalf of such a child concerning the health, safety, welfare, and civil and other rights of the child. During the period from July 1, 2021, through June 30, 2022, we received 636 complaints from 30 facilities in Nevada. Twenty-seven Nevada facilities reported that no complaints were filed during this time.

Purpose

Inspections were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our inspections of 19 children's facilities. As inspections are not audits, these activities were not conducted in accordance with generally accepted government auditing standards.

The purpose of our inspections was to determine if the facilities adequately protect the health, safety, and welfare of the children in the facilities, and whether the facilities respect the civil and other rights of the children in their care.

Inspections included discussions with management, a review of personnel and child files, and observations. Discussions with facility management included the following topics: medication administration, treatment plan process, abuse or neglect reporting, face sheet creation, complaint process, employee background checks and training, and related policies and procedures. In addition, we judgmentally selected files to review which included: personnel files for evidence of employee background checks and required training; and child files for evidence of children's acknowledgment of their right to file a complaint, medication administered, treatment plans, and face sheet information.

Governmental and Private Facilities for Children – Inspections

December 2022

Summary

In 14 of 19 children's facilities inspected, we did not note significant issues that caused us to question the health, safety, welfare, or protection of the rights of the children. However, at the five facilities listed below we identified multiple issues that caused us to question whether the facility adequately protected the children in its care. Based on our observations, we contacted the facilities' licensing agencies and communicated our concerns.

Nevada Homes for Youth

We noted health, safety, welfare, and other issues at Nevada Homes for Youth. Health issues included: incomplete and inaccurate medication records, children self-administering medication, missing medication, contraband, child intoxication, and missing treatment plans. Safety issues included: unsecured chemicals, outdated first aid kit supplies, broken electrical outlets, a broken window, missing statutorily required personnel records, and face sheets were not readily available to staff. Welfare issues included: unsanitary living conditions, inappropriate age-related activities, and the complaint process was not posted. Other issues included: incomplete training records, incomplete and altered child records, and policies and procedures were weak. (page 4)

Never Give Up Youth Healing Center

We noted health, safety, welfare, and other issues at Never Give Up Youth Healing Center. Health issues included: incomplete and missing medication records, administration of medication without consent, and staff were unaware of children's treatment plans. Safety issues included: unsecured laundry supplies and chemicals, damaged property that posed safety hazards, missing statutorily required personnel records and training, missing documentation that an incident was reported in accordance with mandated reporting requirements or investigated internally in accordance with facility policy, and face sheets were not readily available to staff. Welfare issues included: unsanitary living conditions; beds missing pillowcases, sheets, and bed coverings; inappropriate age-related activities; and unsecured complaint boxes. Other issues included incomplete training records and policies and procedures were weak. (page 8)

3 Angels Care

We noted health, safety, welfare, and other issues at three of 3 Angels Care homes. Health issues included incomplete and missing medication records and a missed medication administration for a child. Safety issues included: unsecured tools, chemicals, and laundry supplies; an outside locking storage room being used as a place to sleep; children of opposite gender sharing a room; and lack of supervision. A welfare issue included the use of a storage room as a "quiet room." Other issues included incomplete personnel records and policies and procedures were weak. (page 12)

Advanced Foster Care Homes

We noted health, safety, welfare, and other issues at two homes licensed by the Advanced Foster Care program. Health issues included incomplete and missing medication records and incomplete and missing treatment plans. Safety issues included: unsecured tools, chemicals, and knives; fire escapes were not posted, and documentation of fire drills were missing; storage of medication was not readily available; and missing documentation to support a repeat background check for a foster parent. Welfare issues included: complaint forms not being readily available, the complaint process not being posted, no documentation that children were made aware of their right to file a complaint, and a complaint on behalf of a child was not forwarded to the Legislative Auditor. Other issues included missing and incomplete training records and policies and procedures were weak. (page 14)

Prison Rape Elimination Act (PREA)

In two of eight correction and detention facilities inspected, we noted issues that prompted us to question whether the facilities adequately implemented a PREA process in accordance with federal regulations. PREA standards require the facilities to use a screening tool to assess children for sexual victimization or abusiveness. Two facilities used a screening tool which did not assess for 10 of 11 items required by screening standards. (page 17)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Audit Division
Legislative Counsel Bureau

Public Safety

Audit Highlights

Highlights of performance audit report on the Department of Corrections issued on March 22, 2022.

Legislative Auditor report # LA22-11.

Background

The Department of Corrections (Department) is responsible for the housing and treatment of inmates sentenced to state correctional institutions. The head of the Department is the Board of State Prison Commissioners (Board). Authority over the operations of the prison system is granted to the Board by the Nevada Constitution.

The Department is administered by a Director under the oversight of the Board. The Director establishes regulations, supervises the Department's institutions and facilities, and must take proper measures to protect the health and safety of the public, staff, and inmates.

The Department's headquarters are located in Carson City with an office in Las Vegas and correctional institutions throughout the State. During fiscal year 2021, inmates were housed at 17 facilities. As of March 31, 2021, the total inmate population was 11,196.

Data on use of force incidents is collected in the Nevada Offender Tracking Information System (NOTIS). Use of force incidents are entered in NOTIS via an incident report. Use of force incidents are categorized by the Department as either spontaneous or planned. Spontaneous use of force involves force used in an immediate situation or in response to a threat or emergency situation to dissuade or quell a course of action by an inmate(s). The majority of use of force incidents are categorized as spontaneous. Planned use of force involves an incident when time and circumstances allow for consultation, planning, and approval from the warden or administrator.

Purpose of Audit

The purpose of the audit was to evaluate the Department's processes over use of force reporting and certain related activities.

Audit Recommendations

This audit report contains 16 recommendations to improve the Department's processes over use of force reporting and certain related activities.

The Department accepted the 16 recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on June 15, 2022. In addition, the 6-month report on the status of audit recommendations is due on December 15, 2022.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Use of Force

Department of Corrections

Summary

The Department of Corrections needs to enhance processes over the review and investigation of use of force allegations and incidents. Inmate grievances alleging excessive use of force were not always adequately addressed. In addition, review panels were not always convened to determine if the use of force was appropriate and justified. When convened, review panels were often untimely. Proper review of inmate grievance allegations and investigation of use of force incidents help ensure the Department is complying with requirements to provide a safe and humane environment free of cruel and unusual punishment under the Eighth Amendment.

Prospective officers worked in the Department's facilities without adequate training or supervision prior to completing the Peace Officers' Standards and Training Academy. Additionally, better tracking is needed to ensure refresher and weapons training for certified peace officers is up to date. Further, obsolete weapons should be removed from institutions' armories. Finally, the Department needs to routinely review administrative regulations to ensure changes in legislation are incorporated. Proper training and accurate regulations are necessary to ensure officers only use force in appropriate circumstances, to protect peace officers and inmates, to limit the liability of the Department, and to ensure compliance with state and federal laws.

Use of force data collected by the Department is not accurate, complete, or reliable. Errors in the data cause the Department's statistical reports to understate use of force incidents. Additionally, the Department is not collecting some required data regarding use of force incidents. Relying on inaccurate data may result in management making improper conclusions and taking inappropriate actions.

The Department spent about $192,000 on a body camera program that has not been implemented. As a result, the Department did not collect and report incident data or develop performance measures, requested by the Legislature, regarding the effectiveness of monitoring equipment. Purchasing equipment that is not used is a waste of state funds.

Key Findings

The Inspector General's (IG) Office did not review most grievances alleging excessive use of force. We found for 13 of 20 (65%) grievances, there was no evidence the IG's Office reviewed the grievance. For all seven grievances reviewed, the IG's Office did not provide a timely response to the inmate of the outcome as required by administrative regulation. (page 5)

Use of Force Review Panels (Panel), convened to review use of force incidents, sometimes did not occur. A Panel was not convened for 9 (36%) of the 25 incidents we tested. Of the 16 completed Panel reviews, 10 (63%) were untimely. Panels are necessary to determine if the use of force was justified and consistent within the policies, procedures, and training of the Department. (page 7)

The Department used prospective officers to work in its facilities without proper supervision or training. Our testing revealed 4 of 20 (20%) prospective officers were assigned to work posts alone. Additionally, six (30%) prospective officers were assigned to work dedicated posts, normally requiring a second certified peace office. Finally, we identified four incidents where prospective officers participated in use of force incidents. (page 12)

The Department does not have an effective tracking process to ensure its officers are current with their routine training. We reviewed the training files of 104 officers and found no documentation of pregnant inmate restraint training for 9 officers and staff. Additionally, six officers were issued TASERS, one officer fired a blank shotgun round, and two officers used a restraint chair with no evidence their training was up to date. NAC 289.230 prohibits officers from using weapons unless their training is current. (page 14)

We found 212 out of 744 (28%) weapons located in the armories at the institutions were unauthorized or obsolete. Additionally, 171 of these weapons were currently in use. An authorized weapons list is needed to ensure weapon reliability and quality, proper training, and for weapons tracking. (page 15)

The Department uses restraint chairs but has not adopted an administrative regulation governing their use. Additionally, administrative regulations have not been updated for recent Legislative changes related to certain law enforcement practices and peace officer drug testing. (page 17)

The Department spent $192,000 on 71 body cameras, supporting hardware, and licensing fees but never implemented the program. An additional $26,500 will be incurred annually for licensing fees unless the program is terminated. (page 21)

Audit Division
Legislative Counsel Bureau

Steve Sisolak
Governor

Amy Stephenson
Director

Warren Lowman
Administrator

STATE OF NEVADA
GOVERNOR'S FINANCE OFFICE

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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Amy Stephenson, Director
Governor's Finance Office

Date: December 15, 2022

Subject: Legislative Audit of the Department of Corrections, Use of Force

On March 22, 2022, your office released an audit report (LA22-11) on the Department of Corrections – Use of Force. The Department of Corrections (NDOC) subsequently filed a corrective action plan on June 15,2022. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the Department of Corrections to comply with audit findings.

There were 16 recommendations contained in the report. The extent of the Department of Corrections compliance with the audit recommendations is as follows:

Recommendation 1

Develop a process and training program to the Inspector General's Office to ensure all referred use of force grievances are reviewed and completed timely.

Status – Partially Implemented

Agency Actions – NDOC reported providing training, and in-person instruction when requested, to Inspector General (IG) staff on how to enter grievances into the Nevada Offender Tracking Information System (NOTIS) and Grievance Module. As of November 10, 2022, all 24 staff members of the Inspector General's office have received training and have access to the Grievance Module. NDOC did not provide evidence of having implemented a process for reviewing grievances timely.

Recommendation 2

Ensure use of force grievances are reviewed by the Inspector General's Office prior to inmates being paroled.

Status – Partially Implemented

Agency Actions – NDOC reported effort has been made to review force grievance prior to inmates being paroled through the use of the 90-day parole eligibility reports produced by the Offender Management Division. The 90-day eligibility reports are compared to force subtype grievances to ensure accurate and timely compliance. An expedited process is utilized for offenders who have been paroled and have exited the Department. Two grievances from paroled offenders were identified between the submission of the 60-day response to the audit and the 6-month status report.

Recommendation 3

Ensure individual institutions follow Department policies for screening use of force grievances before referring to the Inspector General's Office.

Status – Partially Implemented

Agency Actions – NDOC reported in their initial response a plan to develop training for all Grievance Coordinators to ensure the screening of use of force grievances are properly completed and processed prior to being referred to the Inspector General's office. Additionally, NDOC planned to incorporate use of force reporting training into their annual In-Service Training. The department reported in their 6-month status report training has not been incorporated due to staffing shortages.

Recommendation 4

Require the Inspector General's Office to track Use of Force Review Panels in accordance with Department regulation to ensure they are conducted and completed timely.

Status – Partially Implemented

Agency Actions –NDOC reported effort has been made to track reports with an IG group-email account used to ensure timely submissions and reviews. The Warden, IG office, and Deputy Director of Operations will have access to the reports. All institutions are instructed to utilize a uniform email subject like when sending Use of Force reports for ease of tracking. DIA notes that while a group-email will make it easier for report submission, no internal tracking process has been developed to track Use of Force review Panels.

Recommendation 5

Forward Use of Force Review Panel Reports to the Inspector General's Office.

Status – Partially implemented

Agency Actions – Department regulations require Use of Force Review Panels be completed within 20 to 45 days depending on the severity of the incident. Regulations requires the Panel to forward reports to the Department's IG's Office who is supposed to track the panel reports for timely completion.[1] The Department has made efforts to forward Use of Force Review Panel Reports to the IG's office within the required time frame. 52 total reports, 39 involving use of force, have been submitted since June 15, 2022. The completion time frame ranged from a few days to 158 days.

Recommendation 6

Ensure adequate oversight of prospective officers when working inside institutions prior to attaining correctional officer credentials.

Status – Partially Implemented

Agency Actions – NDOC reported providing clearer guidelines for prospective officer working inside institutions prior to attaining correctional officer credentials. However, NDOC did not provide a response indicating how the department has addressed providing adequate oversight and ensuring prospective officers duties without proper supervision or training.

Recommendation 7

Develop policies and procedures which provide clear guidance on what functions and duties prospective officers may perform prior to attaining certification as a correctional officer.

Status – Partially Implemented

Agency Actions – NDOC reports formally announcing seven guidelines through a published memorandum establishing rules governing the utilization, oversight, function, and duties that prospective officers may perform when working inside institutions prior to attaining correctional officer credentials. Administrative Regulation 360 – Correctional Employee/Officer Basic Training Program will be updated with the guidelines upon approval from the Board of Prison Commissioners. Administrative Regulation 360 is scheduled to be presented to the Board of Prison Commissioners in the first quarter of 2023.

[1] LA22-11 Department of Corrections – Use of Force audit.

Recommendation 8

Monitor all use of force related training at the Department level. Ensure officer training aligns with weapons assigned and used.

Status – No Action

Agency Actions – NDOC reported implementing a monthly Use of Force Training Review Committee comprised of the Deputy Director of Operations, the Employee Development Manager, and the Regional Training Academy Commanders to present and discuss the uses of force experienced across the Department in the previous month to ensure future officer training aligns with assigned and used weapons. Due to critical shortages, security crisis, and senior leadership turbulence, NDOC had to postpone it's first meeting to November 2022. NDOC Use of Force Training Review Committee meets to address use of force incidents after they have occurred. The recommendation by LCB requires monitoring training for assigned weapons. NDOC should ensure training is up to date when weapons are assigned, not after an incident has occurred.

Recommendation 9

Develop a process for the identification and timely removal of obsolete weapons from armories.

Status – Partially Implemented

Agency Actions – NDOC reported holding a refresher training in November 2022 for all Institutional Armorers and Administrative Service Officers for the proper disposal and removal of obsolete weapons from facility armories. The LCB recommendation requires developing a process for the identification and removal of obsolete weapons from armories. While training an effort to meet the recommendation, it is insufficient without a process in place.

Recommendation 10

Establish a process to periodically review the authorized weapons list to ensure weapons are consistent with those currently used by the Department.

Status – Partially Implemented

Agency Actions – NDOC reported the creation of an Ordinance Manual to be included under Administrative Regulation 412 – Amory Weapons and Control upon the approval of the Board of Prison Commissioners. Additionally, the Ordinance Committee, comprised of the Deputy Director of Operations and four Wardens, was created to review the authorized weapons list to ensure weapons are consistent with those currently used by the Department. The updated Administrative Regulation 412 has not been presented to

the Board of Prison Commissioner for approval. NDOC anticipates presenting it in the first quarter of 2023.

Recommendation 11

Develop a department-wide policy and training program for use of the restraint chair.

Status – No Action

Agency Actions – In NDOC's initial response, the Department tasked the Employee Development Division with developing a training curriculum for use of the restrain chair which is in accordance with Nevada Revised Statures and the manufactures specifications and direction in applying and utilizing the restraint chair. NDOC anticipates completing the curriculum for the restraint chair and including it in all POST-III Academies beginning January 2023.

Recommendation 12

Follow Department policy to routinely review and update administrative regulations and operating procedures.

Status – Partially Implemented

Agency Actions – The Department has made effort to update administrative regulations and operating procedures and submit them for approval to the Board of State Prison Commissioners. However, the submitted administrative regulations governing use of force policy do not address an officer's or supervisor's duty to intervene to stop excessive us of force.

Recommendation 13

Develop department-wide guidance for coding use of force data and train staff to properly classify the data in the Department's computer system.

Status – Partially Implemented

Agency Actions – NDOC reported in its initial response the inclusion of a refresher training class in the 2022 custody supervisor in-service training curriculum which addresses the proper classification of use of force data in the Department's computer system. The update to the curriculum will require an update to Administrative Regulation 400 – General Security/Supervision Guidelines. The Department anticipates training to begin January 2023, after the approval of the updated Administrative Regulation by the Board of State Prison Commissioner.

Recommendation 14

Develop a process for continual review, monitoring, and correcting use of force data to ensure accuracy and completeness.

Status – Partially Implemented

Agency Actions – NDOC reported a committee, assigned, and chaired by Warden Reubart of Ely State Prison, was assembled to select a system to gather, review, monitor, and correct use of force data. The recommendations by the Committee are scheduled to be presented to the Acting Director in December 2022.

Recommendation 15

Collect, analyze, and report required incident data to assist in allocating resources and training development.

Status – No Action

Agency Actions – The Department has not been able to collect incident data and make progress on this recommendation due to a system not having yet been selected. A process for collecting, analyzing, and reporting data can be developed upon the selection, approval, and implementation of a data collecting system.

Recommendation 16

Develop and implement a plan to utilize body cameras as represented to the Legislature. If not feasible, cease payment of annual maintenance costs on unused equipment and allow the cameras to be repurposed or sold.

Status – Partially Implemented

Agency Actions – NDOC reported the Fiscal Division is finalizing a contract with Motorola to exchange the out of date body cameras for updated body cameras. The department estimates implementation by mid-January 2023.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

Amy Stephenson, Director
Governor's Finance Office

cc: William Gittere, Acting Director, Department of Corrections
Warren Lowman, Administrator, Division of Internal Audits

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January 3, 2023

Members of the Audit Subcommittee
of the Legislative Commission
Legislative Building
Carson City, Nevada 89701-4747

In March 2022, we issued an audit report on the Department of Corrections, Use of Force. The Department filed its plan for corrective action in June 2022. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the 16 recommendations contained in the audit report. As of December 15, 2022, the Office of Finance indicated 13 recommendations were partially implemented and 3 recommendations had no action taken. The recommendations and their status are shown below.

	Recommendation	Status
Recommendation No. 1	Develop a process and training program for the Inspector General's Office to ensure all referred use of force grievances are reviewed and completed timely.	Partially Implemented
Recommendation No. 2	Ensure use of force grievances are reviewed by the Inspector General's Office prior to inmates being paroled.	Partially Implemented
Recommendation No. 3	Ensure individual institutions follow Department policies for screening use of force grievances before referring to the Inspector General's Office.	Partially Implemented
Recommendation No. 4	Require the Inspector General's Office to track Use of Force Review Panels in accordance with Department regulation to ensure they are conducted and completed timely.	Partially Implemented
Recommendation No. 5	Forward Use of Force Review Panel Reports to the Inspector General's Office.	Partially Implemented
Recommendation No. 6	Ensure adequate oversight of prospective officers when working inside institutions prior to attaining correctional officer credentials.	Partially Implemented
Recommendation No. 7	Develop policies and procedures which provide clear guidance on what functions and duties prospective officers may perform prior to attaining certification as a correctional officer.	Partially Implemented
Recommendation No. 8	Monitor all use of force related training at the Department level. Ensure officer training aligns with weapons assigned and used.	No Action
Recommendation No. 9	Develop a process for the identification and timely removal of obsolete weapons from armories.	Partially Implemented

Recommendation No. 10	Establish a process to periodically review the authorized weapons list to ensure weapons are consistent with those currently used by the Department.	Partially Implemented
Recommendation No. 11	Develop a department-wide policy and training program for use of the restraint chair.	No Action
Recommendation No. 12	Follow Department policy to routinely review and update administrative regulations and operating procedures.	Partially Implemented
Recommendation No. 13	Develop department-wide guidance for coding use of force data and train staff to properly classify the data in the Department's computer system.	Partially Implemented
Recommendation No. 14	Develop a process for continual review, monitoring, and correcting use of force data to ensure accuracy and completeness.	Partially Implemented
Recommendation No. 15	Collect, analyze, and report required incident data to assist in allocating resources and training development.	No Action
Recommendation No. 16	Develop and implement a plan to utilize body cameras as represented to the Legislature. If not feasible, cease payment of annual maintenance costs on unused equipment and allow the cameras to be repurposed or sold.	Partially Implemented

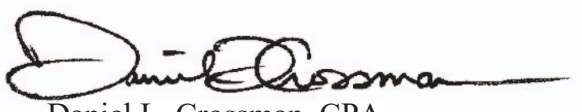
During the March 22, 2022, Legislative Commission's Audit Subcommittee meeting Assemblywoman Miller expressed concerns regarding the timely implementation of the recommendations associated with this audit. LCB audit staff noted full implementation, or at least significant progress towards implementation of the audit recommendations, is expected by the time an agency returns to the Audit Subcommittee for the 6-month follow up. Since the Department has not made significant progress on many of the recommendations, we have the following questions:

Questions

1. Why hasn't the Department made significant progress towards full implementation?

2. What is the Department's timeline for full implementation?

Respectfully Submitted,



Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
cc: Ben Kieckhefer, Chief of Staff, Office of the Governor
Amy Stephenson, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
William Gittere, Acting Director, Department of Corrections

Special Purpose Agency

Audit Highlights

Highlights of performance audit report on the Department of Veterans Services issued on May 14, 2021.

Legislative Auditor report # LA22-07.

Background

The Department of Veterans Services (Department) was established in 1943. The mission of the Department is to provide vital and efficient service to and advocate on behalf of veterans, their dependents and survivors; and provide its community and partners the opportunity to contribute in these endeavors. To fulfill its mission, the Department assists veterans with obtaining federal benefits, providing skilled nursing care, providing burial support at the state veterans cemeteries, and helping veterans successfully integrate into Nevada communities. In February 2021, the Department reported over 240,000 veterans residing in Nevada.

The Department administered nine budget accounts, with $52 million in revenues and $42 million in expenditures during fiscal year 2020. The Department is primarily funded through resident fees for skilled nursing facilities and General Fund appropriations.

The Department's headquarters are located in Reno, with an administrative office in Las Vegas. The Department also has advocacy offices to assist veterans in Carson City, Elko, Fallon, Las Vegas, Pahrump, and Reno. As of June 30, 2020, the Department had 247 authorized positions, of which 232 were filled.

Purpose of Audit

The purpose of the audit was to determine whether the SNSVH has adequate processes over assisting residents with Medicaid enrollment and other matters, ensuring financial information is reviewed upon admission, and obtaining timely bed holds. This audit included a review of resident accounts during fiscal year 2020 and prior periods for some activities.

Audit Recommendations

This audit report contains five recommendations to improve processes over assisting residents with Medicaid enrollment, ensuring financial information is reviewed upon resident admission, and completing forms timely.

The Department accepted the five recommendations.

Recommendation Status

The Department's 60-day plan for corrective action is due on August 10, 2021. In addition, the 6-month report on the status of audit recommendations is due on February 10, 2022.

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

Department of Veterans Services

Summary

The Department can provide more assistance to Southern Nevada State Veterans Home (SNSVH) residents. Specifically, the home needs a formalized process for helping with timely enrollment into Medicaid. Untimely enrollment can result in less revenue for the Department and unnecessary debt for disadvantaged veterans. Additionally, a review of potential residents' financial capability prior to admission is needed to ensure residents are able to pay for their care at the home. Admitting residents without adequately considering how services will be reimbursed can affect home operations. Furthermore, the home's bed hold process could be more consistent to ensure a resident can return to his or her room upon return from a hospital visit. Ensuring a resident's space at the home is secure is important for facility compliance with federal regulations and residents' peace of mind.

Key Findings

The Department does not have an established, formalized process for assisting residents with enrollment into Medicaid. As a result, some residents who could have been enrolled into Medicaid were not and applications for others were delayed. Since Medicaid covers a portion of the veterans' cost for room and board, untimely enrollment can result in less revenue for the Department and unnecessary debt for disadvantaged veterans. (page 7)

In certain instances, the home did not help residents maximize use of public assistance programs. Our testing also found some residents did not submit applications timely, resulting in delayed enrollment and unpaid room and board charges. For some residents, it took over 140 days to submit an application for Medicaid enrollment. Three residents who may have qualified for Medicaid at some point during their stay at the home were not enrolled into the program and had over $81,000 remaining due upon discharge. (page 8)

Adequate review of potential residents' financial capability is not occurring prior to SNSVH admission, which may lead to residents not being able to pay for their care at the home. Admission guidelines require a verified payment source from potential residents. Our review identified 7 of 26 residents did not have a comprehensive review prior to being admitted to the home. By performing financial reviews of potential residents, SNSVH can reduce potential hardships for residents unable to pay for their care by identifying available assistance programs. Our review of outstanding resident accounts as of June 2020 identified a balance of over $83,000 in accounts that were 120 days past due for residents without evidence of a comprehensive financial review upon admission. (page 9)

Policies, procedures, or guidelines are not available for financial reviewers to evaluate a potential resident's ability to pay for uninsured care at the home. Staff indicated guidelines for financial review did not exist. Even though staff obtained financial documentation, including bank statements and tax returns, an evaluation of the resident's ability to pay was not performed. (page 9)

The Department's process for holding a resident's bed when they temporarily leave the home could be more consistent. When a resident is transferred out to a hospital, a bed hold form should be completed. We found bed hold forms are not always obtained timely for SNSVH resident transfers. We tested 24 of 152 residents who were transferred to a hospital in fiscal year 2020. We found 3 of the 24 residents did not receive a bed hold authorization form when transferred, and another 9 were untimely. (page 10)

Audit Division
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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Susan Brown, Director
Governor's Finance Office

Date: February 10, 2022

Subject: Legislative Audit of the Department of Veterans Services.

On May 14, 2021, your office released an audit report (LA 22-07) on the Department of Veterans Services (DVS). DVS subsequently filed a corrective action plan on August 3, 2021. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DVS to comply with audit findings.

There were five recommendations contained in the report. The extent of DVS's compliance with the audit recommendations is as follows:

Recommendation 1

Develop a process and policies to assist residents with timely enrollment into Medicaid.

Status – Fully Implemented

Agency Actions – DVS developed a process and policies to assist residents with timely enrollment into Medicaid. DVS updated the process and policies for assisting residents enroll in Medicaid, Medicare, and services offered by the U.S. Department of Veterans Affairs. The updated policy mandates social workers follow-up within 15 days from the date of admission regarding assistance options available to residents, and a monthly meeting is conducted to review pending Medicaid applications. The new process and policies took effect December 10, 2021. Additionally, DVS reports a Medicaid Eligibility staff will join the Southern Nevada State Veterans Home to assist residents with Medicaid enrollment. The position is funded by the Department of Health and Human Services but will functionally report to the DVS Facility Administrator starting March 2022.

Recommendation 2

Develop guidelines and checklists for determining a resident's financial ability to pay for services prior to admission.

Status – Fully Implemented

Agency Actions – DVS developed guidelines and a checklist for determining a resident's financial ability to pay for services prior to admission. DVS added a financial review section to the Admission Checklist and developed guidelines for determining a resident's ability to pay for services that includes the ability to pay for fee-based care prior to admission. DVS implemented the guidelines and checklist in May 2021. Admissions staff were trained on the process changes and received the new checklist in advance of the changes taking effect.

Recommendation 3

Monitor contractor financial reviews of residents' financial capability to ensure adherence to Department guidelines and checklists.

Status – Partially Implemented

Agency Actions – DVS has taken action to monitor contractor financial reviews of residents' financial capability to ensure adherence to DVS guidelines and checklists. DVS updated the pre-admission financial review guidelines in its admission procedures and on the Admission Checklist to include internal financial reviews of residents' ability to pay. The Admissions Administrator trained staff on the internal financial review process changes prior to the changes taking effect.

Auditor Comment – DVS did not update the pre-admission financial review guidelines to address how Admissions staff will monitor contractor financial reviews of residents' financial ability to pay or when the review will occur. The audit recommends monitoring contractor financial reviews in addition to internal financial reviews to ensure adherence to DVS guidelines. Full implementation of this recommendation is dependent upon DVS documenting in its policies and procedures how contractor monitoring will be performed and when the monitoring will occur.

Recommendation 4

Monitor resident transfer-out reports and follow up on any missing bed hold forms.

Status – Partially Implemented

Agency Actions – DVS has taken action to monitor resident transfer-out reports and follow up on any missing bed hold forms. DVS updated its Bed Hold Notice policy and procedure in November 2021. The new procedure requires a quarterly review of resident transfer-

out reports and bed hold forms by a DVS compliance officer. The updated procedure requires the compliance officer to report bed hold discrepancies and recommended corrective action to the Admissions Administrator and the Deputy Director of Healthcare Services. DVS reports the quarterly review has not yet occurred but is scheduled to be performed March 2022.

Auditor Comment – DVS did not provide resident transfer data or reports to evidence that resident transfer-out discrepancies are identified or to support the assertion that staff are effectively monitoring to ensure follow-up on the missing bed hold forms.

Recommendation 5

Consider making the bed hold form an electronic form prepared during a transfer out in the electronic records database.

Status – No Action

Agency Actions – DVS reports it will consider making the bed hold form an electronic form prepared during a transfer out in the electronic records database. DVS asserts it will research the compatibility of the recommended form with its electronic records database, PointClickCare, by February 2022.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Katherine Miller, Colonel (Ret.), Director, Department of Veterans Services
Amy Garland, Deputy Director, Department of Veterans Services
Warren Lowman, Administrator, Division of Internal Audits

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March 11, 2022

Members of the Audit Subcommittee
of the Legislative Commission
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Carson City, Nevada 89701-4747

In May 2021, we issued an audit report on the Department of Veterans Services (Department). The Department filed its plan for corrective action in August 2021. Nevada Revised Statutes 218G.270 requires the Office of Finance, Office of the Governor, to issue a report within 6 months after the plan for corrective action is due, outlining the implementation status of the audit recommendations.

Enclosed is the 6-month report prepared by the Office of Finance on the status of the five recommendations contained in the audit report. As of February 10, 2022, the Office of Finance indicated two recommendations were fully implemented, two recommendations were partially implemented, and no action was taken on one recommendation. The partially implemented recommendations and recommendation with no action are shown below.

	Recommendation	Status
Recommendation No. 3	Monitor contractor financial reviews of residents' financial capability to ensure adherence to Department guidelines and checklists.	Partially Implemented
Recommendation No. 4	Monitor resident transfer-out reports and follow up on any missing bed hold forms.	Partially Implemented
Recommendation No. 5	Consider making the bed hold form an electronic form prepared during a transfer out in the electronic records database.	No Action

For Recommendation No. 3, the Office of Finance indicated the Department did not update the pre-admission financial review guidelines to address how admissions staff will monitor contractor financial reviews of residents' financial ability to pay or when the review will occur. In March 2022, the Department provided us updated policies and procedures of how contractor monitoring will be performed and when the monitoring will occur. As such, we consider Recommendation No. 3 fully implemented.

For Recommendation No. 4, the Office of Finance stated the Department did not provide resident transfer data or report to evidence that resident transfer-out discrepancies are identified or to support the assertion that staff are effectively monitoring to ensure follow-up on the missing bed hold forms. New procedures require a quarterly review of resident transfer-out

reports and bed hold forms by the Department's compliance officer. In March 2022, the Department informed us that the first quarterly review will be performed March 15, 2022. We will review documentation of this quarterly review when available. As a result, Recommendation No. 4 remains partially implemented.

For Recommendation No. 5, the Office of Finance reported the Department indicated it will consider making the bed hold form an electronic form prepared during the transfer out in the electronic records database. It will research the compatibility of the recommended form with its electronic records database, PointClickCare, by February 2022. In March 2022, the Department informed us that it has reached out to PointClickCare to gauge the feasibility and cost of incorporating the form. The Department is also working on a VA modernization project that will allow the VA and the State Veterans Homes to be able to transmit information electronically and in real time. With the completion of this modernization, this would negate the need for an electronic bed hold from as the State Veterans Homes will be able to obtain information in real time instead of waiting for faxed information. As such, we consider Recommendation No. 5 fully implemented.

Because we plan to monitor the Department's progress on Recommendation No. 4, we do not have any questions for agency officials at this time.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:smy
cc: Yvanna Cancela, Chief of Staff, Office of the Governor
Susan Brown, Director, Office of Finance, Office of the Governor
Warren Lowman, Administrator, Division of Internal Audits, Office of the Governor
Katherine Miller, U.S. Army Colonel (Ret.), Director, Department of Veterans Services
Amy Garland, Deputy Director of Healthcare Services, Department of Veterans Services

Other

Audit Highlights

Highlights of performance audit report on the Nevada State Board of Medical Examiners issued on May 4, 2022.

Legislative Auditor report # LA22-13.

Background

The Nevada State Board of Medical Examiners (Board) is an independent regulating body that was established in 1899. The Board determines the competence of medical providers including physicians, perfusionists, physician assistants, and practitioners of respiratory care. Its mission is to ensure only well-qualified and competent providers receive licenses to practice in Nevada and to respond to complaints against licensees by conducting fair and complete investigations.

As of the end of calendar year 2020, the Board had 13,317 active licensees and usually adds over 1,000 new licensees each year.

The Board consists of nine members appointed by the Governor to serve 4-year terms. Operations are comprised of five divisions: Licensing, Investigations, Legal, Finance, and Administration.

The Board has offices in Reno and Las Vegas with 38 total staff as of February 2021. It is self-funded primarily from license and registration fees. During calendar year 2020, the Board had total revenues of $5.3 and expenditures of $4.9 million.

Purpose of Audit

The purpose of the audit was to evaluate the Board's processes for licensing physicians and investigating complaints, and the Board's purchase of an office building. The scope of the audit focused on a review of the Board's activities for calendar years 2019 and 2020, and from 2016 for certain investigative cases, from 2017 for workload trends, and from 2008 for reserve balance analyses.

Audit Recommendations

This audit report contains 10 recommendations to improve controls over investigative and disciplinary processes, including complaint intake, fines, and cost recoveries.

The Board accepted the 10 recommendations.

Recommendation Status

The Board's 60-day plan for corrective action is due on August 1, 2022. In addition, the 6-month report on the status of audit recommendations is due on February 1, 2023.

Nevada State Board of Medical Examiners

Summary

Better monitoring and oversight of the investigative and disciplinary processes can help the Board provide more timely resolution of complaints and other issues. Additionally, enhancing controls over the administration of fines will ensure they are assessed consistently and fair. Further, maintaining support for investigative costs will help support its cost recovery efforts and provide equitable treatment of licensees.

Board procedures over licensing and publishing of disciplinary data adequately ensured timely and accurate processing. Delays in licensing physicians were largely attributable to applicants and other third parties gathering and providing necessary information. Additionally, disciplinary information on the Board's website and provided to the National Practitioner Data Bank was accurate. Finally, the Board's decision to purchase an office building was based on reliable and accurate analysis and information.

Key Findings

The Board could improve the monitoring of its complaint resolution process which can take as long as several years to finalize. Large gaps of time existed between activities in certain cases where the Board could not provide explanations for delays. Timely resolution of cases is important for ensuring practicing physicians are competent and patients are safe from harm. (page 8)

There are opportunities for the Board to eliminate delays. We found:

- It took an average of 23 days for a complaint to be reviewed and assigned to an investigator. Five cases took significantly longer, up to 68 days. Management stated the intake turnaround goal is 7 days.
- Investigators took 31 days to review complaints, notify licensees they were under investigation, and request medical records, if needed. Seven cases took significantly longer, up to 134 days.
- The disciplinary process, when applicable, took over a year to resolve. Our review of cases showed little documentation existed detailing Board activities, if any, during this time period. (page 9)

Enhancing the process of assessing fines in disciplinary matters could help ensure equity. The Board has discretion in making the final disciplinary determinations and utilizes judgment and licensee history in this process. However, the Division has not established disciplinary guidelines or schedules that recommend penalties based on specific violations. We found such guidelines to be a best practice in our conversations with other states. (page 12)

The Board assessed licensees for the cost of investigations; however, these costs were not adequately supported to determine whether the amount assessed was accurate. For instance, the Board does not maintain a detailed record of the hours worked on each case by Board staff. In addition, invoices paid to external peer reviewers do not always include detail for the hours worked to determine the reasonableness of the charge. Assessing and recovering accurate investigative and disciplinary costs is important for ensuring fair and equitable treatment of licensees. (page 13)

The Board processed applications efficiently with nearly 75% of the time to issue a license related to applicants obtaining the proper documentation. We reviewed the licensing process for 50 applications and found it took the Board an average of 98 days to complete the licensing process, but the majority of those days were related to applicants and third parties gathering required information. (page 17)

Disciplinary information on the Board's website and the National Practitioner Data Bank was accurate for all cases reviewed. State law requires the Board's website to include a list of each licensee and a brief description of any disciplinary actions. This information allows individuals to make informed decisions when choosing health care providers. (page 19)

Board management performed sufficient analysis prior to purchasing a Reno office building in 2018 for $3.4 million. We reviewed documentation provided by management to determine whether quality information was used to make an informed decision regarding this purchase. (page 19)

For more information about this or other Legislative Auditor reports go to: http://www.leg.state.nv.us/audit (775) 684-6815.

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MEMORANDUM

To: Daniel L. Crossman, CPA, Legislative Auditor
Legislative Counsel Bureau

From: Amy Stephenson, Director
Governor's Finance Office

Date: February 1, 2023

Subject: Legislative Audit of the Nevada State Board of Medical Examiners

On May 4, 2022, your office released an audit report (LA 22-13) on the Nevada State Board of Medical Examiners (board). The board subsequently filed a corrective action plan on August 1, 2022. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the board to comply with audit findings.

There were ten recommendations contained in the report. The extent of the board's compliance with the audit recommendations is as follows:

Recommendation 1

Formalize the complaint intake assignment timeline in policy and monitor intake timeliness.

Status – Fully Implemented

Agency Actions – The board formalized the complaint intake assignment timeline in policy and monitors intake timeliness. The board updated the Investigations Division's operations manual to ensure consumer complaints are reviewed within seven business days. The updated manual requires that any consumer complaints alleging imminent danger to public safety or other exigent circumstances must be flagged as priority and be assigned to an investigator within two business days. Complaints flagged as priority are monitored by the Chief of Investigations and the Executive Director or Deputy Executive

Director. The operations manual was updated August 1, 2022, and affected staff were informed of the policy changes.

Recommendation 2

Develop policies and procedures to utilize the time tracking function in the Board's database and actively monitor case activity to ensure timely resolution.

Status – Fully Implemented

Agency Actions – The board developed policies and procedures to utilize the time tracking function in the board's database and actively monitors case activity to ensure timely resolution. The policies and procedures were updated in the operations manual effective August 1, 2022, and affected staff were informed of the policy changes. DIA reviewed consumer complaints from the board's database for open complaints, closed complaints, and complaints referred to another agency. Case notes reviewed indicate board staff are using the time tracking function in the board's database to ensure timely resolution of complaints.

Recommendation 3

Continually evaluate the number of cases reviewed at Investigative Committee meetings or increase the frequency of meetings to enhance timely case review and reduce case backlog.

Status – Fully Implemented

Agency Actions – The board continually evaluates the number of cases reviewed at Investigative Committee meetings and increased the frequency of meetings to enhance timely case review and reduce case backlog. The board created a third Investigative Committee, "Investigative Committee C," that increased the frequency of meetings and reduced case backlog.

Recommendation 4

Establish and monitor timeframes for in-house medical reviews.

Status – Fully Implemented

Agency Actions – The board established and monitors timeframes for in-house medical reviews. The board updated the Investigations Division's operations manual to reflect that the Chief of Investigations or designated Deputy Chief review the case log once per month and identify any cases that have been assigned to a Medical Reviewer that have not been completed within 30 calendar days. Cases not completed timely are flagged in the board's database and reviewed by management using the updated Medical Review Report. The

operations manual was updated August 1, 2022, and affected staff were informed of the changes.

Recommendation 5

Follow newly developed procedures for tracking the receipt and review of fingerprints for disciplinary matters in the Board's internal fingerprint log.

Status – Fully Implemented

Agency Actions – The board follows newly developed procedures for tracking the receipt and review of fingerprints for disciplinary matters in the board's internal fingerprint log. The Legal Division's policies were updated, and Legal Assistants now create a calendar reminder to ensure follow-up after 30 days on each case. DIA reviewed the Fingerprint Log and verified that the log tracks the receipt and review of fingerprints for disciplinary matters.

Recommendation 6

Provide increased oversight of complaints not investigated by establishing an approval or secondary review control.

Status – Fully Implemented

Agency Actions – The board provides increased oversight of complaints not investigated and established a secondary review control. The board updated the Investigations Division's policy and procedures in August 2022 to provide a secondary review if the reviewer determines that a complaint received is not within the board's jurisdiction. DIA reviewed a sample of consumer complaints identified as "closed" and determined that the board has complied with the secondary review policy.

Recommendation 7

Develop procedures to track and notify complainants of the filing of a formal complaint.

Status – Fully Implemented

Agency Actions – The board developed procedures to track and notify complainants of the filing of a formal complaint. The board updated the Legal Division's operations manual to require that claimants be notified of a formal complaint via mail to the last known address on file. The board also updated the Investigations Division's operations manual to require Administrative Assistants to write Acknowledgement Letters to complainants informing them that a formal investigation was opened based on their complaint and who the assigned investigator is. Operations manuals for both divisions were updated August 2022. Legal Assistants track notifications sent to complainants and store case notes in

the board's database. DIA verified that notes are entered into the database to track notifications sent to claimants.

Recommendation 8

Establish guidelines to follow when assessing disciplinary fines.

Status – Partially Implemented

Agency Actions – The board is making progress to establish guidelines to follow when assessing disciplinary fines. Board staff developed the Internal Disciplinary Guidelines for Fines policy on October 31, 2022. The draft policy is scheduled for review and approval at the March 2023 board meeting.

Recommendation 9

Enhance policies and procedures to ensure internal and external costs are tracked and documentation maintained, including hours Board staff dedicate to each case.

Status – Fully Implemented

Agency Actions – The board enhanced policies and procedures to ensure internal and external costs are tracked and documentation maintained, including hours board staff dedicate to each case. The board updated the Legal Division's operations manual in August 2022 to include documenting staff time spent on cases in the board's database and to require that Legal Assistants ensure a copy of all invoices and payment records are included in the case file.

Recommendation 10

Require peer review invoices have sufficient detail regarding time billed to substantiate costs and develop procedures to review invoices for reasonableness and accuracy.

Status – Fully Implemented

Agency Actions – The board requires peer review invoices have sufficient detail regarding time billed to substantiate costs and developed procedures to review invoices for reasonableness and accuracy. The board's Chief of Investigations updated the memorandum sent to peer reviewers in May 2021. DIA verified the memorandum instructed peer reviewers to substantiate and report their time billed in sufficient detail and verified that a peer review invoice was reviewed by appropriate staff for reasonableness and accuracy.

The degree of ongoing compliance with these recommendations is the responsibility of the agency.

cc: Ben Kieckhefer, Chief of Staff, Office of the Governor
Edward O. Cousineau, J.D., Executive Director, State Board of Medical Examiners
Warren Lowman, Administrator, Division of Internal Audits