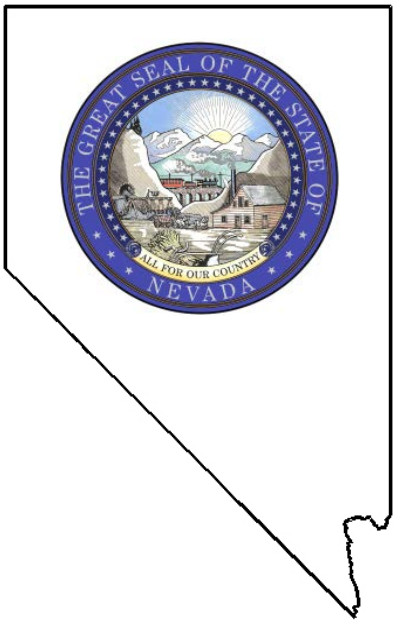
STATE OF NEVADA

Legislative Counsel Bureau
Audit Division

Audit Report Summaries
2019–2020



Eighty-First
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 1, 2021

SUBJECT: **Audit Report Summaries**

This document contains summaries of audits issued during the past biennium. The table of contents references both the summary page and 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 $15 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 $31 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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Finance/Admin

Audit Highlights

Highlights of performance audit report on the Fleet Services Division issued on February 18, 2020.

Legislative Auditor report # LA20-14.

Background

The Fleet Services Division (Division) was established in 1961 to ensure economical utilization of state-owned vehicles, eliminate the unauthorized use of state-owned vehicles, provide a ready means of transportation for state employees and officers on state business, reduce the need for state employees to use private cars on official state business, and provide a central administrative facility for the maintenance, care and operation of selected state-owned vehicles.

Services to state agencies include a short-term rental program, long-term assigned vehicles, car wash and detail, vehicle repairs, and roadside assistance. Short-term vehicle rentals, billed at a daily rate plus mileage, are available to state agencies for up to 30 days. State agencies may lease vehicles on a long-term basis for a monthly base fee plus mileage. The Division operated a fleet of 1,126 vehicles as of June 30, 2019, consisting of 1,048 on long-term assignment to state agencies, and 78 short-term rentals.

For fiscal year 2019, the Division was authorized for 16 positions, with locations in Carson City, Las Vegas, and Reno.

Purpose of Audit

The purpose of the audit was to determine if controls were adequate to ensure the economical utilization of the Division's vehicles and to evaluate the controls over fuel and procurement cards. Specifically, our work included a review of vehicle utilization during calendar year 2018, and fuel and procurement card transactions from July 1, 2018, through April 30, 2019.

Audit Recommendations

This audit report contains five recommendations to help ensure the economical utilization of fleet vehicles, and two recommendations to strengthen controls over fuel cards.

The Division accepted the seven recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on May 12, 2020. In addition, the 6-month report on the status of audit recommendations is due on November 12, 2020.

Fleet Services Division

Department of Administration

Summary

Weak controls hinder the Division from ensuring the economical utilization of its fleet. Vehicles on long-term assignments in calendar year 2018 were frequently driven less than the required annual minimum miles for fleet vehicles. When agencies underutilize assigned vehicles, the average cost per mile becomes excessive. Further, many vehicles had untimely preventive maintenance, potentially compromising vehicle performance and safety. Deficiencies in the Division's vehicle utilization monitoring and related processes are similar to the findings in our 2010 audit.

While the Division's controls over procurement cards were adequate, monitoring of fuel card purchases to reduce the risk of improper charges was not sustained after our prior audit in 2010. Testing of monthly fuel card purchases for 60 vehicles showed 13% had unusually low miles per gallon (mpg) ratios. In addition, the Division did not maintain accurate listings of outstanding fuel cards. Fuel purchases for fiscal year 2019 were nearly $1.4 million.

Key Findings

Many of the vehicles on long-term assignment to agencies did not meet the State's minimum use requirements for miles driven. Specifically, for calendar year 2018, 168 vehicles or approximately 26% of the nonemergency vehicles did not meet minimum mileage requirements. While some vehicles may have met usage requirements in terms of days driven, the data on days driven was not always obtained or accurate. (page 5)

The Division does not actively monitor long-term vehicle assignments for underutilization. Staff informally notify the Administrator of low-use vehicles, in terms of miles driven, but reports of low usage vehicles are not prepared and exception information is not communicated to the user agencies or to the Department of Administration. (page 8)

Agencies pay considerably more per mile for vehicle rentals when their long-term vehicles are underutilized. For the 10 most underutilized vehicles in calendar year 2018, agencies' rental costs ranged from $4.44 to a high of $71.71 per mile. (page 9)

Fleet Services does not have complete usage information on its long-term vehicles. First, the Division does not have the necessary data and does not calculate the percentage of days the vehicles were used, an alternative to the mileage requirement. Second, the Division does not track information on which user group, pooled or individual, its long-term vehicles are assigned. Without knowing the user group, the Division cannot accurately determine underutilization. (page 10)

Preventive maintenance on Division vehicles was not always performed timely. We noted 10 of 25 (40%) vehicles we tested did not have timely required services, such as an oil change, lube, and vehicle inspection. This is a repeat audit finding from our 2010 audit, which reported a 30% exception rate for untimely preventive maintenance. (page 11)

The Division does not have adequate monitoring of fuel card usage for its vehicles. Testing of fuel transactions for 60 vehicles revealed 8 (13%) instances of low mpg ratios. Specifically, each vehicle's mpg fell below the Environmental Protection Agency's range for city and highway driving by more than 2 mpg. (page 14)

The Division did not maintain an accurate listing of outstanding fuel cards. The Division's listings of fuel cards for its two fuel vendors dated May 2019, showed 68 more fuel cards than anticipated. (page 16)

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: November 12, 2020

Subject: Legislative Audit of the Department of Administration, Fleet Services Division

On February 18, 2020, your office released an audit report (LA 20-14) on the Department of Administration (department), Fleet Services Division (division). The division subsequently filed a corrective action plan on May 12, 2020. 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 seven recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Develop policies and procedures for monitoring vehicle utilization. Communicate underutilization information to responsible agencies and the Department of Administration.

Status – Partially Implemented

Agency Actions – The division developed policies and procedures for monitoring vehicle utilization. The division updated its Vehicle Utilization Review Procedures, effective January 1, 2020 and has developed a utilization report within its Fleet Anywhere software to identify vehicle usage for leasing agencies. The division reports it is communicating underutilization information to responsible agencies and the Department of Administration.

Auditor Comments - The vehicle utilization review procedures could not be verified due to Covid-19 quarantine restrictions imposed on the Administrator and staff. These

procedures include reviewing monthly trip reports, updating the utilization tracking log, and communicating underutilization to responsible agencies.

Recommendation 2

Require agencies request exemptions from minimum use requirements, when necessary for mission-critical vehicles.

Status – Partially Implemented

Agency Actions – The division is in the process of requiring agencies request exemptions from minimum use requirements, when necessary for mission-critical vehicles. The division shares its Fleet Anywhere utilization report with GFO to identify underutilized vehicles and communicate that information to responsible agencies; its existing policies and procedures were updated to reflect this process. The division also updated its MP-5 Long-Term Vehicle Request Form to require proper identification of the agency vehicle utilization group. The division drafted revisions to the State Administrative Manual (SAM) Chapters 1300 and 1400 to clarify language and procedures for agencies seeking vehicle minimum use exemptions. The draft SAM revisions are expected to be presented for approval at the November Board of Examiners (BOE) meeting.

Recommendation 3

Follow policies and procedures for corrective action when agencies underutilize assigned vehicles, including reassignment or elimination of unused vehicles.

Status – Partially Implemented

Agency Actions – The division is making progress to follow policies and procedures for corrective action when agencies underutilize assigned vehicles, including reassignment or elimination of unused vehicles. The division updated its Vehicle Utilization Review Procedures, effective January 1, 2020 which include guidance for determining when reallocation is appropriate. The division drafted revisions to SAM Chapters 1300 and 1400 to clarify language and procedures for agencies underutilizing assigned vehicles. The revisions strengthen language needed to give the division more authority to transfer underutilized vehicles. The draft SAM revisions are expected to be presented for approval at the November BOE meeting.

Recommendation 4

Ensure required monthly vehicle usage data is obtained from agencies and calculate utilization in accordance with requirements.

Status – Partially Implemented

Agency Actions – The division is in the process of ensuring required monthly vehicle usage data is obtained from agencies and utilization is calculated in accordance with requirements. The division updated its Vehicle Utilization Review Procedures, effective January 1, 2020. Additionally, the division has developed a utilization report within its existing Fleet Anywhere software to identify vehicle usage for leasing agencies. The division revised its MP-3 Monthly Vehicle Trip Report to include Total Days Used for the Month.

Auditor Comments - The vehicle utilization review procedures could not be verified due to Covid-19 quarantine restrictions imposed on the Administrator and staff. These procedures include reviewing monthly trip reports, updating the utilization tracking log, and communicating underutilization to responsible agencies and the Department of Administration.

Recommendation 5

Establish controls to help ensure vehicle maintenance is performed timely.

Status – Partially Implemented

Agency Actions – The division is in the process of establishing controls to help ensure vehicle maintenance is performed timely. The division updated its Monitoring of Scheduled Vehicle Maintenance procedures, effective January 1, 2020. The division reports that an "Equipment Due for Service" report is generated monthly for follow-up by station managers, who then report noncompliant vehicles to the Administrator. The Administrator reportedly notifies noncompliant agencies. Additionally, the division drafted revisions to SAM Chapters 1300 and 1400 to clarify language and procedures for vehicle maintenance. The revisions strengthen language needed to give the division more authority to enforce consequences for non-compliance as well as to clarify vehicle maintenance requirements. The draft SAM revisions are expected to be presented for approval at the November BOE meeting.

Auditor Comments - The "Equipment Due for Service" reports could not be verified as reported due to Covid-19 quarantine restrictions imposed on the Administrator and staff. Likewise, the follow-up with non-compliant agencies could not be verified.

Recommendation 6

Reestablish procedures for using miles per gallon ratios to monitor fuel card billings and investigate fuel purchases for vehicles with unreasonably low miles per gallon.

Status – Partially Implemented

Agency Actions – The division is in the process of reestablishing procedures for using miles per gallon ratios to monitor fuel card billings and investigating fuel purchases for vehicles with unreasonably low miles per gallon. The division updated its Audit of Fuel Usage procedures, effective January 1, 2020. Additionally, the division drafted revisions to SAM Chapters 1300 and 1400 to clarify language and procedures for fuel card use and to establish the division's responsibility when fuel abuse is detected.

Auditor Comments - The Audit of Fuel Usage procedures could not be verified due to Covid-19 quarantine restrictions imposed on the Administrator and staff. These procedures include a monthly review of a select agency's fuel purchases and mileage data, calculating miles per gallon for each vehicle, and communicating questionable transactions or fuel card misuse with agencies' leadership.

Recommendation 7

Establish procedures to periodically review and update fuel card listings.

Status – Partially Implemented

Agency Actions - The division is in the process of establishing procedures to periodically review and update fuel card listings. The division reports it reviews all assigned fuel cards monthly and updates any changes or deletions in a timely manner and tracks all changes in its Fleet Anywhere software.

Auditor Comments - The procedures to review and update the fuel card listings could not be verified due to Covid-19 quarantine restrictions imposed on the Administrator and staff.

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Laura Freed, Director, Department of Administration
Robbie Burgess, Administrator, Fleet Services Division, Department of Administration
Warren Lowman, Administrator, Division of Internal Audits

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January 6, 2021

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

In February 2020, we issued an audit report on the Fleet Services Division (Division) of the Department of Administration. The Division filed its plan for corrective action in May 2020. 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 November 12, 2020, the Office of Finance indicated none of the recommendations were fully implemented and seven recommendations were partially implemented. In its report, the Office of Finance indicated it was unable to confirm whether recommendations had been implemented due to the COVID-19 pandemic. The partially implemented recommendations are shown below.

	Recommendation	Status
Recommendation No. 1	Develop policies and procedures for monitoring vehicle utilization. Communicate underutilization information to responsible agencies and the Department of Administration.	Partially Implemented
Recommendation No. 2	Require agencies request exemptions from minimum use requirements, when necessary for mission-critical vehicles.	Partially Implemented
Recommendation No. 3	Follow policies and procedures for corrective action when agencies underutilize assigned vehicles, including reassignment or elimination of unused vehicles.	Partially Implemented
Recommendation No. 4	Ensure required monthly vehicle usage data is obtained from agencies and calculate utilization in accordance with requirements.	Partially Implemented
Recommendation No. 5	Establish controls to help ensure vehicle maintenance is performed timely.	Partially Implemented
Recommendation No. 6	Reestablish procedures for using miles per gallon ratios to monitor fuel care billings and investigate fuel purchases for vehicles with unreasonably low miles per gallon.	Partially Implemented
Recommendation No. 7	Establish procedures to periodically review and update fuel card listings.	Partially Implemented

In November 2020, we discussed the status of the seven partially implemented recommendations with Division management. We requested documentation from the Division and reviewed new State Administrative Manual regulations. Based on our review of limited documentation and regulations, it appears the Division has fully implemented the seven recommendations. Therefore, we do not have any questions for agency officials.

Many of the recommendations noted above were because the Division did not sustain implementation of the corrective action plan from our previous audit. While we have determined the current recommendations to be fully implemented currently, it is important the agency follow policies and procedures and sustain implementation of these recommendations in the future.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Laura Freed, Director, Department of Administration
Robbie Burgess, Administrator, Fleet Services Division, Department of Administration

Audit Highlights

Highlights of performance audit report on the Department of Taxation issued on March 14, 2019.

Legislative Auditor report # LA20-05.

Background

The Department of Taxation (Department) administers, collects, and distributes a majority of the State's taxes. The Department collects about $6 billion annually from 17 different taxes. In November of 2016, voters approved the Regulation and Taxation of Marijuana Act which legalized the sale of recreational marijuana in Nevada. The Department is responsible for administering the Act.

The Department oversees and enforces marijuana statutes and regulations; issuance, renewal, suspension, and revocation of licenses; and collection of taxes, fees, and penalties.

A tax of 15% is assessed on the first wholesale transfer of marijuana. In addition, a 10% tax is assessed on recreational marijuana sales at the time of purchase. In fiscal year 2018, about $70 million was collected from these excise taxes. The tax revenues cover the cost of the program, fund schools, and supplement the Rainy Day Fund. In addition to the taxes above, sales tax is collected at the appropriate county rate for all retail marijuana sales.

Purpose of Audit

The audit included a review of certain marijuana regulatory and cash collection activities for fiscal year 2018. The purpose of our audit was to determine if regulatory activities related to monitoring marijuana inventory and taxes were adequate, including controls over cash collections.

We encountered certain limitations in obtaining licensee inventory and other records. Documentation could have provided insight regarding system and tax return accuracy.

Audit Recommendations

This audit report contains 13 recommendations to improve the regulation of marijuana. These recommendations will help ensure the Department effectively monitors marijuana tax revenues and inventory.

The Department of Taxation accepted the 13 recommendations.

Recommendation Status

The Department of Taxation's 60-day plan for corrective action is due on June 7, 2019. In addition, the six-month report on the status of audit recommendations is due on December 7, 2019.

Marijuana Regulation and Enforcement

Department of Taxation

Summary

The Department needs to improve its regulation and oversight of the marijuana industry. For instance, the Marijuana Enforcement Tracking Reporting and Compliance (METRC) information system was not accurate or complete. This system is central to the Department's regulation of the industry and maintaining an accord with federal authorities because it is the primary way marijuana cultivation, production, and sales are tracked to prevent diversion and inappropriate activity. Because data in the system is not accurate and complete, it cannot be utilized to verify marijuana tax returns, which did not always appear to be correct. Inaccurate and incomplete data occurred partly because effective monitoring and oversight of the system has not been performed by the Department and guidance has not been provided to licensees. Additionally, the Department has not identified how METRC can be efficiently used, nor has it implemented procedures to identify inappropriate licensee activity. Finally, enhancements to the cash collection process are necessary due to the increase in marijuana taxes.

Marijuana regulation and enforcement is a new and emerging function for the Department. Therefore, an efficient and effective regulatory program is necessary to ensure licensees comply with laws and regulations and the industry withstands federal scrutiny. Because METRC is not used to its capabilities, efficiency is lost and it is difficult for the Department to determine the resources needed to effectively regulate the program.

Key Findings

The Department does not reconcile METRC data to licensee inventory records or tax returns to ensure data in the system is accurate or complete. We compared the tax returns of 10 cultivators and 5 dispensaries to METRC data for the 6-month period spanning January to June 2018, and found the following:

- For wholesale marijuana tax returns filed by cultivators, METRC data did not agree about 70% of the time.
- For retail marijuana tax returns filed by dispensaries, METRC data did not reasonably compare about 57% of the time.
- For sales tax returns filed by dispensaries, METRC data did not reasonably compare about 60% of the time.

Variances reflecting lower inventory sales and transfers in METRC indicate licensees are not recording all appropriate transactions in METRC. Conversely, sales and transfer totals in METRC exceeding that reported on tax returns suggests tax collections may be improper or inadequate. (page 7)

Current procedures performed by the Department do not involve reviewing the accuracy of waste data entered in METRC. As a result, 9 of 10 cultivators tested did not enter data, or entered meaningless information into the system that was not identified and corrected by the Department. Monitoring waste data is important for preventing marijuana products from being diverted outside the regulated system. (page 9)

Products designated for medical cardholders due to the tetrahydrocannabinol (THC) content exceeding statutory limits were sold to recreational consumers. Specifically, we found 262 of 610 (42.9%) single units of medical products tested were sold inappropriately. The Department did not identify or follow-up with licensees regarding inappropriate sales because THC content is not consistently reported in METRC and the Department is not monitoring for these types of activities. (page 10)

Procedures have not been developed to ensure medical marijuana products are accounted for under the proper license in METRC. The Department indicated high potency products should only be associated with a medical license. However, we found dual-licensed facilities are not always associating products or consumer sales to the correct license. As a result, inappropriate sales cannot be easily identified. (page 12)

The Department is not effectively using METRC to monitor production waste amounts. Our analysis of nine cultivators revealed significant fluctuations in the percentage of product recorded as waste during the harvest process. The average waste percentage calculated for individual cultivators varied from a low of 7.9% to a high of 54.3%. (page 13)

METRC's system notifications, which could assist the Department by flagging irregular transactions, have not been activated. METRC allows regulatory agencies to setup custom notifications based on a variety of parameters. When notifications are not active, errors and adjustments made by the licensees are not automatically brought to the attention of the Department. (page 14)

Steve Sisolak
Governor

Susan Brown
Director

Warren Lowman
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: December 7, 2019

Subject: Legislative Audit of the Department of Taxation, Marijuana Regulation and Enforcement Division

On March 14, 2019, your office released an audit report (LA 20-05) on the Department of Taxation (department), Marijuana Regulation and Enforcement Division (division). The department subsequently filed a corrective action plan on June 7, 2019. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the department to comply with audit findings.

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

Recommendation 1

Develop additional policies and procedures to verify the ongoing accuracy and completeness of METRC data. Procedures should address significant data elements.

Status – Fully Implemented

Agency Actions –The division developed additional policies and procedures to verify the ongoing accuracy and completeness of METRC data. The new procedures addressed significant data elements, such as package adjustments, package limits, plants destroyed, dispensary sales not reported, dispensary sales above the THC baseline of 115mg, transfers, and lack of activity. Through METRC notifications the division examines any irregularities and/or violations of state regulations. If any irregularities are found, the notifications are assigned to the appropriate auditor/inspector. The auditor/inspector conducts a review and either proposes a Plan of Correction (POC) and refers to the Compliance Investigator for civil penalty recommendations or provides

reasoning as to why no further actions are deemed necessary. To ensure compliance with updated processes and procedures METRC training was conducted for cultivators, dispensaries, and processors in June 2019.

Recommendation 2

Utilize METRC to identify licensees at risk for potential tax deficiencies and incorporate the use of METRC data into the audit selection process.

Status – Fully Implemented

Agency Actions –The division utilizes METRC to identify licensees at risk for potential tax deficiencies and incorporates the use of METRC data into the audit selection process. The division uses data pulls in conjunction with standardized monthly and quarterly reports to better identify tax deficiencies, and this data is further incorporated into the audit selection process. The division issued listserv emails with a directive that effective January 1, 2019 all licensed cultivation, production, and retail stores were required to provide monthly reports in an effort to collect and compile data from the industry. Additionally, all licensed cultivation, production, and retail stores were required to submit quarterly inventory documents to the department. The division issued civil penalty warning letters to operators who were not compliant with aforementioned reporting procedures.

Recommendation 3

Obtain reports required by NRS 372A.285. Compare the reports to METRC and utilize information to regulate the industry.

Status – Partially Implemented

Agency Comments – The division obtained reports as required by NRS 372A.285 and is currently in the process of comparing the reports to METRC and utilizing the information to regulate the industry. In accordance with statute, the division issued listserv emails with a directive that effective January 1, 2019 all licensed cultivation, production, and retail stores were required to submit monthly reports to the department that included data for harvests, production, and sales. Civil penalty letters were distributed regularly to licensees that were delinquent or failed to provide monthly reports. The division is in the process of hiring additional auditors to utilize the information from the reporting procedures to regulate the industry. The division expects full implementation by January 2020.

Recommendation 4

Develop procedures to monitor data in METRC regarding harvest weights, waste, package weights, and moisture loss. Follow up on incomplete, erroneous, or irregular entries.

Status – Fully Implemented

Agency Comments – The division developed procedures to monitor data in METRC regarding harvest weights, waste, package weights, and moisture loss. The division is following up on incomplete, erroneous, or irregular activity through newly developed audit procedures. METRC notifies the division of packages adjusted, transfers not received, packages exceeding weight limit, large amounts of destroyed/wasted product, packages with excessive adjustments, sales not reported, packages exceeding weight limits, large amount of destroyed/wasted product, etc. If any irregularities are found the notifications are assigned to the appropriate auditor/inspector. The auditor/inspector conducts a review and either proposes a Plan of Correction (POC) and refers to the Compliance Investigator for civil penalty recommendations or provides reasoning as to why no further actions were necessary.

Recommendation 5

Establish additional procedures to regulate and identify inappropriate sales of high potency (medical) products.

Status – Fully Implemented

Agency Actions – The division established additional procedures to regulate and identify inappropriate sales of high potency products. On May 13, 2019, Bulletin #026 was distributed to all METRC users and included details on new reporting requirements and new features. The reporting requirement highlighted in the bulletin was the new process for reporting THC content. Effective May 17, 2019 all medical and retail facilities were required to enter the “THC Content” for each of their items. METRC notifications allow the division to examine any irregularities and/or violations of state regulations. If any irregularities are found the notifications are assigned to the appropriate auditor/inspector. The auditor/inspector conducts a review and either proposes a Plan of Correction (POC) and refers to the Compliance Investigator for civil penalty recommendations or provides reasoning as to why no further actions were necessary.

Recommendation 6

Establish procedures to ensure marijuana products are accounted for and sold under the proper license.

Status – Fully Implemented

Agency Actions – The division established procedures to ensure marijuana products are accounted for and sold under the proper license. METRC system allows the division to query each transaction to determine if it was sold to a patient or a customer. Additionally, per Bulletin #026, all medical and retail facilities are required to add THC Content for each of their items. This change allows the division to identify high potency (medical) products. Furthermore, a METRC notification for sale of products with a THC baseline of 100mg has been established, which allows each notification to be addressed and documented with actions taken by the division.

Recommendation 7

Develop statistics and benchmarks from METRC data regarding regulatory activities.

Status – Partially Implemented

Agency Actions – The division is developing statistics and benchmarks from METRC data regarding regulatory activities. METRC notifications are now active for package adjustments, transfers not received, package weights, limited or no activity, destroyed/wasted product, and external transfers. As of October 2019, the division was in the process of hiring auditors with the goal of making advancements in developing statistics and benchmarking data. The division expects full implementation by January 2020 as improvements are made with METRC functionality and data.

Recommendation 8

Establish a program to monitor METRC data and identify and investigate irregular activity.

Status – Fully Implemented

Agency Actions – The division established a program to monitor METRC data and identify and investigate irregular activity. Through METRC notifications the division can examine any irregularities and/or violations of state regulations. If any irregularities are found, the notifications are assigned to the appropriate auditor/inspector. The auditor/inspector conducts a review and either proposes a Plan of Correction (POC) and refers to the Compliance Investigator for civil penalty recommendations or provides reasoning as to why no further actions were deemed necessary. METRC training was conducted in June 2019 for cultivators, dispensaries, and processors to ensure compliance with updated processes and procedures.

Recommendation 9

Identify and establish system notifications using METRC data. Review and follow up on notifications.

Status – Fully Implemented

Agency Actions – The division identified and established system notifications using METRC data. The division is reviewing and following up on notifications through newly implemented audit procedures. METRC is active and includes notifications for limited/no activity, test results, package limits, product waste/destruction, transfers, and sales not reported. The implementation of several other notifications is currently pending with METRC. Through METRC notifications the division can examine any irregularities and/or violations of state regulations. If any irregularities are found the notifications are assigned to the appropriate auditor/inspector. The auditor/inspector conducts a review and either proposes a Plan of Correction (POC) and refers to the Compliance Investigator for civil penalty recommendations or provides reasoning as to why no further actions were deemed necessary.

Recommendation 10

Revise how THC is reported in METRC and on lab reports. Ensure total product THC is identifiable and congruent with state law.

Status – Fully Implemented

Agency Actions – The division revised how THC is reported in METRC and on lab reports and ensures that total product THC is identifiable and congruent with state law. On May 13, 2019 Bulletin #026 was distributed to all METRC users that included details on new reporting requirements and new features. The reporting requirement highlighted in the bulletin was the new process for reporting THC content. Effective May 17, 2019 all medical and retail facilities were required to enter the "THC Content" for each of their items. This change allows industry users and division staff to more easily identify high potency (medical) products.

Recommendation 11

Provide licensees guidance regarding data input requirements for THC information and lab results. Monitor licensee compliance with data input.

Status – Fully Implemented

Agency Actions – The division provides licensees guidance regarding data input requirements for THC information and lab results and monitors compliance with data input. METRC Bulletin #006 requires licensees to contact METRC and the department

to upload lab tests prior to transferring product. On February 28, 2019 the division issued a listserv email that specified all licensees were required to have lab results for beginning inventory uploaded into METRC prior to April 1, 2019. Any beginning inventory that didn't have lab results was to be destroyed before April 15, 2019. On May 13, 2019 METRC Bulletin #026 was distributed to all METRC users and required licensees to enter the "THC Content" for each of their items. The division randomly samples licenses on a monthly basis to ensure compliance with THC data input.

Recommendation 12

Revise tax return instructions to provide appropriate guidance to licenses regarding how month-end wholesale transactions should be recorded on tax returns.

Status – Fully Implemented

Agency Actions – The division revised tax return instructions to provide appropriate guidance to licenses regarding how to record month-end wholesale transactions should be recorded on tax returns. Wholesale marijuana tax return forms and retail marijuana tax return forms have been updated with a clarifying statement, "All sales must be reported in the month that the sale occurred." Detailed instructions have been created to help guide individuals through both forms. Additionally, a listserv email was sent out on February 28, 2019 further noting that all sales had to be reported in the month that the sale occurred.

Recommendation 13

Evaluate and install additional security measures.

Status – Fully Implemented

Agency Actions – The division evaluated and installed additional security measures. We reviewed security details with the department on November 6, 2019. Due to the sensitive nature of this information, we are not able to provide details.

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Melanie Young, Executive Director, Department of Taxation
Tyler Klimas, Executive Director, Cannabis Compliance Board
Warren Lowman, Administrator, Division of Internal Audits

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February 8, 2020

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

In March 2019, we issued an audit report on the Department of Taxation, Marijuana Regulation and Enforcement Division (Division). The Division filed its plan for corrective action in June 2019. 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 13 recommendations contained in the audit report. As of December 7, 2019, the Office of Finance indicated 11 recommendations were fully implemented and 2 recommendations were partially implemented. The partially implemented recommendations are shown below.

	Recommendation	Status
Recommendation No. 3	Obtain reports required by NRS 372A.285. Compare the reports to METRC and utilize information to regulate the industry.	Partially Implemented
Recommendation No. 7	Develop statistics and benchmarks from METRC data regarding regulatory activities.	Partially Implemented

For Recommendation No. 3, the Office of Finance indicated the Division is requiring entities to submit reports monthly, but the information was not utilized to regulate the industry. According to the Division, it needed to hire additional auditors to utilize the information contained in these reports to regulate the industry. The Division informed us in January 2020 that it is currently comparing report and METRC data. Variances are referred for further audit review or investigation. As such, we consider Recommendation No. 3 fully implemented.

For Recommendation No. 7, the Office of Finance indicated the Division was developing statistics and benchmarks from METRC data regarding regulatory activities. The Division intends to utilize data to monitor the industry. The Division provided an update in January 2020 stating it has compiled all 2019 statistical data from METRC and is working to identify state-wide industry trends. In addition, the Division is working with METRC to gather and analyze

nationwide data and trends. Once information is obtained and analyzed, the Division intends to utilize these statistics and benchmarks in regulating the industry.

We acknowledge that compiling and analyzing data, to be accurate and useful for regulatory purposes, can take time. The Division continues to make progress in implementing Recommendation No. 7. As such, we do not have any questions for the Division at this time. We will continue to monitor the Division's progress in fully implementing Recommendation No. 7.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Melanie Young, Director, Department of Taxation (TAX)
Tyler Klimas, Executive Director, Cannabis Compliance Board, TAX

Education

Audit Highlights

Highlights of performance audit report on the Nevada Office of the Western Interstate Commission for Higher Education issued on February 18, 2020.

Legislative Auditor report # LA20-10.

Background

The Office of the Governor, Nevada Office of the Western Interstate Commission for Higher Education (Office) is responsible for identifying critical gaps in the statewide health care workforce. In response, the Office provides financial assistance, reduced tuition, and preferential admission to Nevada students at participating schools. Participants must return to Nevada for 2 to 4 years to meet workforce shortages. Many remain in Nevada and continue providing needed services after they meet contractual requirements. The Office expands access to health care throughout Nevada and generates additional employment opportunities.

The Office is located in Carson City. The Office has two permanent positions: a Director and an Accounting Technician.

The Office has two budget accounts with total expenditures of $1.48 million in fiscal year 2019.

Purpose of Audit

The purpose of the audit was to evaluate if program controls and processes ensure participants met contractual obligations and if controls over loan advances and repayments were adequate.

Our audit focused primarily on fiscal years 2018 and 2019. We also reviewed prior years as necessary.

Audit Recommendations

The audit report contains 10 recommendations to improve controls over ensuring participants meet contractual obligations and protecting financial data accuracy.

The Office accepted the 10 recommendations.

Recommendation Status

The Office's 60-day plan for corrective action is due on May 12, 2020. In addition, the 6-month report on the status of audit recommendations is due on November 12, 2020.

Nevada Office of the Western Interstate Commission for Higher Education

Office of the Governor

Summary

The Office does not have strong controls to ensure participants meet contractual obligations, including repaying program fees and fulfilling in-state practice requirements. For example, the Office does not adequately monitor if participants report on meeting practice requirements or verify if information received is accurate. Additionally, incomplete data and limited collection activities could result in participants not repaying loans. Office files did not contain evidence of practice requirements for approximately $1.6 million in grants to participants. Stronger controls can help maintain program viability for future students and address critical workforce shortages in Nevada.

Financial transactions were not always properly recorded nor were participant records accurate and complete. For instance, the Office did not reconcile advances or payment records between the state accounting system and the loan processing system. As a result, about $116,700 in transactions were incorrectly recorded between the two systems. Additionally, 67% of files contained errors such as missing or inaccurate payments, incorrect dates, and loans with an improper status. Better controls would help ensure financial integrity and sustainability, and may increase staff efficiency as well.

The Office does not have clear documentation on the division of roles and responsibilities between Office staff, the Office of Science, Innovation and Technology (OSIT), and the Commission. Furthermore, many of the issues noted in this report occurred because policies and procedures were insufficient or not followed. As a result, important programmatic and accounting functions did not occur.

Key Findings

The Office does not adequately monitor participants to ensure they meet in-state professional practice requirements. Participants who do not return to practice in Nevada must repay the grant. Over 41% of participant files tested did not have current documentation showing compliance with requirements. Statute requires participants to provide documentation regarding practice obligations annually. However, the Office does little to ensure participants comply or grants are repaid when obligations are not met. As a result, revenue from grant repayments decreased from $197,000 to $70,000 between fiscal years 2017 and 2018. (page 6)

Graduation dates in the loan processing system were not always complete. About $45,200 in program fees remain uncollected because the Office does not have adequate controls over data accuracy. The Office's loan processing system will not require repayment of program fees unless valid graduation dates are entered. (page 9)

The Office does not adequately follow up on past due loans. Seventeen loans, totaling $94,700 were past due as of February 2019. The Office can perform collection activities earlier which may prevent accounts from becoming severely delinquent. (page 10)

The loan processing system contained significant errors. Many of the errors noted could have been identified if the Office performed reconciliations of its financial transactions. Three advances paid during fiscal year 2018, totaling about $36,000, were never recorded in the system. Furthermore, the Office applied $68,000 more to participant accounts than was actually paid. Finally, the Office did not receive nearly $10,000 from the contracted loan processor for payments made on participant accounts. Because funding is limited, the recovery of amounts due is essential to the program's continued operation. (page 12)

The Office did not calculate interest on advances correctly because amounts were not entered into the loan software timely or accurately. In total, about $15,000 in interest on 51 accounts was not calculated by the system and automatically applied to participant accounts. (page 13)

The Office does not have adequate documentation on the division of roles and responsibilities between Office staff, OSIT, and the Commission. Additional clarity would enhance programmatic and accounting functions, such as following up with participants on their contractual obligations and protecting financial data accuracy. (page 15)

Steve Sisolak
Governor

Susan Brown
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: Susan Brown, Director
Governor's Finance Office

Date: November 12, 2020

Subject: Legislative Audit of the Office of the Governor, Nevada Office of the Western Interstate Commission for Higher Education

On February 18, 2020, your office released an audit report (LA 20-10) on the Office of the Governor, Nevada Office of the Western Interstate Commission for Higher Education (office). The office subsequently filed a corrective action plan on May 12, 2020. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the office to comply with audit findings.

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

Recommendation 1

Enhance policies and procedures to ensure participants report on practice requirements. Procedures should address documenting and verifying practice requirements, employment and licensure, and sending reminder notifications.

Status – Partially Implemented

Agency Actions – The office enhanced policies and procedures to ensure participants report on practice requirements and to address documenting and verifying practice requirements, employment and licensure, and sending reminder notifications. The office is developing an internal tracking spreadsheet and subscribed to a mass communication service that sends reminder notifications to participants. The reminder notifications will help in the verification of practice requirements, employment status, and licensure. However, the office states it has not completed the verification of practice requirements

and has not resolved all open accounts. The office anticipates full implementation by September 30, 2021.

Recommendation 2

Develop an efficient program tracking tool.

Status – Partially Implemented

Agency Actions – The office developed an efficient program tracking tool to begin tracking and ensuring participants report on practice requirements. The tracking tool is a spreadsheet that will help in assessing students accounts by collecting information such as: service grants and loan balances, graduation date, and date the office last requested to confirm employment status.

The tracking spreadsheet has not been fully populated with current information and there are multiple accounts with non-current information. The office is reviewing and updating accounts in the tracking spreadsheet and anticipates the spreadsheet will be fully populated by September 30, 2021.

Recommendation 3

Develop a course of action against current and future participants who provide false information on practice questionnaires. Include steps for escalating to the Office of the Attorney General when appropriate.

Status – Partially Implemented

Agency Actions – The office reports it is developing a course of action against current and future participants who provide false information on practice questionnaires, including steps for escalating to the Office of the Attorney General when appropriate. The office identified four individuals that provided false information on practice questionnaires and referred two to the Attorney General's Office and the other two to the commission for conversion of their grants to loans.

Although the office referred the four cases to the appropriate authorities, a formal, written course of action is still being developed. The office represents a formal written course of action will be developed by April 30, 2021.

Recommendation 4

Develop policies and procedures to ensure that data is accurate, and systems are working as intended.

Status – Partially Implemented

Agency Actions – The office reports it is in the process of developing policies and procedures to ensure that data is accurate, and systems are working as intended. According to the office, the first step in this process is conducting an internal audit of open student accounts to identify and correct data entry errors. The office represents that due to limited staffing, the anticipated implementation date is April 30, 2021.

Recommendation 5

Update and follow policies and procedures for debt collection actions, including time frames for collection on past due loans.

Status – Partially Implemented

Agency Actions – The office reports it is updating policies and procedures for debt collection actions, including the time frames for collection on past due loans. The office represents it is now reviewing open accounts and identifying those that need to be referred to the Controller's Office for write-off.

In addition, the office resumed using its loan service provider to make telephone calls to participants on past due accounts in September 2020, which resulted in collections on two of 18 delinquent accounts. The office anticipates policies and procedures will be updated by April 30, 2021.

Recommendation 6

Perform reconciliations between the state accounting system, loan processing system, program database, and participant files.

Status – Fully Implemented

Agency Actions – The office started performing monthly reconciliations between the state accounting system and the loan processing system in July 2020. We reviewed three monthly reconciliations (July through September) and confirmed the new process is effective at identifying variances between the state accounting system and the loan processing system.

Recommendation 7

Obtain any missing payments from the loan processor.

Status – Fully Implemented

Agency Actions – The office obtained the missing payments from the loan processer totaling $9,928.76. We reviewed the missing payments schedule and reconciled it to the amount recorded in the state's accounting system to confirm the payments were received.

Recommendation 8

Monitor the timeliness and accuracy of data entered into information systems.

Status – Partially Implemented

Agency Actions – The office represents it is monitoring the timeliness and accuracy of data entered into information systems by reviewing each participant's account to identify and correct data entry errors. Additionally, the office is revising data entry procedures to ensure the accuracy of participant data moving forward. The office anticipates full implementation of this recommendation by April 30, 2021.

Recommendation 9

Develop policies and procedures regarding the roles, responsibilities, and structure between Office staff, OSIT, and the Commission.

Status – Partially Implemented

Agency Actions – The office represents it is in the process of developing policies and procedures to clarify the roles, responsibilities, and structure between the office staff, OSIT, and the Commission. The office anticipates full implementation of this recommendation by April 30, 2021.

Recommendation 10

Review all policies and procedures and update as necessary. Develop controls to ensure procedures are followed.

Status – Partially Implemented

Agency Actions – The office represents it is in the process of reviewing and updating its existing policies. Once policies and procedures are updated, the office represents it will develop controls to ensure these procedures are followed. The office anticipates full implementation of this recommendation by April 30, 2021.

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Jennifer Ouellette, Director, Nevada Office of the WICHE
Warren Lowman, Administrator, Division of Internal Audits

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January 6, 2021

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

In February 2020, we issued an audit report on the Nevada Office of the Western Interstate Commission for Higher Education (Office) of the Office of the Governor. The Office filed its plan for corrective action in May 2020. 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 10 recommendations contained in the audit report. As of November 12, 2020, the Office of Finance indicated two recommendations were fully implemented and eight recommendations were partially implemented. The partially implemented recommendations are shown below.

	Recommendation	Status
Recommendation No. 1	Enhance policies and procedures to ensure participants report on practice requirements. Procedures should address documenting and verifying practice requirements, employment and licensure, and sending reminder notifications.	Partially Implemented
Recommendation No. 2	Develop an efficient program tracking tool.	Partially Implemented
Recommendation No. 3	Develop a course of action against current and future participants who provide false information on practice questionnaires. Include steps for escalating to the Office of the Attorney General when appropriate.	Partially Implemented
Recommendation No. 4	Develop policies and procedure to ensure that data is accurate, and systems are working as intended.	Partially Implemented
Recommendation No. 5	Update and follow policies and procedures for debt collection actions, including time frames for collection on past due loans.	Partially Implemented
Recommendation No. 8	Monitor the timeliness and accuracy of data entered into information systems.	Partially Implemented
Recommendation No. 9	Develop policies and procedures regarding the roles, responsibilities, and structure between Office staff, OSIT, and the Commission.	Partially Implemented
Recommendation No. 10	Review all policies and procedures and update as necessary. Develop controls to ensure procedures are followed.	Partially Implemented

The 6-month report indicates the Office plans on fully implementing the remaining recommendations between April 2021 and September 2021.

Question

1. How does the agency anticipate meeting the implementation dates in the 6-month report?

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Jennifer Ouellette, Director, Nevada Office of the Western Interstate Commission for Higher Education Programs

Commerce/Industry

Audit Highlights

Highlights of performance audit report on the Office of the Nevada Attorney for Injured Workers issued on January 14, 2021.

Legislative Auditor report # LA22-01.

Background

The Office of the Nevada Attorney for Injured Workers (NAIW) was established in 1977 within the Department of Business and Industry. NAIW represents injured workers in litigation for workers' compensation benefits by providing free legal representation and access to workers' compensation information to help ensure an injured worker has an equal opportunity to a fair judgment.

In the event an injured worker has their workers' compensation claim denied by an insurer or employer, they can appeal the denial to a Hearing Officer of the Department of Administration. If the Hearing Officer upholds the denial, the injured worker can further appeal to an Appeals Officer and request representation from NAIW. The Appeals Officer will appoint the case to NAIW who can represent the worker in front of an Appeals Officer, District Court Judge, or Supreme Court Judge.

For fiscal year 2020, NAIW had 32 authorized full-time positions with office locations in Carson City and Las Vegas.

Purpose of Audit

The purpose of this audit was to determine whether NAIW had adequate controls over information systems, performance measures, sensitive information, and case management timeliness. The scope of the audit focused on NAIW's activities for the 18-month period, July 2018 to December 2019.

Audit Recommendations

This audit report contains seven recommendations to improve administrative controls over information systems, performance measures, and safeguarding of sensitive information.

NAIW accepted the seven recommendations.

Recommendation Status

NAIW's 60-day plan for corrective action is due on April 9, 2021. In addition, the 6-month report on the status of audit recommendations is due on October 9, 2021.

Office of the Nevada Attorney for Injured Workers

Department of Business and Industry

Summary

The Office of the Nevada Attorney for Injured Workers (NAIW) can improve its oversight of certain activities. Specifically, information systems administration needs additional monitoring to ensure the continuation of critical services. Additionally, NAIW reported unreliable performance measures to decision makers and could improve by emphasizing outcome based performance measures. Finally, the security of personally identifiable information was not adequate.

Case management administration was adequate in ensuring the timeliness of cases although NAIW experienced delays in receiving crucial evidence and information from third parties. Specifically, case processes were generally timely including NAIW sending and requesting necessary documents in a prompt manner. However, the need for evidence from third parties delayed some hearings. Injured workers can experience financial and mental stress while fighting for workers' compensation benefits so timely resolution of cases is important.

Key Findings

Controls over information systems administration were deficient. Specifically:

- NAIW was not timely in renewing its service level agreement for information technology (IT) services which resulted in NAIW having no guarantee that their data was being properly backed up. The most recent agreement with NAIW's IT vendor expired in June 2019 and had not been renewed until April 2020. (page 4)
- User accounts that provide access to critical systems have not been periodically reviewed, which increases the risk of unauthorized access to sensitive data. In addition, unnecessary user accounts were not always disabled or removed in a timely manner. (page 5)
- Continuation of critical services was not ensured. Specifically, NAIW does not verify the adequacy of server backups and has not requested backup testing results from their IT vendor in the past. In addition, NAIW does not have a written IT contingency plan. Furthermore, background checks were not conducted on NAIW's IT service vendor's employees which helps lower the risk of harm or disruption to a system. (page 6)
- NAIW was not aware of its responsibility to ensure the IT vendor's employees completed required annual security awareness training. Without completing such training, NAIW has less assurance that data and systems are adequately protected. (page 7)

The accuracy of performance measures reported in the Governor's Executive Budget could not be substantiated. NAIW did not retain appropriate supporting documentation on four fiscal year 2018 measures. Our review of supporting documentation regarding the remaining four measures found: supporting documents did not show how NAIW calculated three of the measures; supporting documents did not always agree to amounts reported; there was no evidence of review by management for any measure tested; and extensive manual work was required by staff to calculate two reported measures. Additionally, NAIW does not have comprehensive policies or procedures for performance measures. (page 7)

Measures used in the State's budgeting process can be revised to incorporate outcome based performance measures. The fiscal year 2018 measures NAIW reported provide workload and timeliness statistics. Outcome based measures were not emphasized but are recommended as they better demonstrate an agency's impact on citizens of Nevada. (page 9)

NAIW does not adequately secure personally identifiable information during nonbusiness hours. Individuals who are authorized to enter NAIW's offices, such as the non-state employed janitorial crews, have access to clients' personal information including Social Security numbers and medical records in unsecured file cabinets. (page 10)

NAIW was timely in sending and requesting necessary case management documents. These documents include welcome packages to commence work on a case, claim files that contain facts of each case prior to NAIW's appointment, and case closure letters which notify clients of their right to appeal further to the District Court. (page 13)

The need for evidence and information from third-party sources delayed some cases. NAIW does not have control over the timeliness of receiving claim files, medical records, doctors' opinions, and independent medical evaluations. We found that waiting for this evidence and information contributed to delayed hearings. (page 14)

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 Real Estate Division issued on September 3, 2020.

Legislative Auditor report # LA20-17.

Background

The mission of the Real Estate Division (Division) is to protect the public and Nevada's real estate sectors by fairly and effectively regulating real estate professionals through licensure, registration, education, and enforcement. The Division shares authority with three Governor-appointed commissions. These commissions conduct disciplinary hearings, assess fines, adopt regulation changes, approve education courses, as well as hold other authorities to regulate the real estate marketplace.

The Division's main office is located in Las Vegas, with a secondary office located in Carson City. The Division administers five budget accounts, funded primarily through fees and a General Fund appropriation. In fiscal year 2019, the Division recorded over $14 million in revenues, and expenditures totaled over $7 million.

As of June 30, 2019, the Division had 51 filled positions.

Purpose of Audit

The purpose of this audit was to determine if controls over the collection of certain cash receipts and accounts receivable were adequate, and if the Division has adequate processes to ensure licensees comply with laws related to reporting requirements for broker trust accounts. This audit included a review of financial and administrative activities during fiscal year 2019, and accounts receivable information from prior years.

Audit Recommendations

This audit report contains six recommendations to improve oversight and controls over cash receipts, six recommendations to strengthen the Division's regulation of broker trust accounts, and two recommendations to improve collections of accounts receivable.

The Division accepted the 14 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on December 3, 2020. In addition, the 6-month report on the status of audit recommendations is due on June 3, 2021.

Real Estate Division

Department of Business and Industry

Summary

The Division's financial and administrative controls over revenues are inadequate. Specifically, there are limited system controls in the Division's database to prevent users from making changes to licensees' accounts to misappropriate cash, or to detect fraud once it has occurred. Furthermore, internal control procedures designed to compensate for the lack of system controls are not being adhered to by supervisors and staff. Additionally, the Division's procedures for processing refunds and reconciling revenues received and posted to real estate licensees' accounts and the state accounting system are inadequate. In fiscal year 2019, the Division collected over $8 million in licenses and fees, with 6% being cash collections. A lack of controls over revenues leaves the Division vulnerable to fraud and errors.

The Division has not provided effective oversight of broker trust fund accounts. Specifically, the Division only tracks submissions and assesses fines to a subset of the broker population, when all brokers are required to submit annual forms regarding their trust accounts or attest to the lack thereof. In addition, for the brokers who do submit trust account reconciliations, the Division's review of the documentation is inadequate and inconsistent. Inadequate records or failure to maintain control of trust funds can result in theft, commingling, or misuse of trust account funds.

The Division does not actively pursue collections of past due accounts and continues to have difficulty monitoring and submitting debt timely to the State Controller. Similar problems with collections were reported in our prior two audits in 2000 and 2009. Additionally, the Division's internal tracking spreadsheets are inaccurate, affecting collections on accounts and reporting of accounts receivable by the State Controller. In fiscal year 2019, the Division's three commissions levied nearly $3 million in fines, but only collected $130,000 of that amount (a 5% collection rate). If the Division does not actively pursue past due amounts early, the likelihood of collecting debt decreases with time.

Key Findings

Controls over voiding cash receipts and for making other adjustments to real estate licensees' accounts within the Division's database are inadequate. Specifically, there is no segregation of duties within the database; thereby, allowing employees to add or delete revenues from an account without any record of the edits to the account. In fiscal year 2019, 7% of all transactions processed in the Division's database were voided. (page 6)

The Division lacks controls to ensure refunds are posted timely to its database, and that only valid refunds are posted and issued. In fiscal year 2019, the average number of days between a refund check being issued from the state accounting system and the refund being entered into the Division's database was 140 days. The longest refund examined took 2,661 days to post in the Division's database, or nearly 7 years after the check was already issued. Without adequate controls over refunds, there is a higher risk of refunds being duplicated, or that credits in the system could be used to conceal theft. (page 9)

The Division's current practice only holds brokers that manage properties accountable for submitting trust account information annually. However, regulation requires all brokers to report trust account information, or attest that they do not manage trust accounts. Brokers that are property managers are less than half of the population within the State, but are the only ones held accountable for reporting by the Division. Brokers that are property managers and do not comply with reporting requirements may be fined thousands of dollars, while brokers that are not property managers are not fined nor requested to report. (page 11)

The Division's procedures for monitoring trust accounts are inadequate and ineffective. For 13 of 19 (68%) broker trust account reconciliations tested, we observed the information reported to the Division was incomplete or contained unallowed accounting entries. In addition, the Division does not have an effective process to track and verify all trust accounts are reported, and to help ensure brokers do not hide fraudulent activities. Without proper monitoring of trust accounts, individuals may be at risk from broker misconduct. (page 13)

Over the last 5 fiscal years (2015–2019), the Division submitted debt for collections with the State Controller, on average, 1.9 years after the debt became 60 days past due, with the longest in our testing taking 6.7 years. In addition, the Division has not maintained accurate accounts receivable information for reporting outstanding amounts to the State Controller. (page 18)

STEVE SISOLAK
Governor

STATE OF NEVADA

TERRY REYNOLDS
Director

SHARATH CHANDRA
Administrator

DEPARTMENT OF BUSINESS AND INDUSTRY
REAL ESTATE DIVISION
www.red.nv.gov

December 3, 2020

Susan Brown, Director
Governor's Finance Office
209 East Musser Street
Carson City, Nevada 89701

Re: Nevada Real Estate Division Corrective Action Plan

Dear Ms. Brown:

On September 3, 2020, an audit by the Legislative Council Bureau was issued for the Department of Business and Industry, Real Estate Division. Pursuant to NRS 218G.250 and 218G.270 the Real Estate Division has prepared a plan of corrective action to address the recommendations in the audit report.

The Division wants to thank the LCB auditors and the Chairman and members of the Audit Sub-Committee of the Legislative Commission. The Real Estate Division is committed to identifying and improving agency operations in addition to compliance with state guidelines and statutory requirements.

We are confident that these efforts will enhance and strengthen the Division as we move forward. If you have any comments or questions, please do not hesitate to contact me.

Respectfully,

Sharath Chandra - Administrator
Nevada Real Estate Division
Department of Business and Industry

Enc: Agency Corrective Action Plan

Cc: Warren Lowman, Administrator, Division of Internal Audits
Daniel Crossman, Legislative Auditor, LCB - Audit Division
Terry Reynolds, Director, Department of Business and Industry
Budd Milazzo, Deputy Director, Department of Business and Industry

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Corrective Action Plan

Nevada Real Estate Division

1. **Evaluate all user roles in the database to ensure staff access is appropriate for their duties and responsibilities, in addition to ensuring proper segregation of duties.**

   Completed: The Division has obtained a master document of functional user permissions from the database vendor.

   Completed: The Division has created a spreadsheet of current roles and users in the database.

   On Going: The Division will identify functions within current roles in the Database that require segregation.

   Next Steps: Division will work with Vendor to identify if certain functions within current roles could be modified to restrict access.

   Next Steps: If modifying or customizing requires costly upgrades to the Database, Division will reevaluate system roles based on staff duties and responsibilities, using the master document and spreadsheet as a key.

2. **Establish monitoring controls to ensure supervisors and staff are following the Division's internal control procedures for documenting and approving voids.**

   Completed: The Division has reviewed current internal controls regarding voids and has identified several areas of improvement.

   Completed: Licensing and Administration managers have informed appropriate staff of the procedures for handling void transactions and staff have begun using these procedures

   Ongoing: The Division has developed and is finalizing the revised and updated internal control procedures.

3. **Develop procedures for documenting transferred payments between accounts and credit adjustments**

   Ongoing: The Division use transfers for certain transactions and occasional credit adjustments Division will develop procedures for documenting credit adjustment and

transfer transactions. This will dovetail into #6 Audit Recommendation which recommends the Division perform a regular revenue reconciliation between Advantage and the Division's database.

4. **Update internal control policies and procedures to include an independent verification that a refund issued by the State Controller was accurately posted in the database and perform a monthly reconciliation, agreeing all refunded amounts to the state accounting system.**
5. **Post refunds timely in the database once a check has been issued by the State Controller.**

Completed: These two (2) recommendations encompass the entire refund process. Prior to commencement of the audit, the Division had begun developing a comprehensive internal control policy that addressed refunds processed in the database including documentation, supervisory approval, verifying that the Controller's office issued the check, and the final reconciliation. This detailed internal control policy was sent to the LCB auditors. The Division also received suggestions from the LCB auditors on accessing data from DAWN to confirm refund checks were issued.

Ongoing: Final steps of reconciling with DAWN to the Division's database are being worked on with Business and Industry fiscal staff. Draft procedures are being prepared and will be formalized.

6. **Perform a revenue reconciliation between the database and the state accounting system routinely, addressing any differences timely.**

The Division's database was developed as a licensing database and was never intended to be an accounting program. Throughout the years efforts have been made to adapt the database to provide some assistance with the accounting side, however only in patch form. The Division currently has a technology investment notification (TIN) to update the Division's database.
Advantage and the Division's database do not communicate together at all. One example would be that the database combines all budget accounts into the revenue general ledger. There is no budget account segregation. Advantage segregates the revenue general ledgers into separate budget accounts. Additionally, each system refers to different posting/transaction dates between receipt of the funds and posting.

Next Steps: The Division will work with Business and Industry fiscal staff to develop a process to perform a revenue reconciliation between the database and the state accounting system regularly. The process being developed includes fiscal staff from

Business and Industry verifying coding provided by the Division to transactions entered into Advantage. Fiscal staff will download reports from both DAWN and SOAR to provide to the Division's designated staff, when discrepancies are identified. Business and Industry will work with the Division to develop a document to track all adjustments.

8. **Develop policies and procedures for waiving sanctions, including sufficient documentation of reasoning for waiver.**

   Completed: Waiving of fines for not submitting trust account reconciliations or form 546A in lieu of trust account reconciliation was initially implemented as a way to encourage brokers to submit the forms every year. Currently, waiving of sanctions are only approved by the Chief Investigator and on a case by case basis.

   Completed: Documentation for sanctions that were waived is included in the database. There may be isolated exceptions due to a significant life event a licensee may have experienced for a fine to be waived.

   Ongoing: The documentation for waiving an administrative sanction is entered into the database under the case number so that this information can be reviewed if the licensee ever receives the same sanction again. The Division will continue to ensure that the documentation is sufficient and detailed.

   Next Step: The Division will develop a procedure for ensuring notes and supporting documentation is included in the database for administrative sanctions other than trust account reconciliations that were approved to be waived.

7. **Require all brokers to file trust account forms annually and assess administrative sanctions for noncompliance.**

9. **Utilize the database to track trust account reconciliation submittal for all licensed real estate brokers.**

10. **Implement a monitoring process to include comparing bank account information submitted on the annual trust account reconciliations to what was submitted by each broker in their prior year filings, following up on any discrepancies.**

11. **Develop and implement controls to monitor outstanding trust account reconciliation items.**

12. **Develop a risk-based approach for monitoring and initiating inspections of broker trust accounts.**

The Division would like to address recommendations **7**, **9**, **10**, **11** and **12** collectively as it involves trust accounts and the Division's ability to collect, monitor, track, review, inspection, and discipline licensees.

Completed: The Division has now implemented a process where brokers on their biennium renewal will be required to submit a trust account reconciliation Form 546 or Form 546Ain lieu of a reconciliation to complete their license renewal. This will ensure compliance at renewal.

Ongoing: The Division will work with the database vendor to identify a system upgrade that will allow the Division to easily identify in the database whether trust accounts for brokers were received. This will also allow for the development of a report the Division can run to identify the non-compliance

Ongoing: The Division will continue communicating the requirement of broker trust account reconciliation submittals through the newsletter.

Risk Based Approach: Approximately 50% of the licensed brokers also have a property manager permit. By selectively targeting this population of licensees, the Division is able to maximize its effectiveness.

Resources: The Division currently has one (1) administrative position that combines trust account reviewer duties and administrative duties. In 2013, the Division's Enforcement Section began the enforcement of brokers to submit reconciliations and reviewing reconciliations. In 2016, the requirement for brokers to submit the form 546A in lieu of reconciliations became effective by regulation. In 2017, the Division's Enforcement Section began the enforcement of brokers to submit form 546A but only as part of the trust account reconciliation enforcement.

Current trust account reconciliation enforcement which includes report generation, contacting brokers, broker follow up, generation of violation letters, tracking of payments, and collections requires one (1) full time position for approximately ten (10) working days each month. Currently the Division's Enforcement Section does not have the resources to enforce the requirement for all brokers to report annually and keep up with the complaint investigation demands of the section.

Next Steps: The Division is currently working on more detailed procedures on receiving, reviewing, and tracking trust account submissions.

13. **Work with the Department of Business and Industry to develop clear policies and procedures for the debt collection process, documenting the Division's and the Department's respective duties.**

    Ongoing: Business and Industry fiscal has provided the Division with a written policy that defines duties and assignments addressing the debt collection process and the Department's duties.

    Ongoing: The Division is in the process of updating its internal controls and will continue to work with Business and Industry fiscal staff to further improve on the debt collection processes.

14. **Enhance existing internal control policies and procedures to ensure amounts entered in the commission fines shared tracking spreadsheets are accurate, verifying that amounts posted in the database and reported to the State Controller for collection are correct as well.**

    Completed: Commission fines are entered into the database by the commission coordinator. The coordinator then forwards the order to the Administration Section Manager who enters the fine and costs on the shared tracking spreadsheet and verifies the amount in the database is accurate. This will allow for a second level of review for accuracy.

Audit Highlights

Highlights of performance audit report on the Nevada Gaming Control Board issued on March 12, 2019.

Legislative Auditor report # LA20-04.

Background

Nevada's gaming industry is regulated through a two-tiered system comprised of the Nevada Gaming Control Board (Board) and the Nevada Gaming Commission (Commission). The Board includes three full-time members appointed by the Governor. Recommendations of the Board in licensing matters are considered and acted upon by a five-member Commission, who are also appointed by the Governor. A 12-member Gaming Policy Committee serves as an advisory group to the Board and Commission.

Together, the Board and Commission govern Nevada's gaming industry through strict regulation of all persons, locations, practices, associations, and related activities. Its mission and purpose is to protect the integrity and stability of the gaming industry through investigations, licensing, and enforcement of laws and regulations; to ensure the collection of gaming taxes and fees; and to maintain public confidence in gaming. In fiscal year 2018, the Board collected over $866 million in gaming taxes and fees.

The Board is comprised of six divisions with offices in Carson City, Elko, Las Vegas, Laughlin, and Reno. In fiscal year 2018, the Board's primary operating account had $42.5 million in expenditures and 371 filled positions as of June 30, 2018.

Purpose of Audit

The purpose of this audit was to determine if the internal controls and related financial practices of gaming licensees prescribed by Nevada Revised Statutes 463.157 to 463.1592 have been efficiently, effectively, and equitably administered; and to evaluate the collection and administrative processes for gaming taxes and certain fees. This audit included a review of the Board's audit process and certain administrative activities during fiscal year 2018 and fiscal year 2017 for some areas.

Audit Recommendations

This audit report contains one recommendation to improve the efficiency of Board audits.

The Board accepted the one recommendation.

Recommendation Status

The Board's 60-day plan for corrective action is due on June 5, 2019. In addition, the six-month report on the status of the audit recommendation is due on December 5, 2019.

Nevada Gaming Control Board

Summary

The Board's Audit Division (Division) has efficiently, effectively, and equitably administered state laws concerning the financial practices of gaming licensees. The Division sufficiently regulated licensees' compliance with gaming laws and regulations by requiring licensees to have sufficient internal controls, and by effective report monitoring and efficient audits. The Division has maintained its effectiveness in conducting audits and performing other responsibilities. Although the Division effectively monitors licensees and continually meets its long-standing performance goal of auditing licensees at least every 2.5 years, the efficiency of its audit process can improve by implementing electronic audit workpapers.

The Board has an effective process for the collection of gaming taxes and fees. During fiscal year 2018, the Board collected over $866 million in gaming taxes and fees, while maintaining a collection rate of more than 99%. Additionally, the Board administered transferable tax credits and distributions of gaming taxes and fees in accordance with state laws. The Board's computer system provides key controls in the collection process. The system correctly calculates gaming taxes due, verifies payment amounts are accurate, identifies delinquent licensees, and accurately accounts for each type of gaming tax revenue.

Key Findings

The Board has adopted regulations to strengthen the internal control systems at Nevada casinos. Strong internal controls are important to ensure licensees: (1) properly report revenues; (2) comply with gaming laws, regulations, and policies; and (3) provide accurate financial reports. The Audit Division is responsible for ensuring casinos fulfill internal control and financial reporting requirements. (page 8)

The Audit Division's monitoring of reports ensured licensees submitted required reports. Gaming regulations require licensees submit various types of internal control and financial reports. We reviewed 100 reports submitted by 20 of 144 Group I licensees during fiscal year 2018. Although our testing revealed 4 of the 100 reports were not submitted timely, the Division adequately monitored licensees and promptly requested delinquent reports, which resulted in submission. (page 9)

The Audit Division has maintained its effectiveness in conducting audits and performing other responsibilities. Our review of performance information found the Division maintained valid and reliable information to manage its activities. Information on the Division's operations is essential to providing effective oversight, ensuring efficient use of resources, and for identifying areas needing improvement. (page 10)

Although the Audit Division has provided effective regulatory oversight of its licensees, implementing electronic audit workpapers can improve the efficiency of the Board's audit process. Currently, staff carry several large paper files containing current and prior audit workpapers to each licensee location. Audit supervisors are unable to review staffs' work remotely; therefore, must wait for the auditor to return to review their work. Benefits of electronic audit workpapers include increased accessibility, improved tracking, faster review and reporting, better security, and less paper. Implementing electronic workpapers would allow for greater productivity, efficiency, and collaboration. (page 13)

The Board has strong controls over the collection of gaming taxes and fees. We selected 50 payments, totaling more than $45.3 million, from percentage fee tax, entertainment tax, quarterly nonrestricted slot tax, quarterly games tax, and annual slot and games tax. These types of taxes made up 98% of total gaming taxes and fees collected in fiscal year 2018. The Division also appropriately distributed gaming taxes and fees to other state agencies and counties, and applied transferable tax credits to amounts due in accordance with state law. In addition to the Board's controls, strict gaming laws and regulations ensure licensees submit appropriate fees or risk losing their gaming license. (page 15)

Steve Sisolak
Governor

Susan Brown
Director

Warren Lowman
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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 5, 2019

Subject: Legislative Audit of the Gaming Control Board

On March 12, 2019 your office released an audit report (LA20-04) on the Gaming Control Board (Board). The Board subsequently filed a corrective action plan on April 25, 2019. 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 was one recommendation contained in the report. The extent of the Board's compliance with the audit recommendation is as follows:

Recommendation 1

Perform a needs assessment and a cost-benefit analysis of electronic workpaper software solutions.

Status – No Action

Agency Actions – The Board took no action on this recommendation because it plans to perform a needs assessment and a cost-benefit analysis of electronic workpaper software solutions as part of its Alpha Migration Project (AMP) in the 2021-2023 biennium. The Board plans to migrate data from its legacy software application to a new software application that supports electronic workpapers as part of the AMP. The Board anticipates full implementation during the 2021-2023 biennium.

The degree of ongoing compliance with this recommendation is the responsibility of the Board.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Sandra D. Morgan, Chairwoman, Gaming Control Board
Warren Lowman, Administrator, Division of Internal Audits

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February 8, 2020

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

In March 2019, we issued an audit report on the Nevada Gaming Control Board. The Board filed its plan for corrective action in April 2019. 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 one recommendation contained in the audit report. As of December 5, 2019, the Office of Finance indicated the recommendation was not implemented. The recommendation is shown below.

	Recommendation	Status
Recommendation No. 1	Perform a needs assessment and a cost-benefit analysis of electronic workpaper software solutions.	Not Implemented

The 6-month report indicated the Board plans on performing its assessment and analysis during the 2021–2023 Biennium as part of its Alpha Migration Project. An off-the-shelf software program for electronic audit workpapers is being considered.

In addition to our review of the 6-month report and subsequent follow up with Division staff, we will review the Board's implementation of the recommendation during the upcoming budget process. Because we plan to monitor the Board's progress on this recommendation, we do not have any questions for agency officials at this time.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Sandra Morgan, Chair, Nevada Gaming Control Board
Jamie Black, Esq., Chief, Administration Division, Nevada Gaming Control Board

Audit Highlights

Highlights of performance audit report on the State Department of Agriculture, Division of Consumer Equitability issued on February 18, 2020.

Legislative Auditor report # LA20-08.

Background

The State Department of Agriculture (Department) was established in 1915 to promote a business climate that is fair, economically viable, and encourages environmental stewardship that serves to protect food, fiber, and human health and safety through effective service and education. Governance and policy setting is overseen by the Board of Agriculture, which is comprised of 11 members representing various aspects of agricultural and related industries. The Department has five divisions, which include Administration, Consumer Equitability, Plant Industry, Animal Industry, and Food and Nutrition. As of August 2019, the Department had 180 approved, full-time positions.

The purpose of the Division of Consumer Equitability (Division) is to license, test, and deem correct all commercially used weighing and measuring devices in the State. Additionally, the Division is responsible for sampling motor fuels for chemical analysis; maintaining a metrology lab which houses the state standards for mass, length, and volume; inspecting the advertising and labeling of motor fuel dispensers; and inspecting packaged goods to determine whether the stated amounts, sizes, and prices are correct.

Purpose of Audit

The purpose of the audit was to evaluate policies, procedures, and controls for inspections, complaints, and billings related to the weights and measures program. The scope of the audit focused on the Division's regulatory and financial processes over weighing and measuring devices for fiscal year 2019.

Audit Recommendations

This audit report contains seven recommendations to enhance the Department's regulatory processes in the Consumer Equitability Division.

The Department accepted the seven recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on May 12, 2020. In addition, the 6-month report on the status of audit recommendations is due on November 12, 2020.

Division of Consumer Equitability

State Department of Agriculture

Summary

The Division of Consumer Equitability within the State Department of Agriculture does not have effective policies, procedures, or controls related to oversight of weighing and measuring devices. Specifically, the Division did not always perform inspections in a timely manner or take enforcement action for devices found to be out of tolerance. Additionally, invoicing was not consistent or compliant with regulation, and sanctions were not applied to locations that failed to pay. Finally, policies and procedures need to be developed for Division processes. The lack of effective policies, procedures, and controls leaves consumers vulnerable to deficient weighing and measuring devices.

Key Findings

Overall, about 9% of all locations with weighing and measuring devices were operating without assurance that these devices were within acceptable tolerance levels. Inspections protect the public from overpaying for product not received, most notably for motor vehicle fuel. As part of our audit, we tested 85 locations and found:

- Seven inspections (8%) were not performed timely. Specifically, two locations had not been inspected in the past 24 months and five locations received inspections late.
- Of 12 locations that required a follow-up inspection due to irregularities identified during a routine inspection, 3 locations (25%) never received a follow-up inspection and 2 follow-up inspections (22%) were performed late. (page 5)

The Division did not place a device out-of-service when found to be out of tolerance, and there is no enforcement action taken when these devices are prematurely placed back into service. Regulations require authorization from the Division, or a registered service agent, before previously malfunctioning devices may be used by consumers. (page 6)

Invoices were not always generated when required. Five of eight complaints (63%) were not invoiced the fee for a follow-up inspection. Per NAC 581.210, the Division is to charge for the retest of a malfunctioning device. Invoicing issues result from manual processes and lack of supervisory oversight and review. (page 7)

The Division did not always apply late fees timely to invoices in accordance with regulation. In one instance, we found late fees were not applied until nearly a year after fees were due. (page 7)

The Division has the authority to assess civil penalties and remove devices from service for any violation of NRS 581; however, the Division has not developed enforcement methods to entice payment of annual fees that remain unpaid. By allowing devices to remain in service when fees remain habitually unpaid, the Division promotes inequity among regulated entities. Furthermore, the perceived authority of the Division is eroded when entities do not comply with regulations and increasing enforcement actions are not imposed. (page 8)

Significant improvements to operations can be realized by developing and implementing policies and procedures for key processes. The Division had limited, if any, documented policies and procedures for program functions. Limitations include the inspection, complaint, and invoicing processes. Policies and procedures help retain institutional knowledge, ensure consistency, and provide clear expectations for staff and management. (page 9)

An updated system, or implementation of electronic inspection software, can help the Division perform regulatory duties more efficiently and effectively. The current system houses location and device information, but has limited functionality and is not readily accessible by inspectors. Inspectors currently operate using a paper-based record keeping system. This outdated system has resulted in inspections being overlooked, and untimely and inaccurate information being input into the system. (page 9)

Steve Sisolak
Governor

Susan Brown
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: Susan Brown, Director
Governor's Finance Office

Date: November 12, 2020

Subject: Legislative Audit of the Department of Agriculture, Division of Consumer Equitability

On February 18, 2020, your office released an audit report (LA 20-08) on the Department of Agriculture (department), Division of Consumer Equitability (division). The division subsequently filed a corrective action plan on May 1, 2020. 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 seven recommendations contained in the report. The extent of the division's compliance with the audit recommendations is as follows:

Recommendation 1

Establish controls to ensure all weighing and measuring devices receive timely inspections.

Status – Fully Implemented

Agency Actions – The division established controls to ensure all weighing and measuring devices receive timely inspections. The division developed system queries to identify devices that have not been inspected in more than 12 months and more than 24 months. Enforcement activities are now documented, which allows the division to improve monitoring and oversight of all weighing and measuring devices. Additionally, the division established operating procedures for regular inspection and testing of commercial weighing and measuring equipment. These documented procedures provide staff with clear expectations, directions, and ensure consistency in operations.

Recommendation 2

Create and adhere to a plan to identify and eliminate the backlog of past due inspections.

Status – Partially Implemented

Agency Actions – The division is in the process of creating and adhering to a plan to identify and eliminate the backlog of past due inspections. The division developed system queries to identify devices that have not been inspected in more than 12 months and more than 24 months. These queries provide improved reporting and immediate access to information for decision making by staff and management. Due to vacancies in Weights and Measures Inspector positions and suspension of routine device inspections during the Covid-19 pandemic stay-at-home order, the backlog of past due device inspections is expected to be completed, at the earliest, by July 2021.

Recommendation 3

Establish a graduated and equitable system of sanctions.

Status – Partially Implemented

Agency Actions – The division is in the process of establishing a graduated and equitable system of sanctions per NRS and NAC Chapters 581, 582, and 590. The division established penalties or sanctions for businesses that disregard state regulations and created operating procedures for the assessment of civil penalties. A Fee Billing Chart was created to provide guidance for Weights and Measures Inspectors; guidance details applicable penalty types and amounts for each violation. Additionally, the division established uniform procedures for devices found to be in violation of applicable standards but within a tolerance and operational range that allows the device to remain in service while necessary repairs are pending. Similarly, uniform procedures were established for devices, dispensers, and/or fuel tanks that are tested and/or inspected and found to be out of tolerance and/or compliance with applicable standards and must be removed from service while necessary repairs are pending. The division is still in the process of developing operating procedures for the assessment of criminal and administrative penalties and promulgating the associated regulations. These systems are expected to be fully implemented by February 2021 following recruitment and training of newly filled positions.

Recommendation 4

Develop controls to ensure invoices are generated for follow-up inspections.

Status – Fully Implemented

Agency Actions – The division developed controls to ensure invoices are generated for follow-up inspections. The division revised Certificate of Inspection forms to include check boxes/fields for all possible inspections and fee types. Additionally, the division established uniform procedures for the completion, submission, processing, and retention of Certificates of Inspection. These procedures include Weights and Measures Fees to be referenced by staff to ensure proper fee amounts for inspections are coded and charged.

Recommendation 5

Implement controls to ensure late fees are applied timely in accordance with regulation.

Status – Fully Implemented

Agency Actions – The division implemented controls to ensure late fees are applied timely in accordance with regulation. The division adapted system software to create invoice aging reports and established standard invoice terms to include late fee terms. Procedures were established for the assessment of late fees for delinquent payment of invoices and collection enforcement efforts. All staff overseeing the collection of past-due invoices will have access to the Weights and Measures software system that replaces manual processes.

Recommendation 6

Develop policies and procedures for Division operations. Enhance supervisory oversight to ensure policies and procedures are followed by staff.

Status – Partially Implemented

Agency Comments – The division is in the process of developing policies and procedures for operations and enhancing supervisory oversight to ensure policies and procedures are followed by staff. The division identified all Administrative and Weights and Measures program activities for which standard operating procedures were necessary. Once identified, drafting assignments were issued for each standard operating procedure. The division also implemented a standard review process for drafting, initial review, and finalization of standard operating procedures. Additionally, a SOP Template was created to help provide guidance for establishing uniform standard operating procedures. Completion of certain standard operating procedures has been deferred due to the Covid-19 pandemic but are expected to be fully implemented by July 2021 following recruitment and training of newly filled positions.

Recommendation 7

Perform a cost-benefit analysis on enhancing the weights and measures system to gain efficiencies.

Status – Partially Implemented

Agency Comments – The division is in the process of performing a cost-benefit analysis on enhancing the weights and measures system to gain efficiencies. The division submitted an informal Request for Information (RFI) to obtain a preliminary estimate of costs associated with acquiring and implementing an information technology system. The purpose of the new IT system is to streamline, modernize, and automate most of the divisions processes related to licensing, inspection, certification, and regulatory activities of the Weights and Measures program. Based on responses to the RFI, the division determined that such an initiative would cost approximately $900,000. The division also performed a benefit analysis and estimated short term benefits of approximately $560,000 through FY 2028. A business requirements document detailing current status and desired enhancements to the Weights and Measures software system is expected to be fully implemented by February 2021.

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Jennifer Ott, Director, Department of Agriculture
Cadence Matijevich, Administrator, Division of Consumer Equitability
Warren Lowman, Administrator, Division of Internal Audits

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January 6, 2021

Members of the Audit Subcommittee
of the Legislative Commission
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In February 2020, we issued an audit report on the Division of Consumer Equitability (Division) of the State Department of Agriculture. The Division filed its plan for corrective action in May 2020. Nevada Revised Statute 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 November 12, 2020, the Office of Finance indicated three recommendations were fully implemented and four recommendations were partially implemented. The partially implemented recommendations are shown below.

	Recommendation	Status
Recommendation No. 2	Create and adhere to a plan to identify and eliminate the backlog of past due inspections.	Partially Implemented
Recommendation No. 3	Establish a graduated and equitable system of sanctions.	Partially Implemented
Recommendation No. 6	Develop policies and procedures for Division operations. Enhance supervisory oversight to ensure policies and procedures are followed by staff.	Partially Implemented
Recommendation No. 7	Perform a cost-benefit analysis on enhancing the weights and measures system to gain efficiencies.	Partially Implemented

The Office of Finance's report indicates the backlog of past due inspections has not been eliminated due to vacancies in inspector positions and the suspension of inspections during the COIVD-19 pandemic stay-at-home order. The backlog is anticipated to be eliminated in July 2021. In addition, the Division has made progress at establishing a system of sanctions by creating penalties and forming procedures for the assessment of penalties. Furthermore, the Division identified operating activities for which procedures are necessary.

In November 2020, we discussed the status of the partially implemented recommendations with Division management and learned the system of sanctions is now anticipated to be fully implemented in December 2020. However, the completion of standard operating procedures is not expected until July 2021 following the recruitment and training of new personnel. Finally, the Division did perform a cost-benefit analysis on a new information technology system and plans to produce a business requirements document detailing desired enhancements to be used for future budgeting requests. The business requirements document is expected to be implemented in February 2021.

Questions

1. Did the Division fully implement a system of sanctions in December 2020?

2. Is the Division still on track to implement the remaining three recommendations in February and July 2021?

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Jennifer Ott, Director, State Department of Agriculture (SDA)
Cadence Matijevich, Administrator, Division of Consumer Equitability, SDA

Audit Highlights

Highlights of performance audit report on the Supported Living Arrangement Program issued on March 19, 2019.

Legislative Auditor report # LA20-06.

Background

The Aging and Disability Services Division is a division within the Department of Health and Human Services. Its mission is to ensure the provision of effective support and services to meet the needs of individuals and families, helping them lead independent, meaningful, and dignified lives. The Division offers programs for infants and toddlers with disabilities, persons with physical disabilities, and persons with intellectual or developmental disabilities.

The focus of this audit was the Division's SLA program. The SLA program is authorized by NRS 435 to serve those whose diagnosis is an intellectual or developmental disability. SLA providers that contract with regional centers offer residential support to help individuals with intellectual or developmental disabilities live in the least restrictive community setting possible.

Three regional centers oversee SLA providers. These regional centers were legislatively approved for 457 full-time positions. As of October 2018, there were 428 filled positions. SLA services are funded through State General Fund or Medicaid Home and Community-Based Waiver dollars. The regional centers' expenditures for fiscal year 2018 exceeded $190 million.

Purpose of Audit

The purpose of this audit was to determine whether SLA provider homes served individuals with intellectual or developmental disabilities as defined in NRS 435.3315, and to evaluate the living conditions at SLA provider homes. The scope of our audit included the verification of client eligibility for the Division's SLA program, a review of client diagnoses and evidence of treatment, and the placement of clients in SLA provider homes. Specifically, our work included a review of client eligibility and client diagnoses during fiscal year 2018, and SLA home placements and home conditions as of January 2019.

Audit Recommendations

This audit report contains two recommendations to help ensure SLA providers are certified to serve individuals with additional diagnoses related to mental health and to improve the Division's record keeping practices.

The Division accepted the two recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on June 12, 2019. In addition, the six-month report on the status of audit recommendations is due on December 12, 2019.

Supported Living Arrangement Program

Aging and Disability Services Division

Summary

The Aging and Disability Services Division's (Division) processes help ensure providers of Supported Living Arrangement (SLA) homes serve the intended population, as defined in statute. While all of the Division's clients have a primary diagnosis of an intellectual or developmental disability, many clients also have mental health diagnoses. Documentation showed these clients were receiving treatment for their mental health diagnoses. Although the public has expressed concerns that SLA providers are housing clients outside of their statutory authority, we found SLA providers are housing only Division clients with a primary diagnosis of an intellectual or developmental disability. To improve operations, we found the Division can take steps to strengthen its record keeping practices regarding the location of homes and the accuracy of active client placements. Finally, our unannounced visits to 87 provider homes found these homes were generally clean, safe, and in good repair.

Because NRS 435 does not specifically indicate whether SLA providers are authorized to also serve individuals with additional diagnoses related to mental health, we obtained a legal opinion. Based on how the statutes are currently written, it is the opinion of the Legislative Counsel Bureau's Legal Division that SLA providers need to also be certified as community-based living arrangement (CBLA) providers when serving intellectually or developmentally disabled individuals who also have mental health diagnoses. Because dual certification as an SLA and CBLA provider may not be an efficient practice, the Legislature may want to consider amending statute to allow SLA providers to serve clients who also have mental health diagnoses, provided that SLA staff receive adequate training to care for these clients.

Key Findings

All of the Division's active clients in fiscal year 2018 had a diagnosis of an intellectual or developmental disability as defined under NRS 435. Many of these clients had other diagnoses, including mental health related diagnoses, for which the Division also provided support. Besides ensuring only qualified clients are served by the Division, the application process helps ensure the Division places intellectually or developmentally disabled clients with its certified SLA providers. (page 6)

Although the SLA program serves individuals with a primary diagnosis of an intellectual or developmental disability, many of the individuals served have multiple diagnoses, including mental health diagnoses. For 53 of 100 client files tested, there was evidence that these clients had at least 1 mental health related diagnosis. Because many individuals in the SLA program also have mental health diagnoses, the Division helps ensure services are obtained to support these diagnoses. These services help ensure individuals with mental health diagnoses receive services, either through medication management or periodic visits with a psychiatrist or psychologist. We examined all 53 client files and found that their mental health diagnoses were either being medically managed or they visited with professionals to address their mental health needs. (page 7)

Providers of 24-hour SLA homes housed only Division clients. We physically inspected 87 of 379 (23%) SLA homes certified by the Division, and located throughout the State, and did not find any evidence of non-division clients residing in the homes. The Division's quality control processes help ensure SLA providers' 24-hour homes house the intended population. (page 9)

The Division did not always have up-to-date information regarding SLA client placements. While the Division had two systems for tracking client placements, neither system contained accurate placement information. Based on our testing, the error rates for both systems exceeded 12%. The Division's policies and procedures did not address record keeping practices related to client placement. Strong record keeping practices are needed to reduce the risk that clients' locations will be unknown and SLA provider homes will not be inspected. (page 10)

The Division's contracted SLA provider homes were generally clean, safe, and in good repair. We performed unannounced visits at 24-hour SLA homes throughout Nevada. For 76 of 87 (87%) homes inspected, we did not observe any conditions that would affect the health or safety of the individuals living in the homes. For the other 11 homes inspected, most of the issues observed were minor or were not frequently present in multiple homes. The Division has implemented controls to help ensure SLA homes meet certain standards. Based on our review, these controls are working as intended. (page 12)

Steve Sisolak
Governor

Susan Brown
Director

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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 12, 2019

Subject: Legislative Audit of the Aging and Disability Services Division

On March 19, 2019 your office released an audit report (LA20-06) on the Aging and Disability Services Division (division). The division subsequently filed a corrective action plan on June 19, 2019. 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 two recommendations contained in the report. The extent of the division's compliance with the audit recommendations are as follows:

Recommendation 1

Develop a process to ensure SLA homes provide the necessary treatment to Division clients, who are intellectually or developmentally disabled and have a mental health diagnoses, by also obtaining CBLA certification, or seek legislation to clarify and enhance existing statutes to ensure SLA homes can serve clients with mental health diagnoses, ensuring that proper care is given.

Status – Fully Implemented

Agency Actions – The division developed a process to ensure SLA homes provide the necessary treatment to Division clients, who are intellectually and developmentally disabled and have a mental health diagnosis and sought legislation to clarify and enhance existing statutes to ensure SLA homes can serve clients with mental health diagnoses, thereby ensuring that proper care is given. We reviewed the division's "CBLA & SLA Training Crosswalk" listing and noted the division added the mental health training component to its SLA training requirements which meets all CBLA

training standards. The division introduced Assembly Bill 471 which was passed and signed by Governor Sisolak on May 14, 2019 to clarify and enhance existing statutes.

Recommendation 2

Develop policies and procedures to ensure that Division records contain accurate client and provider location information, including procedures to periodically test the accuracy of the information.

Status – Partially Implemented

Agency Actions – The division is working on revising and updating its existing policy "46-1 Developmental Services Electronic Documentation" to ensure division records contain accurate client and provider location information, including procedures to periodically test the accuracy of the information. The division is working to create new 24-hour SLA home records by division quality assurance staff to ensure individuals are enrolled and/or removed from SLA homes within the mandated 24-hour period. The division reports it expects full implementation by March 1, 2020.

The degree of ongoing compliance with this recommendation is the responsibility of the division.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Dena Schmidt, Administrator, Aging and Disability Services Division
Jessica Adams, Deputy Administrator, Aging and Disability Services Division
Jennifer Frischmann, Quality Assurance Manager, Aging and Disability Services
Kimberly Fahey, Management Analyst, Department of Health and Human Services
Warren Lowman, Administrator, Division of Internal Audits

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February 8, 2020

Members of the Audit Subcommittee
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In March 2019, we issued an audit report on the Supported Living Arrangement Program of the Aging and Disability Services Division (Division), Department of Health and Human Services. The Division filed its plan for corrective action in June 2019. 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 two recommendations contained in the audit report. As of December 12, 2019, the Office of Finance indicated one recommendation was fully implemented and one recommendation was partially implemented.

In January 2020, we discussed the status of the one partially implemented recommendation with Division management and reviewed relevant documentation. Our review indicated the Division has now fully implemented the recommendation. Therefore, we do not have any questions for agency officials.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Richard Whitley, MS, Director, Department of Health and Human Services (DHHS)
Dena Schmidt, Administrator, Aging and Disability Services Division, DHHS

Audit Highlights

Highlights of performance audit report on the Delivery of Treatment Services for Children With Autism issued on January 14, 2021.

Legislative Auditor report # LA22-04.

Background

ASD is a developmental disability that can cause significant social, communication, and behavioral challenges. Individuals with ASD communicate, interact, behave and learn in ways that are different from others.

While the causes of ASD are not fully understood, early interventions with evidenced-based services and treatments such as ABA have proven effective in helping children develop, maintain, or restore to the maximum extent practicable, functioning in ways that are both efficacious and cost effective.

The State of Nevada helps provide access to evidence-based treatment for lower income families with children diagnosed with autism primarily through the Autism Treatment Assistance Program (ATAP) or the Division of Health Care Financing and Policy (Nevada Medicaid).

Purpose of Audit

This audit was required by Chapter 507, Statutes of Nevada 2019 (Senate Bill 174). The scope of our audit included the time period from July 1, 2015, to June 30, 2020. Our objectives were to:

- Determine if revenues and expenditures related to autism therapy were sufficient and appropriate.
- Evaluate and review whether children wait for services and if enough providers exist to serve Nevada's population of children with ASD.
- Identify and assess factors that inhibit access to and delivery of autism treatment services.

Audit Recommendations

This audit report contains 14 recommendations to improve the delivery of autism treatment services.

The Division of Health Care Financing and Policy and Aging and Disability Services Division accepted all 14 recommendations.

Recommendation Status

The Division of Health Care Financing and Policy's and the Aging and Disability Services Division's 60-day plans for corrective action are due on April 9, 2021. In addition, the 6-month reports on the status of audit recommendations are due on October 9, 2021.

Delivery of Treatment Services for Children With Autism

Department of Health and Human Services

Summary

Funding for Autism Spectrum Disorder (ASD) has been sufficient to cover children receiving services through Nevada autism programs since 2015. However, we found evidence of improper billing and possible fraud in Medicaid claims. While funding has been sufficient to cover those applying for services, families continue to struggle to obtain treatment and opportunities exist to assist families in obtaining more timely diagnosis and treatment. Assisting families in getting more timely services is critical to improving the outcomes of children with autism.

Barriers to treatment are mostly influenced by an insufficient provider base to provide therapy to all children who medically require services. We estimate there are only enough providers to serve about two of every three children who would most benefit from Applied Behavior Analysis (ABA) services. While many factors influence the number of providers delivering medical services, Registered Behavior Technician (RBT) reimbursement rates are significantly lower than private insurances and challenges in the workplace contribute to limited capacity. Finally, improved communication will enhance outcomes, ease transitions, and result in more robust delivery of services for families of children with autism.

Key Findings

State agencies did not spend all funds budgeted for autism treatment. In the 2015 Legislative Session, the State estimated the cost to provide autism treatment to be $35.7 million annually. This amount was projected to cover an estimated 2,500 children needing treatment services. However, since fiscal year 2017 only about $15 million per year, on average, has been spent on autism therapy services. (page 8)

Our analysis of fee-for-service Medicaid claims for autism treatment services found unreasonable and possibly fraudulent claims paid. Specifically, too many hours were charged for a single day. We found nearly 1,000 of 113,000 days for individual providers in which 24 or more hours were billed. Claims, some of which may overlap between providers and children, totaled about $6 million since fiscal year 2016 for excessive service hours for both providers and children. However, we could not calculate an overpayment because we could not determine what portion of each claim was legitimate, if any. (page 12)

ATAP currently helps families once children have been formally diagnosed with autism documented through a school-based Individualized Educational Program (IEP) or medical diagnosis. However, many families surveyed indicated the process of obtaining a formal autism diagnosis needed to meet criteria to receive ABA treatment is difficult. Obtaining a diagnosis often takes several months and, in some cases, even longer. Providing families additional assistance to help them obtain a diagnosis, including information about available providers can reduce the time needed to obtain a diagnosis and ease parental stress and concern. (page 22)

Families also face challenges in obtaining treatment for their children once they have received an autism diagnosis. Delays in starting treatment range from several months to over a year. Although these delays have been declining recently, there are opportunities for ATAP to reduce the time further between diagnosis and treatment. More timely treatment of children is critical to improving outcomes. (page 24)

While the number of licensed ABA providers in Nevada significantly increased between August 2019 and October 2020, many children continue to wait several months before receiving treatment, because providers do not have openings in schedules to accept children right away. Over the last few years, the number of providers has steadily increased as more insurers, including Nevada Medicaid, support ABA therapy as a treatment option for autism. However, the number of providers is still not sufficient to provide service to those wanting service, as evidenced by waitlists, but also for those who would benefit from but are not seeking treatment. (page 30)

The shortage of ABA providers for children with Medicaid is worse than for children with private insurance since only about a third of licensed ABA providers served Medicaid children in fiscal year 2020. Consequently, children covered by Medicaid and ATAP programs wait for treatment to begin longer than children with private insurance. The providers who deliver the majority of one-on-one therapy, RBTs, are paid half the rate by Medicaid and ATAP that private insurers pay. In addition, providers indicated the process for being enrolled in Medicaid is burdensome and takes considerable time. (page 33)

A significant barrier to school-aged children receiving ABA therapy services is the time spent in school. Many school districts have programs designed to provide therapy and assistance to school-aged children with autism. Medicaid has been providing school districts with the necessary knowledge of what is allowable to bill under ABA services and intends to provide additional support to provide children more comprehensive services. (page 38)

Audit Highlights

Highlights of performance audit report on the Adult Mental Health Services, Payments to Contractor and State-Employed Psychiatrists and Psychologists was released on May 2, 2019.

Legislative Auditor report # LA20-07.

Background

Within the Division of Public and Behavioral Health (Division), the Clinical Services Branch provides adult mental health services primarily through Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Counseling and Supportive Services. The primary clients of these agencies are Nevadans with mental illness who are underinsured, uninsured, and those whose conditions have resulted in interaction with law enforcement.

The Division operates two civil psychiatric hospitals: Dini-Townsend in Sparks, and Rawson-Neal in Las Vegas for individuals needing a high level of psychiatric care requiring 24-hour observation and supervision by mental health professionals. In addition, two forensic psychiatric hospitals, Lake's Crossing Center at NNAMHS and the Stein Forensic Unit at SNAMHS, provide maximum security facilities to offenders referred from the court system for competency issues.

NNAMHS and SNAMHS provide behavioral health outpatient services including crisis intervention, day treatment, medication clinics, psychiatric services, group and individual mental health therapy, mental health court in collaboration with the criminal justice system, and the mobile crisis team.

Purpose of Audit

The purpose of the audit was to determine whether the Division has adequate controls over payments to contractors and state-employed psychiatrists and psychologists during fiscal year 2017, but included review of certain information from prior years and January 2019.

Audit Recommendations

This audit report contains five recommendations to improve the Division's oversight of payments to psychiatrists and psychologists and four recommendations to improve internal controls over contracting processes.

The Division accepted the nine recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on July 29, 2019. In addition, the six-month report on the status of audit recommendations is due on January 29, 2020.

Adult Mental Health Services
Payments to Contractor and State-Employed Psychiatrists and Psychologists

Division of Public and Behavioral Health

Summary

The Division needs stronger program oversight for payments to psychiatrists and psychologists (clinicians) to improve accountability by its contractors and employees. In many instances, supporting documentation was not available to verify hundreds of hours paid to the clinicians. Better monitoring of hours worked will enhance accountability by clinicians that work at inpatient and outpatient settings. Furthermore, $167,000 was improperly paid over a period of years to two psychiatrists that claimed on-call pay when they were ineligible.

The Division also needs stronger internal controls over contracting for clinical services to reduce the risk of overpayments. Contract rates were not adequately documented for two large staffing contractors with State Purchasing Division contracts. In addition, payments were processed to staffing contractors and contract clinicians despite rate discrepancies or incomplete documentation in 19 of 65 (29%) payments we tested. Finally, abuse of travel expenses went unchecked for the payments we tested to a contractor that provided interpreter services to a SNAMHS patient.

Key Findings

A significant portion of the hours billed by inpatient contractors, primarily at SNAMHS, could not be verified as worked. For 23 payments to contractors, 702 of 1,344 hours billed (52%) were unsupported. Management stated the unverified time was linked to SNAMHS' policy of permitting offsite work, which clinicians "self-reported" without any documentation requirements. In contrast, NNAMHS' management did not permit offsite work. (page 8)

Similar issues with lack of accountability for hours claimed were noted for state-employed clinicians assigned to inpatient facilities. For the 13 paychecks of inpatient employees we tested, comparison of the daily hours paid to building controlled access records and to the employees' usage data in the Avatar system, showed there was no accountability for 346 of 878 (39%) regular hours worked. Furthermore, there was no requirement for state-employed clinicians to be accountable for their offsite time. (page 9)

We identified concerns over the propriety of certain payments to psychiatrists in management positions at NNAMHS and SNAMHS. First, improper payments totaling over $167,000 for on-call pay were made for many years to two state-employed psychiatrists in management positions at SNAMHS. One of these individuals received on-call pay for 363 days in fiscal year 2017, by claiming the pay for on-call duties at both NNAMHS and SNAMHS, and while taking annual and administrative leave from the individual's management job at SNAMHS. Second, NNAMHS uses an independent contractor to fill an administrative position. The contractor's responsibilities include administrative powers over employees that may qualify as an employment relationship with the State, rather than independent contractor status. (page 11)

Contract rates were not adequately documented for two large staffing contractors that NNAMHS and SNAMHS paid over $3.4 million in 2017. NNAMHS staff indicated managers determine the rates based upon comparable state positions, but the process was undocumented. SNAMHS staff had a similar explanation and had no documentation of negotiated rates for psychiatrists and psychologists. When agencies utilizing staffing contractors do not document standardized rates or the rationale for the agreed-upon rates, there is an increased risk that favoritism or bias may result in paying a higher rate than necessary. (page 17)

Questionable and incorrect billing rates were noted for 13 of 65 (20%) payments to staffing contractors and contract clinicians. For example, six payments were to a NNAMHS staffing contractor that received $190 per hour for a specific licensed psychiatrist. This was the highest contract rate for a licensed psychiatrist that we noted. NNAMHS' file documentation showed the rate increase was done by separate contract, so as not to set a precedent concerning the going rate for other contract clinicians. (page 18)

The Division did not adequately monitor travel and hours worked by a contractor to prevent improper payments. Abuse of travel expenses went unchecked concerning a contractor that provided certified deaf and hearing interpreter services to a SNAMHS patient at the Stein Forensic Unit. We found over $2,300 in travel claims exceeded amounts allowed by the State and the vendor's contract. In addition, $5,520 was paid for interpreter services that were unsupported. Review of payment voucher documentation showed SNAMHS fiscal personnel did not understand the state travel requirements and approved the billings without adequate supporting documentation. (page 21)

Steve Sisolak
Governor

Susan Brown
Director

Tiffany Greenameyer
Deputy Director

Warren Lowman
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: January 29, 2020

Subject: Legislative Audit of the Division of Public and Behavioral Health

On March 19, 2019 your office released an audit report (LA20-07) on the Division of Public and Behavioral Health (DPBH). DPBH subsequently filed a corrective action plan on July 29, 2019. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DPBH to comply with audit findings.

There were nine recommendations contained in the report. The extent of DPBH's compliance with the audit recommendations are as follows:

Recommendation 1

Ensure new policies and procedures for monitoring the hours worked by contract and state-employed clinicians are consistently implemented statewide.

Status – Fully Implemented

Agency Actions – DPBH developed new policies and procedures to ensure monitoring the hours worked by contract and state-employed clinicians are consistently implemented statewide. For fiscal year 2019, we reviewed: DPBH's policy, HR 1.36 Medical Staff/Psychology Contractor Time Tracking; documentation of staff who completed training; and doctor attendance records. We found hours are monitored throughout the state for contract and state-employed clinicians consistent with the new policies and procedures by comparing timesheets and billing invoices to electronic key card access system reports and/or sign-in sheets approved by the Medical Director.

We tested a four-month sample of contract and state-employed clinician timesheets and billing invoices and compared them to the electronic key card access system reports and noted no variances. We also reviewed DPBH's reconciliation report of approved offsite work hours with medical record entries to ensure timesheets were accurate and clinicians were working full days; we noted no variances.

Recommendation 2

Ensure new policies and procedures for the documentation and approval of offsite hours allowed for contractors and state employees are consistently implemented statewide.

Status – Partially Implemented

Agency Actions – DPBH developed new policies and procedures to ensure documentation and approval of offsite hours allowed for contractors and state employees are consistently implemented statewide. For fiscal year 2019, we reviewed: DPBH's policy, HR 1.35 DPBH Medical and Psychology Staff Offsite Work Activities; documentation of staff who completed training; and doctor attendance records. DPBH developed the "Request for Payment for Hours Worked Offsite" form in October 2019 and implemented the form in December 2019 to help ensure and document time clinicians work offsite.

Auditor Comment – We found that documentation and approval for offsite hours allowed for contractors and state-employed clinicians are consistently implemented statewide by comparing timesheets and billing invoices approved by the Medical Director to time noted in Avatar. Avatar is the electronic medical records software used to manage patient medical records, process billing claims, and produce reports for program analysis. We tested a four-month sample of contract and state-employed clinician timesheets and billing invoices and compared them to the electronic key card access system reports and noted no variances. We also reviewed DPBH's reconciliation report of approved offsite work hours with medical record entries in Avatar to ensure clinician timesheets were accurate and clinicians were working full days; we noted no variances. However, contract doctors at SNAMHS averaged 33 percent of their compensated hours offsite, an increase of 25 percent since August 2018. Full implementation is expected by February 1, 2020.

Recommendation 3

Consult with legal counsel regarding seeking reimbursement of improper payments for on-call pay.

Status – Fully Implemented

Agency Actions – DPBH, in consultation with the Attorney General's Office regarding seeking reimbursement of improper payments for on-call pay, concluded the documentation does not support the ability to seek reimbursement.

Recommendation 4

Develop policies and procedures for on-call pay to ensure requests sufficiently document the work performed and payments are only to eligible clinicians.

Status – Partially Implemented

Agency Actions – DPBH developed new policies and procedures for on-call pay to ensure requests sufficiently document the work performed and payments are only to eligible clinicians. For fiscal year 2019, we reviewed: DPBH's policy, HR 1.38 Medical and On-Call; documentation of staff who completed training; and doctor attendance records. DPBH developed and implemented the "Request for Payment for On-Call Hours Worked" form in December 2019 to help ensure on-call time is sufficiently documented.

Auditor Comment – We found that documentation and approval for on-call hours allowed for contractors and state-employed clinicians are consistently implemented statewide by comparing timesheets and billing invoices approved by the Medical Director. We tested a four-month sample of contract and state-employed clinician timesheets and billing invoices to ensure sufficient documentation of work performed and payments were only to eligible clinicians. We noted only one doctor in our sample with on-call pay. We noted sufficient documentation and work performed approved by the Medical Director without exception. Full implementation is expected by February 1, 2020.

Recommendation 5

Consult with legal counsel to determine whether the NNAMHS director position is eligible for independent contractor status.

Status – Partially Implemented

Agency Actions – DPBH, in consultation with the Attorney General's Office, determined the NNAMHS director position is eligible for independent contractor status. DPBH represents NNAMHS is currently in the process of entering into an independent contract with a new provider for a lead psychiatrist; language will be added to that contract to ensure the provider agrees to perform tasks as requested by the Chief Medical Officer. This recommendation is estimated to be fully implemented by June 2020.

Recommendation 6

Establish standardized rates for positions staffed by contractors.

Status – Fully Implemented

Agency Actions – DPBH established standardized rates for positions staffed by contractors. We reviewed DPBH's policy, HR 1.37, Standardized Rates for Contract Staff and noted standardized rates for contractors that are employed by the state for services rendered within inpatient hospitals and outpatient clinics. We also reviewed payments to contract staff; no staff are being paid above established standardized rates.

Recommendation 7

Establish requirements for documentation from contractors to support their hours billed.

Status – Fully Implemented

Agency Actions – DPBH established requirements for documentation from contractors to support their hours billed in its newly created policies and procedures. For fiscal year 2019, we reviewed: DPBH's policy, HR 1.36 Medical Staff/Psychology Contractor Time Tracking; documentation of staff who completed training; and doctor attendance records, including documentation from contractors to support their hours billed. We found hours billed by contract clinicians are compared to timesheets and electronic key card access system reports and/or sign-in sheets approved by the Medical Director and noted no variances. We tested a four-month sample of contract and state-employed clinician timesheets and billing invoices and compared them to the electronic key card access system reports and noted no variances. We also reviewed DPBH's reconciliation report of approved offsite work hours with medical record entries in Avatar to ensure clinician timesheets were accurate and documentation appropriately supports the hours and rates billed; we noted no variances.

Recommendation 8

Establish written policies and procedures for reviewing and processing contractors' billings, including a process to verify the documentation appropriately supports the hours and rates billed.

Status – Fully Implemented

Agency Actions – DPBH established written policies and procedures for reviewing and processing contractors' billings, including a process to verify the documentation appropriately supports the hours and rates billed. For fiscal year 2019, we reviewed: DPBH's policy, HR 1.36 Medical Staff/Psychology Contractor Time Tracking; documentation of staff who completed training; and doctor attendance records. We

found contractors' billings are compared to timesheets and rates to electronic key card access system reports and/or sign-in sheets approved by the Medical Director. We tested a four-month sample of contract and state-employed clinician timesheets and billing invoices and compared them to the electronic key card access system reports and noted no variances. We also reviewed DPBH's reconciliation report of approved offsite work hours with medical record entries in Avatar to ensure clinician timesheets were accurate and documentation appropriately supports the hours and rates billed and noted no variances.

Recommendation 9

Ensure travel claims submitted by contractors are reviewed by staff with the appropriate training and skills.

Status – Partially Implemented

Agency Actions – DPBH ensured travel claims submitted by contractors are reviewed by staff with appropriate training and skills. We reviewed documentation of staff who completed training on DHHS Travel Policy and Procedures on Travel. As of this review, DPBH represents there have been no contractor travel claims filed in fiscal year 2020.

The degree of ongoing compliance with this recommendation is the responsibility of the DPBH.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff to Governor Steve Sisolak
Richard Whitley, Director, Department of Health and Human Services
Lisa Sherych, Administrator, Division of Public and Behavioral Health
Warren Lowman, Administrator, Division of Internal Audits

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February 8, 2020

Members of the Audit Subcommittee
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In May 2019, we issued an audit report on the Payments to Contractor and State-Employed Psychiatrists and Psychologists of the Adult Mental Health Services, Division of Public and Behavioral Health (Division), Department of Health and Human Services. The Division filed its plan for corrective action in July 2019. 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 nine recommendations contained in the audit report. As of January 29, 2020, the Office of Finance indicated five recommendations were fully implemented and four recommendations were partially implemented.

In January 2020, we discussed the status of the four partially implemented recommendations with Division management and reviewed relevant documentation. Our review indicated the Division has now fully implemented these four recommendations. Therefore, we do not have any questions for agency officials.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Richard Whitley, MS, Director, Department of Health and Human Services (DHHS)
Lisa Sherych, Administrator, Division of Public and Behavioral Health, DHHS

Audit Highlights

Highlights of performance audit report on the Bureau of Health Care Quality and Compliance issued on March 1, 2019.

Legislative Auditor report # LA20-03.

Background

The Bureau of Health Care Quality and Compliance (Bureau) is under the Division of Public and Behavioral Health (Division), which is part of the Department of Health and Human Services. The mission of the Bureau is to promote the safety and welfare of the public through regulation, licensing, enforcement, and education. The three main programs the Bureau oversees, and the focus of this audit, are the licensing of health care facilities, medical laboratories, and child care facilities. The Bureau's oversight of these processes includes conducting periodic inspections of the facilities it licenses and conducting complaint investigations related to facilities and individuals it licenses.

As of June 2018, the Bureau had 119 approved, full-time positions.

Purpose of Audit

The purpose of this audit was to: (1) determine if controls related to the protection of sensitive information were adequate; and (2) evaluate the adequacy of certain administrative controls related to complaint investigations, facility reported incident reviews, personnel management, and inspection timeliness tracking. The scope of our audit focused on the Bureau's regulatory and financial activities for calendar year 2017 and inspection activities through fiscal year 2018.

Audit Recommendations

This audit report contains three recommendations to improve the protection of sensitive information and five recommendations to improve controls over complaint investigations, facility reported incident reviews, personnel management, and inspection timeliness tracking.

The Bureau accepted the eight recommendations.

Recommendation Status

The Bureau's 60-day plan for corrective action is due on May 24, 2019. In addition, the six-month report on the status of audit recommendations is due on November 24, 2019.

Bureau of Health Care Quality and Compliance

Division of Public and Behavioral Health

Summary

The Bureau's controls related to the protection of criminal history record information (CHRI) and personally identifiable information need improvement. Some CHRI was unprotected and accessible by all Division employees. Additionally, the Bureau did not ensure Social Security numbers and other personal information it received was restricted to appropriate employees. By not properly securing sensitive personal information, the Bureau is leaving individuals vulnerable to their personal information being misused or disseminated without their consent.

The Bureau's controls related to oversight of certain regulatory activities need strengthening. For instance, some of the Bureau's complaint investigation procedures were not conducted timely and not all investigative notifications were sent in accordance with policies. In addition, the Bureau's process to review facility reported incidents needs improvement, including creating additional internal controls to ensure reviews are timely and documented appropriately. Additionally, the Bureau did not follow the Division's performance evaluation policies and record keeping standards related to out-stationed staff that work remotely. Finally, the Bureau needs to continue its efforts to reduce its backlog of periodic inspections.

Key Findings

The Bureau did not adequately protect CHRI stored on shared network drives. We found 7,269 child care facility employee background check files were maintained on a shared network drive, with the information accessible by all 1,457 employees within the Division. We reviewed 100 of the 7,269 child care facility employee background check files, and found 7% contained the full background check report including CHRI, 98% contained the applicant's Social Security number, and 87% contained only a determination of employment eligibility, and not the full CHRI. (page 5)

The Bureau needs to improve its practices of electronic document storage for personally identifiable and sensitive information. The Bureau maintained documents related to facility reported incidents on a shared network drive that contained sensitive information such as Social Security numbers and health information. These files were accessible by all Bureau employees. We tested 75 incident files and found 46 (61%) contained a Social Security number. (page 7)

The Bureau was not in compliance with its policies related to timeliness in conducting complaint investigations, timeliness in notifying the facilities of complaint results, and sending the complainant notices related to the investigation. We tested 75 complaints and found that of the 62 cases that required an on-site investigation, 21 (34%) were not investigated timely. We also found the Bureau was unaware of 21 (2%) complaints that had not been investigated. (page 9)

The Bureau did not conduct reviews of facility reported incidents in a timely manner, did not adhere to policies and procedures outlining oversight of facility reported incidents, and did not have appropriate internal controls for ensuring facility reported incidents are reviewed timely and are not overlooked. We tested 75 facility reported incidents received during calendar year 2017 and found 59 (79%) were not reviewed timely. (page 13)

The Bureau is not in compliance with Division policies and procedures relating to its out-stationed employees who work remotely. We found 19 of the 26 employees (73%) did not have a current performance evaluation within the prior 12 months, 8 employees (31%) did not receive a performance evaluation prior to starting their out-stationed assignment, and 5 employees (19%) did not have a signed out-stationed agreement on file for 2017. (page 16)

During the December 2017 Interim Finance Committee (IFC) meeting, the Bureau reported an inspection backlog of 300 health care facilities. In April 2018, the Bureau reported the backlog was reduced to 249 facilities. After analyzing the Bureau's backlog tracking process, we can provide reasonable assurance the reported information is accurate and reliable. However, the Bureau needs to continue its efforts to reduce the backlog of health care facility inspections. (page 17)

Steve Sisolak
Governor

Susan Brown
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Warren Lowman
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: November 24, 2019

Subject: Legislative Audit of the Department of Health and Human Services, Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance

On March 1, 2019, your office released an audit report (LA 20-03) on the Department of Health and Human Services (department), Division of Public and Behavioral Health (division), Bureau of Health Care Qualify and Compliance (bureau). The bureau subsequently filed a corrective action plan on May 23, 2019. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by the Bureau to comply with audit findings.

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

Recommendation 1

Restrict access to the sensitive information stored in the shared network drive in accordance to NRS 603A and the Bureau's background desk manual.

Status – Fully Implemented

Agency Actions – The bureau has restricted access to the sensitive information stored in the shared network drive in accordance to NRS 603A and the bureau's background desk manual. Four restricted access folders were created with the assistance of the division's Office of Information Technology (OIT) for child care licensing, individual licensing, healthcare facilities, and medical laboratories. Access to the restricted folders is on a need-to-know basis as determined by supervisory staff and may only be requested by division manager/supervisors. The bureau updated its Child Care Licensing (CCL) policy to prohibit background check information being disseminated or stored electronically.

Recommendation 2

Work with the Records, Communications and Compliance Division to ensure sensitive background check information stored electronically is appropriately secured.

Status – Fully Implemented

Agency Actions – The bureau worked with the Records, Communications and Compliance Division to ensure sensitive background check information stored electronically is appropriately secured. After conferring with Nevada Department of Public Safety (NDPS), Records, Communications and Compliance Division (RCCD), the bureau retrained staff and created restricted access folders for sensitive information. An audit by RCCD concluded CCL's policies and procedures were fully compliant with FBI/State policies.

Recommendation 3

Develop policies and procedures for Child Care Licensing that address and properly mitigate the risk associated with the use and storage of sensitive personal information.

Status – Fully Implemented

Agency Comments – The bureau developed policies and procedures for Child Care Licensing that address and properly mitigate the risk associated with the use and storage of sensitive personal information. The bureau updated its Child Care Licensing (CCL) policy to prohibit background check information being disseminated or stored electronically. Four restricted access folders were created with the assistance of the Division's Office of Information Technology (OIT). Access to the restricted folders is based on a need-to-basis as determined by supervisory staff and may only be requested by Division manager/supervisors. After conferring with Nevada Department of Public Safety (NDPS), Records, Communications and Compliance Division (RCCD), the Bureau retrained staff. An audit by RCCD concluded CCL's policies and procedures were fully compliant with FBI/State policies.

Recommendation 4

Establish internal controls for supervisors for tracking open complaints, completing complaint investigations timely, ensuring letters to the complainant are documented, and ensuring facilities are timely notified of investigation results.

Status – Fully Implemented

Agency Comments – The bureau established internal controls for supervisors for tracking open complaints, completing complaint investigations timely, ensuring letters to the complainant are documented, and ensuring facilities are timely notified of investigation

results. Three tracking reports were developed for Health Facilities and Laboratories to provide a means by which supervisors can monitor the timeliness and documentation of complaint correspondence. The bureau outlined supervisor monitoring responsibilities in the Complaint Internal Control Desk Manual.

Recommendation 5

Investigate the 21 uninvestigated complaints from calendar year 2017.

Status – Fully Implemented

Agency Actions – The bureau investigated 20 of the 21 uninvestigated complaints from calendar year 2017. One complaint was determined to be a duplicate. The bureau determined these complaints were overlooked due to failure to enter either or both of two fields (assigned team and/or assigned location) during the complaint intake process. The bureau created two reports to identify any complaints with either of the two missing fields. The reports are run monthly with any identified complaints assigned by the supervisor for follow-up.

Recommendation 6

Develop internal controls to ensure facility reported incident reviews are being conducted in accordance with Bureau policy and no facility reported incidents are overlooked.

Status – Fully Implemented

Agency Actions – The bureau developed internal controls to ensure facility reported incident reviews are being conducted in accordance with bureau policy and no facility reported incidents are overlooked. The bureau created four reports to assist management in its effort to monitor the review process of facility reported incidents. The bureau documented the internal controls related to the four reports in the Self Report Internal Control Desk Manual, which provides procedural guidance to bureau staff when administering incidents reported by healthcare facilities.

Recommendation 7

Comply with Division policies related to out-stationed worker evaluations and renewals of employee agreements.

Status – Fully Implemented

Agency Actions – The bureau complied with Division policies related to out-stationed worker evaluations and renewals of employee agreements. We reviewed the tracking document used by the bureau to track the due dates of performance evaluations and out-station agreements for out-stationed employees. All performance evaluations were conducted and out-station agreements renewed within the past 12 months.

Recommendation 8

Continue efforts to reduce the backlog of required periodic inspections of health care facilities.

Status – Partially Implemented

Agency Actions – The bureau continues efforts to reduce the backlog of required periodic inspections of health care facilities. The bureau states it has contracted with qualified vendors to supplement the inspection workload, authorized overtime when appropriate, and expanded recruiting efforts that have reduced vacancy to its current 6% level. The inspection tracking log currently shows a backlog of 151 state inspections (federal inspection backlog is not included). Additional positions were requested for the fiscal years 20-21 budget but were denied due to a lack of workload analysis. Staff noted during our review that a workload analysis is being performed but has focused on front line inspection staff rather than supervisory workload. Once the supervisory and management workload analysis is conducted, it may result in a rebalancing of supervisory duties from South to North and may include the need to request additional supervisory or managerial staff. The Legislative Auditor should determine the backlog level appropriate to be considered "fully implemented;" therefore, we deem this recommendation "partially implemented."

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Lisa Sherych, Administrator, Division of Public and Behavioral Health (DPBH)
Margot Chappel, DPBH Deputy Administrator, Regulatory and Planning Services
Debi Reynolds, DPBH Deputy Administrator, Administrative Services
Paul Shubert, Bureau Chief, Health Care Quality and Compliance
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February 8, 2020

Members of the Audit Subcommittee
of the Legislative Commission
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In March 2019, we issued an audit report on the Bureau of Health Care Quality and Compliance (Bureau) of the Division of Public and Behavioral Heath, Department of Health and Human Services. The Bureau filed its plan for corrective action in May 2019. 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 eight recommendations contained in the audit report. As of November 24, 2019, the Office of Finance indicated seven recommendations were fully implemented and one recommendation was partially implemented.

In January 2020, we discussed the status of the one partially implemented recommendation with Division management and reviewed relevant documentation. Our review indicated the Division has now fully implemented the one recommendation. Therefore, we do not have any questions for agency officials.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Richard Whitley, MS, Director, Department of Health and Human Services (DHHS)
Lisa Sherych, Administrator, Division of Public and Behavioral Health (DPBH), DHHS
Margot Chappel, Deputy Administrator of Regulatory Planning Services, DPBH, DHHS
Paul Shubert, Chief, Bureau of Health Care Quality and Compliance, DPBH, DHHS

Audit Highlights

Highlights of performance audit report on the Division of Welfare and Supportive Services issued on February 18, 2020.

Legislative Auditor report # LA20-11.

Background

The mission of the Division of Welfare and Supportive Services (Division) is to engage clients, staff, and the community to provide public assistance benefits to all who qualify, and reasonable support for children with absentee parents to help Nevadans achieve safe, stable, and healthy lives.

The Division, as part of the Department of Health and Human Services, is tasked with administering various state and federal welfare programs, including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, the Energy Assistance Program (EAP), and the Child Support Enforcement Program.

Caseloads for SNAP and Medicaid have increased significantly in response to economic pressures and the Affordable Care Act. The population of SNAP recipients has increased from 125,000 in 2007 to 440,000 in 2018; for Medicaid, these figures total 175,000 in 2007 and 650,000 in 2018.

The Division had expenditures of about $606 million in fiscal year 2019. Primary funding sources include General Fund appropriations and federal grants. The Division's administrative office is in Carson City, with 21 district offices located throughout the State.

Purpose of Audit

The purpose of this audit was to determine whether the Division had sufficient controls over eligibility, income determinations, and fraud. Our audit focused on Division activities in fiscal year 2018 although we reviewed wage and other information prior to and after this time period for eligibility testing.

Audit Recommendations

This audit report contains eight recommendations to improve the Division's processes over eligibility and fraud detection.

The Division accepted the eight recommendations

Recommendation Status

The Division's 60-day plan for corrective action is due on May 12, 2020. In addition, the 6-month report on the status of audit recommendations is due on November 12, 2020.

Division of Welfare and Supportive Services

Department of Health and Human Services

Summary

Generally, the Division is properly assessing available information at the time eligibility is determined for most programs, but should improve its processes over identifying unreported wages and wage increases. Utilizing quarterly wage information more robustly could identify ineligibility sooner. Additionally, system notifications of changes in recipient circumstances should be reviewed timely. Even though health and welfare programs are largely funded by the federal government, the State should have processes to restrain unnecessary benefits as much as possible.

Enhancing the use of quarterly wage information can potentially reduce millions in improper payments. Projecting the results of our testing to the population of Medicaid and SNAP recipient households, we conservatively estimate ineligible recipients received benefits worth more than $69 million per year, but amounts could potentially be much higher. Unless recipients self-report changes in income timely, most of these improper payments are not preventable by the Division using available wage information.

The Division can improve its processes over detecting, deterring, and recovering improperly paid public assistance benefits. First, the Division does not adequately prioritize investigations and overpayment claims. As a result, a significant backlog exists. Second, the Division does not fully utilize its fraud detection system to identify misuse or fraud. Finally, certain reports generated to identify recipients receiving benefits in multiple states contained inconsistent information.

Key Findings

Recipients did not always notify the Division of income changes as required. Because of this, and the fact that Division systems do not routinely compare quarterly wage information, increases in income went undetected by the Division. Program agreements state recipients must report income changes to the Division. (page 4)

During our audit, we reviewed Employment Security Division quarterly wage data during participants' annual eligibility periods for 50 of the over 417,000 Medicaid recipient households. We found 11 households had unreported increases in income for one or more quarters. (page 5)

We requested the Division of Health Care Financing and Policy provide information on benefits paid for the 11 households and found $54,321 in ineligible benefits paid on recipients' behalf. We conservatively estimate ineligible recipients may have received more than $59.8 million in Medicaid benefits per year based on population totals. Only a small portion of Medicaid payments, about 20%, may be prevented by the Division. (page 5)

Our testing also included 50 of over 234,000 SNAP recipient households. Six households had unreported increases in income for one or more quarters. We requested the Division provide information on benefits paid for the six households in our sample with increased income and found $10,095 in excess benefits were paid. We conservatively estimate ineligible recipients may have received more than $9.5 million based on population totals. These excess benefit payments are likely unpreventable by the Division for the SNAP program due to the timing of wage information. (page 6)

The Division frequently did not clear system generated notifications regarding changes in recipient circumstances within 10 days. Some notifications do not appear overly useful. This volume of low value notifications impacts the Division's ability to review and take action on relevant issues. (page 8)

As of June 2019, the Division had a backlog of 3,800 unassigned investigation leads. These leads were open for an average of 1,023 days and 90% were more than a year old. Additionally, over 5,300 claim referrals remained unestablished pending a review. Claims had been open for an average of 559 days with about half open more than 1 year. (page 11)

The Division contracted with a data analytics service in 2017 to enhance fraud detection in the SNAP program. However, the Division has not fully determined the fraud detection reports most useful to its operations or developed policies and procedures over the use of the program and related reports. As a result, fraud and abuse is likely more prevalent in the program than identified under existing processes. (page 12)

Steve Sisolak
Governor

Susan Brown
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Tiffany Greenameyer
Deputy Director

Warren Lowman
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: November 12, 2020

Subject: Legislative Audit of the Department of Health and Human Services, Division of Welfare and Supportive Services

On February 18, 2020, your office released an audit report (LA20-11) on the Division of Welfare and Supportive Services (DWSS). DWSS subsequently filed a corrective action plan on May 11, 2020. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by DWSS to comply with audit findings.

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

Recommendation 1

Make use of quarterly wage information in the interim between eligibility determinations. Assess whether changes in household income warrant changes in eligibility status or benefit amounts.

Status – No Action

Agency Actions – Due to COVID-19, DWSS will address this recommendation when the emergency COVID-19 actions have been lifted.

Recommendation 2

Revise policies and procedures over the Child Care and Development Program eligibility determinations to require subgrantees use all available information when assessing income and monitor subgrantee use of systems.

Status – Fully Implemented

Agency Actions – DWSS revised policies and procedures over the Child Care and Development Program (CCDP) eligibility determinations to require subgrantees use all available information when assessing income and monitor subgrantee use of systems. DWSS revised Child Care and Development Program Policy PT 03-19 that mandates staff utilize certain resources to obtain verification when processing cases. During its case reviews, Quality Control (QC) designates noncompliance with PT 03-19 as an "error" and notifies CCDP staff to provide additional training. DIA verified QC's determination of noncompliance for five sample cases that were selected from CCDP's most recent federal review.

Recommendation 3

Eliminate duplicate and low-value notifications.

Status – No Action

Agency Actions – Due to COVID-19, DWSS will address this recommendation when the emergency COVID-19 actions have been lifted.

Recommendation 4

Improve controls to ensure case notifications are addressed timely.

Status – No Action

Agency Actions – Due to COVID-19, DWSS will address this recommendation when the emergency COVID-19 actions have been lifted.

Recommendation 5

Analyze investigation and overpayment claims to identify those most significant to program integrity and overpayment recovery.

Status – Partially Implemented

Agency Actions – DWSS is in the process of analyzing investigation and overpayment claims to identify those most significant to program integrity and overpayment recovery. The Investigations and Recovery (I&R) section developed a referral triage tool to assign

a priority level to all investigative and overpayment referrals. I&R implemented a new 90-day "aged-out" policy, formalized in DWSS's Administrative Manual Chapter 3204.2, which outlines procedures to review unassigned referrals for proper disposition. The division reports its current investigative backlog stands at approximately 350 cases. DWSS has temporarily suspended this procedure due to COVID-19 and will address this recommendation when emergency COVID-19 actions have been lifted.

Recommendation 6

Establish procedures to assign higher priority investigations.

Status – Fully Implemented

Agency Actions – DWSS established procedures to assign higher priority investigations by developing the I&R Prioritization Calculator, a referral triage tool, to help determine a priority level for all incoming investigative referrals and overpayment refunds. The triage tool provides criteria to be applied by staff when assigning the priority level as well as helpful definitions and scenarios to assist in that determination.

Recommendation 7

Enhance policies and procedures over fraud detection reports to identify the most valuable reports and utilize reports to ensure program integrity.

Status – Fully Implemented

Agency Actions – DWSS's Investigations and Recovery section enhanced policies and procedures over fraud detection reports to identify the most valuable reports and utilize reports to ensure program integrity. DWSS entered into a State Law Enforcement Bureau (SLEB) agreement with USDA's Food and Nutrition Service (FNS) to conduct investigations into possible Supplemental Nutrition Assistance Program (SNAP) fraud to obtain benefits with federal debit cards. DWSS assigned two Compliance Investigators, one in the North and one in the South, to work increased retailer trafficking alerts in the data analytics and case management system, Pondera. DWSS has also worked with Pondera to identify useful alerts and modify them for the best indicators of fraud in Nevada. The division represents the SLEB activity has resulted in disqualification of eight retailers due to these efforts.

Recommendation 8

Develop controls over program integrity reports to ensure accuracy and completeness.

Status – Fully Implemented

Agency Actions – DWSS developed controls over program integrity reports to ensure accuracy and completeness of its Public Assistance Reporting Information Systems

(PARIS) report in Pondera. PARIS match files are sent to Pondera on a quarterly basis for crossmatching against DWSS recipient data to identify instances of duplicate benefits. The resulting crossmatches are pushed to the fraud dashboard on Pondera for review and possible investigation. DIA compared data for ten randomly selected individuals in PARIS to the information reflected in Pondera and found no inconsistencies.

The degree of ongoing compliance with this recommendation is the responsibility of the DWSS.

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Richard Whitley, Director, Department of Health and Human Services
Steve H. Fisher, Administrator, Division of Welfare and Supportive Services
Warren Lowman, Administrator, Division of Internal Audits

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January 6, 2021

Members of the Audit Subcommittee
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In February 2020, we issued an audit report on the Division of Welfare and Supportive Services (Division) of the Department of Health and Human Services. The Division filed its plan for corrective action in May 2020. Nevada Revised Statute 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 eight recommendations contained in the audit report. As of November 12, 2020, the Office of Finance indicated four recommendations were fully implemented, one partially implemented, and 3 had no action taken. The partially implemented and no action recommendations are shown below.

	Recommendation	Status
Recommendation No. 1	Make use of quarterly wage information in the interim between eligibility determinations. Assess whether changes in household income warrant changes in eligibility status or benefit amounts.	No Action
Recommendation No. 3	Eliminate duplicate and low-value notifications.	No Action
Recommendation No. 4	Improve controls to ensure case notifications are addressed timely.	No Action
Recommendation No. 5	Analyze investigation and overpayment claims to identify those most significant to program integrity and overpayment recovery.	Partially Implemented

The Office of Finance's report indicates the Division had made some progress in analyzing investigation and overpayment claims as they developed a triage tool which outlined procedures to review unassigned referrals for proper disposition. However, the Division suspended this procedure due to COVID-19.

The Office of Finance's report notes that the Division has not taken action on three recommendations. The report indicates no action has been taken due to COVID-19 actions and

the Division does not intend to address these recommendations until COVID-19 actions have been lifted. We have the following question for the Division.

Question

1. Considering the COVID-19 pandemic is ongoing, how much time after actions have been lifted does the Division estimate it will begin to implement remaining recommendations?

We will continue to monitor the Division's progress toward implementation on those recommendations still outstanding.

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:sy
cc: Michelle White, 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
Richard Whitley, Director, Department of Health and Human Services
Steve H. Fisher, Administrator, Division of Welfare and Supportive Services

Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued in 2019.

Report # LA20-02.

Background

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

As of June 30, 2018, we had identified 60 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 40 private facilities. In addition, 77 Nevada children were placed in 16 facilities in eight different states as of June 30, 2018.

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, 2017, through June 30, 2018, we received 1,531 complaints from 33 facilities in Nevada. Twenty-seven facilities reported that no complaints were filed during this time.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our reviews of 2 children's facilities, unannounced site visits to 8 children's facilities, and a survey of 60 children's facilities. As reviews and not audits, they 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 reviews 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.

These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2016. In addition, we discussed related issues and observed related processes during our visits.

Review of Governmental and Private Facilities for Children

December 2018

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at the two facilities reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of youths at the facilities, and they respect the civil and other rights of youths in their care. However, we identified several areas for improvement at both facilities.

We also conducted unannounced site visits to eight children's facilities. At one facility, Northwest Academy, we observed several issues that prompted us to question whether the facility adequately protected the health, safety, and welfare of the youths at the facility. As a result, we contacted Northwest Academy's licensing agency, the Bureau of Health Care Quality and Compliance, to express our concerns (see page 35).

Review Conclusions

Statutes do not require most health facilities licensed by the state's Bureau of Health Care Quality and Compliance (HCQC) to ensure employees who have direct contact with children are trained in certain areas specific to children. This includes private psychiatric hospitals that provide 24-hour care to children, facilities for the treatment of abuse of alcohol or drugs that provide residential services to children, and psychiatric residential treatment facilities. In contrast, training is required by law for employees at state-operated psychiatric hospitals (NRS 433B.175), governmental and private child care facilities and institutions (NRS 432A.177), group foster homes (NRS 424.0365), and correction and detention facilities (NRS 63.190 and NRS 62B.250) which includes:

- Controlling the behavior of children;
- Using force and restraint on children;
- Suicide awareness and prevention;
- Rights of children in the facility;
- Other matters affecting the health, welfare, safety, and civil and other rights of children in the facility; and
- Working with lesbian, gay, bisexual, transgender, and questioning children.

The Legislature may wish to consider enacting legislation to require psychiatric hospitals that provide 24-hour care, psychiatric residential treatment facilities, and facilities for the treatment of abuse of alcohol or drugs and that provide residential treatment to children who have been placed in a facility pursuant to an order of a court to require staff who have direct contact with children be trained in areas specific to children. (page 5)

Clark County's Juvenile Detention Center – Detention Facility (page 9)

Health	★★☆☆☆	Oversight of medical contractor and contractor policies needed. Neither the contractor's nor the Center's policies and procedures addressed psychotropic medication administration processes and procedures. In addition, our review of three youths' medication files found several errors: missing physicians' orders, missing documentation of verification of medication at intake, blank spaces on medication administration records, evidence of missed medication for up to 11 days, and missing documentation of the contractor's staff's medication training.
Safety	★★★★☆	Additional procedures for completing incident reports are needed.
Welfare	★★★★★	No issues noted.
Rights	★★★★☆	Update of youth's handbook is needed, including the grievance process.

Willow Springs Center – Psychiatric Hospital (page 17)

Health	★★½☆☆	Policies and procedures need to be established for consent to administer psychotropic medication, medication release at discharge, documentation of prescriptions, and admittance with an addiction disorder.
Safety	★★★☆☆	Background check policy needs to be updated, abuse reporting policy needs to be followed, and the face sheet policy needs to be updated.
Welfare	★★★★★	No issues noted.
Rights	★★★☆☆	Policies need to be updated to address the grievance process, patients' rights, and contraband.

Review Highlights

Highlights of Legislative Auditor report on the Review of Governmental and Private Facilities for Children issued on February 18, 2020.

Report # LA20-12.

Background

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

As of June 30, 2019, we had identified 58 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 38 private facilities. In addition, 71 Nevada children were placed in 14 facilities in 7 different states as of June 30, 2019.

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, 2018, through June 30, 2019, we received 1,339 complaints from 30 facilities in Nevada. Twenty-eight facilities reported that no complaints were filed during this time.

Purpose of Reviews

Reviews were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our reviews of four children's facilities, unannounced site visits to 11 children's facilities, and a survey of 58 children's facilities. As reviews and not audits, they 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 reviews 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.

These reviews included an examination of policies, procedures, processes, and complaints filed since July 1, 2017. In addition, we discussed related issues and observed related processes during our visits.

Review of Governmental and Private Facilities for Children

January 2020

Summary

Based on the procedures performed and except as otherwise noted, the policies, procedures, and processes in place at two of the four facilities reviewed provide reasonable assurance that they adequately protect the health, safety, and welfare of youths at the facilities, and they respect the civil and other rights of youths in their care. The other two facilities provide only marginal assurance that they adequately protect the health, safety, and welfare of the youths at the facilities, and they respect the civil and other rights of the youths in their care.

The following four pages contain a brief summary of the issues noted at the four facilities reviewed:

- Oasis On-Campus Treatment Homes; (page i)
- Never Give Up Youth Healing Center; (page ii)
- Apple Grove Foster Care Agency; (page iii)
- Koinonia Family Services. (page iv)

We also conducted unannounced site visits to 11 children's facilities and did not note anything that caused us to question the health, safety, welfare, or protection of the rights of the children in 8 of the facilities. At two facilities, we observed conditions that caused us to question the welfare of the youths in its care. Based on our observations, we contacted the facilities' licensing agency. The licensing agency initiated corrective actions. At one facility, we observed several issues that caused us to question whether the facility adequately protected the health, safety, and welfare of the youth in its care. Based on our observations, we contacted the facility's licensing agency. The facility was subsequently closed. (page 48)

Review Conclusions

The most common and significant weaknesses noted at the four facilities reviewed included:

- Consent to Administer Psychotropic Medication – We found issues at all four facilities related to the statutorily required consent of the person legally responsible for the psychiatric care of the child prior to administering psychotropic medications (NRS 432B.4687 and 432B.4688).
- Annual Medication Training – Not all foster parents or employees received annual training on medication administration, or did not receive the training timely, at three of the four facilities.
- Background Investigations – Three facilities' policies and procedures were incomplete, inaccurate, or non-existent.
- Complaints – All four facilities need to update their policies and procedures. (page 4)

In December 2019, we sent a letter to 56 of the 58 facilities listed in Appendix D of the report informing them of the requirements for obtaining consent from the person legally responsible prior to administering psychotropic medications. In addition, we asked the facilities to respond whether their policies and procedures address the statutory requirements and whether each employee who administers medication had received a copy of the policies and procedures and understood the consent requirements. As of December 31, 2019, we had received responses from 42 facilities stating their policies and procedures do address the statutory requirements and all employees who administer medication had received a copy of the policies and procedures and understood the consent requirements. Of the remaining 14 facilities:

- Three facilities confirmed their policies and procedures address the statutory requirements, but did not address whether all employees received a copy or understood the consent requirements.
- One facility confirmed it does have policies and procedures to address the statutory requirements and it is in the process of distributing a copy to employees.
- Three facilities confirmed they are in the process of updating policies and procedures, even though staff have received a copy and understand the consent requirements.
- One facility responded it does not have policies and procedures addressing the statutory consent requirements.
- Six facilities did not respond. (page 4)

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

Review Highlights

Highlights of Legislative Auditor report on the Governmental and Private Facilities for Children – Inspections issued on January 14, 2021.

Legislative Auditor Report # LA22-03.

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, 2020, we had identified 61 governmental and private facilities that met the requirements of NRS 218G: 20 governmental and 41 private facilities. In addition, 56 Nevada children were placed in 13 facilities across 9 different states as of June 30, 2020.

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, 2019, through June 30, 2020, we received 1,013 complaints from 25 facilities in Nevada. Thirty-six facilities reported that no complaints were filed during this time.

Purpose of Inspections and Surveys

Inspections and surveys were conducted pursuant to the provisions of NRS 218G.570 through 218G.595. This report includes the results of our inspections of 15 children's facilities, and surveys of 7 children's facilities. As inspections and surveys are not audits, they 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 inspections and surveys 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 and surveys included discussions of select policies, procedures, and related issues with facility management. In addition, we reviewed youth and personnel files.

Governmental and Private Facilities for Children – Inspections

December 2020

Summary

In 12 of 15 children's facilities 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 two of the facilities, Kiddos Nevada and 3 Angels Care, we observed conditions that caused us to question whether the facilities adequately protected the health, safety, and welfare of the children in their care. Based on our observations, we contacted the facilities' licensing agency. The licensing agency initiated corrective action, resulting in management at one facility closing its home. At the remaining facility, Specialized Alternatives for Families and Youth of Nevada, Inc., we observed conditions that caused us to question the safety and welfare of the children in its care. The licensing agency initiated corrective action, after we communicated our concerns to them. (page 5)

Kiddos Nevada

We noted health, safety, and welfare issues. For example, health issues observed included incomplete medication records and required documentation was missing. Safety issues observed included unsecured laundry detergent pods in a child's bedroom. Welfare issues observed included: the children's bathroom was filthy including the sink and floors; children's bedrooms contained beds without sheets or a bedframe, and there were piles of children's clothing on the floors, behind doors, and in bins; one child's bedroom smelled of human waste; and there was a pile of children's clothing on the garage floor. (page 5)

Facility management did not meet minimum foster care standards outlined in the Nevada Administrative Code (NAC) including: reasonable housekeeping standards; clean living spaces, bedrooms, and bathrooms which are free of trash and safety hazards; beds with sheets and bedframes; maintenance of medical records; and securing of laundry products. Facility management voluntarily closed the home after considering its licensing agency's quality of care concerns and our visit. (page 7)

3 Angels Care

At one of two 3 Angels Care foster homes, we noted health, safety, and welfare issues. For example, health issues observed included unsecured medication, incomplete medication documentation, and inaccessible records. Safety issues observed included an unsecured canister of Lysol spray, air freshener, a pair of scissors in a child's bedroom, and unsecured tools outside the home. Welfare issues observed included filth and piles of clothing throughout the home, so it was difficult to decipher clean from dirty laundry. In addition, the children's bedrooms had clothing on the floor, in laundry baskets, and bins alongside trash. Also, the children's bathroom was dirty, there was no towel rack, the trash can was overflowing, and there were clothes and toilet paper behind the door. Further, the kitchen floor was sticky. (page 7)

Management did not ensure its foster parents met minimum foster care standards outlined in NAC, including: reasonable housekeeping standards and separating clean and dirty clothing; clean living spaces, bedrooms, and bathrooms which are free from trash and safety hazards; maintenance of medical records and securing of medication; and securing cleaning products, tools, and equipment. (page 9)

Specialized Alternatives for Families and Youth of Nevada, Inc.

At one of three foster homes observed, we noted safety and welfare issues. For example, safety issues observed included unsecure laundry detergent. Welfare issues observed included: the hallway between the children's bedrooms had toys and litter; the children's bathroom had clothes, a towel, and trash on the floor; and the kitchen had dishes covering the entire counter top and dirty cookware on the stove. (page 9)

Management did not ensure its foster parents met minimum foster care standards outlined in NAC, including: reasonable housekeeping standards; clean living spaces, bedrooms, and bathrooms; or securing of laundry products. (page 10)

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Audit Division
Legislative Counsel Bureau

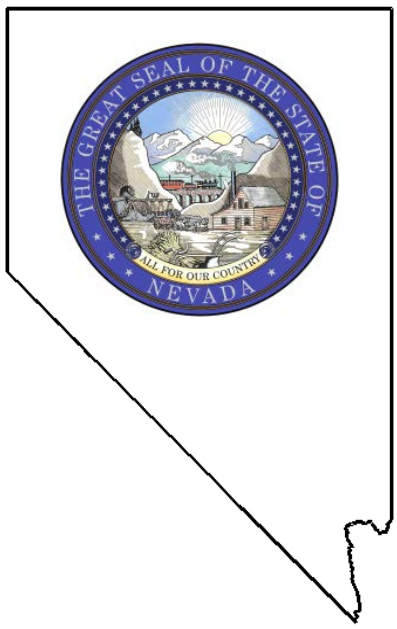
STATE OF NEVADA

Performance Audit – Addendum

Department of Public Safety
Records, Communications and Compliance Division

Information Security – Servers
LA18-12A

Operating System and Database Application Software



Legislative Auditor
Carson City, Nevada

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Legislative Commission
Legislative Building
Carson City, Nevada

This report addendum (LA18-12A) contains supplemental findings, conclusions, and recommendations from our performance audit of the Department of Public Safety's Records, Communications and Compliance Division, Information Security (LA18-12). We issued that report on January 17, 2018. The audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to provisions of Nevada Revised Statutes 218G.010 and 218G.350.

An addendum to report LA18-12 was necessary because security vulnerabilities existed in certain information systems within the Records, Communications and Compliance Division. Providing details regarding those vulnerabilities, at the time we published the original report, would have unnecessarily exposed those information security weaknesses. Since the Division has performed sufficient corrective actions, we are issuing this addendum as a supplement to our original report. Readers are encouraged to refer to report LA18-12 and this report addendum to gain a complete and comprehensive understanding of the audit's scope and objective, findings, recommendations, and methodology.

This addendum includes four additional recommendations to improve the security of the Division's servers. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

May 7, 2020
Carson City, Nevada

Addendum to Audit Report LA18-12

Server Software Lacked Critical Security Updates

Many of the Records, Communications and Compliance Division's (Division) servers had critical security vulnerabilities due to outdated and unsupported software. The Division did not ensure that operating systems and database application software were upgraded to supported versions in a timely manner. As software becomes outdated, the Division can no longer rely on security updates or technical support to keep software current. Knowing key dates in a software asset lifecycle plan ensures an organization makes informed decisions about when to upgrade or make other changes to its software. Without proper software upgrade planning, the Division compromises security, performance, and overall efficiency.

As of August 2016, 19 of the Division's 97 servers were running outdated Windows operating system software with critical security vulnerabilities. Also, seven of the servers were running outdated Oracle database software. There were no current security updates available, as the vendors no longer supported the versions of software installed.

The Division maintains information such as the sex offender registry, criminal history, and point-of-contact firearm information on its systems. Considering the criticality of the information, keeping software current is vital, as this mitigates security risks. The Division could have identified software vulnerabilities in a timely manner through a current software inventory and routine scans, which it did not. Conducting vulnerability scans on a frequent basis identifies vulnerabilities and prioritizes them on each system. The Division had controls in place such as security awareness training, network segmentation, and encrypted communications intended to prevent unauthorized access; however, the controls did not fully mitigate the vulnerabilities.

State security standards require operating systems that reach its end-of-life must be upgraded, application software be current with updates, and vulnerability scans be conducted on existing state systems and networks to identify areas of risk at least annually. Additionally, state standards require security exceptions be placed on file with the Office of Information Security, Division of Enterprise Technology Services (EITS) for justification of noncompliance with security policies and standards. The Division did not file security exceptions for any of its outdated software.

The Division indicated oversight lapsed as an unintentional consequence of the 2013 reorganization through which many Division information technology staff were consolidated under EITS. Three information security officers were retained to provide oversight of the Division's information technology functions. Regardless, it is the Division's responsibility to ensure software is maintained, upgraded, and outlined in a server software asset lifecycle plan. In response to the original audit report, LA18-12, a service-level agreement was completed and signed between the Division and EITS to ensure information technology operations and responsibilities are clarified.

Recommendations

1. Develop and maintain a division-wide server software asset lifecycle plan.
2. Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates.
3. Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.
4. Coordinate efforts with EITS to ensure operating system and database software are upgraded timely to current supported versions.

Actions Taken by the Agency to Resolve the Security Vulnerabilities

After the outdated software was identified in August 2016, the Division indicated it would require time and significant resources to initiate a project charter encompassing all of the outdated software that needed upgrading. Beginning in December 2017, the Division entered into an end-of-life server software upgrade project with a dedicated EITS project manager, who served as a liaison to the Division and coordinated efforts. This project involved comingled systems between various Department of Public Safety divisions, with varying degrees of integration between servers, databases, and applications. These systems are critical to ensuring the protection of Nevada citizens, visitors, and sworn law enforcement officers.

Over the course of the audit, we conducted monthly meetings to obtain status reports and monitor the progress of system and software upgrades. EITS successfully completed upgrading all of the Division's servers' software to current, vendor-supported versions in March 2020.

Methodology

To assess the logical security controls of all of the Division's 97 servers, we tested to ensure they were protected with current antivirus, operating system, and database application software updates. Based on the results of this test work and identifying outdated software, we conducted monthly meetings with EITS staff, project managers, and Division IT staff and management to follow the end-of-life server software upgrade project's progress. Additionally, we examined the server rooms housing the Division's equipment for physical security including adequate access controls, effective temperature monitoring controls, and after-hours automated notifications.

Our audit work was conducted from June 2016 to March 2020 as we continued to monitor the Division's progress in mitigating the vulnerabilities found early on in the audit cycle. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate

evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In accordance with Nevada Revised Statutes (NRS) 218G.230, we furnished a copy of our preliminary report addendum to the Records, Communications and Compliance Division. On April 27, 2020, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report addendum. That response begins on page 5.

Statutorily Required Corrective Action and Follow-Up

The four recommendations on page 2 are in addition to the ten issued in the original report (LA18-12) and are subject to the corrective action and follow-up requirements outlined in NRS 218G.250 and 218G.270. The Division's 60-day plan for corrective action on the four recommendations in this addendum is due on December 3, 2020, and the 6-month report on the status of audit recommendations is due on June 3, 2021.

Contributors to this report included:

Shirlee Eitel-Bingham, CISA
Deputy Legislative Auditor

Sarah Gasporra, BBA
Deputy Legislative Auditor

S. Douglas Peterson, CISA, MPA
Information Systems Audit Supervisor

Shannon Riedel, CPA
Chief Deputy Legislative Auditor

Response From the Records, Communications and Compliance Division

Steve Sisolak
Governor

Nevada Department of
Public Safety
DEDICATION PRIDE SERVICE

George Togliatti
Director

Sheri Brueggemann
Deputy Director

Mindy McKay
Division Administrator

Records, Communications and Compliance Division
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Carson City, Nevada 89716
Telephone (775) 684-6262 - Fax (775) 687-3289

May 4, 2020

Daniel L. Crossman, CPA
Legislative Auditor
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89701-4747

Dear Mr. Crossman,

This letter constitutes a written statement of explanation to the audit report addendum dated April 22, 2020 attached. Specifically, the addendum (LA18-12A) contains supplemental findings, conclusions, and recommendations from the Legislative Counsel Bureau's performance audit of the Department of Public Safety's Records, Communications and Compliance Division (RCCD), Information Security (LA18-12). The addendum includes four (4) recommendations to improve the security of the division's servers which the division has accepted. Below is a brief status on each recommendation.

Recommendation 1: Develop and maintain a division-wide server software asset lifecycle plan.

Response: RCCD accepts this recommendation.

A plan is being written by the Department's Information Security Officer which should be ready for review by mid-May and implementation shortly thereafter.

Recommendation 2: Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates.

Response: RCCD accepts this recommendation.

Draft policies and procedures are being developed by the Department's Information Security Officer which should be ready for review by mid-May and implementation shortly thereafter.

Recommendation 3: Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.

Response: RCCD accepts this recommendation.

Draft policies and procedures are being developed by the Department's Information Security Officer which should be ready for review by mid-May and implementation shortly thereafter.

Recommendation 4: Coordinate efforts with EITS to ensure operating system and database software are upgraded timely to current supported versions.

Response: RCCD accepts this recommendation.

The existing Service Level Agreement between EITS and DPS will be amended to include the requirement for EITS to ensure all operating system and database software is upgraded timely to current supported versions.

The division appreciates this opportunity to improve its information security posture. It has been a pleasure working with everyone at LCB during this audit. I appreciate everyone's professionalism, guidance and patience. We look forward to a formal audit closure. Please contact me if you require anything further.

Respectfully,

Mindy McKay, Administrator and CJIS Systems Officer
Records, Communications and Compliance Division

Cc: Shirlee Eitel-Bingham, LCB Deputy Legislative Auditor
Sarah Gasporra, LCB Deputy Legislative Auditor
George Togliatti, DPS Director
Sheri Brueggemann, DPS Deputy Director
Curtis Palmer, DPS Senior Fiscal Officer
Shaun Rahmeyer, DPS Office of Cyber Defense Coordination Administrator
Charlene Boegle, DPS Administrative Services Officer
Tom Dorsey, DPS Information Security Officer

Records, Communications and Compliance Division's Response to Addendum Recommendations

	Recommendations	Accepted	Rejected
1.	Develop and maintain a division-wide server software asset lifecycle plan	X	
2.	Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates	X	
3.	Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk	X	
4.	Coordinate efforts with EITS to ensure operating system and database software are upgraded timely to current supported versions	X	
	TOTALS	4	

Steve Sisolak
Governor

Nevada Department of
Public Safety
DEDICATION PRIDE SERVICE

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November 19, 2020

Susan Brown
Director, Governor's Finance Office
209 E. Musser Street, Room 302
Carson City, NV 89701-4298

Dear Director Brown,

Pursuant to NRS 218G.250, the Department of Public Safety's Records, Communications and Compliance Division submits the following Corrective Action Plan for audit #LA18-12A.

Recommendation 1: Develop and maintain a division-wide server software asset lifecycle plan.

Planned Corrective Action: Enterprise Information Technology Services (EITS) has created a Server Management Plan for the servers hosted and managed by EITS. This plan will be reviewed quarterly, and upgrades should be planned at least 12 months in advance of the published end of life date. The Department of Public Safety (DPS) Information Security Officer's (ISO) will be responsible for ensuring third-party equipment is properly monitored quarterly for software lifecycle.

Estimated Completion Date: November 13, 2020

Recommendation 2: Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates.

Planned Corrective Action: DPS Standing Order number 05/014/20 was created and put into effect on May 14, 2020. This policy establishes the minimum IT system patch and upgrade management standard for information systems and IT resources that support all DPS. Procedures have been established and will be maintained by the DPS ISO. Language has also been added to the Service Level Agreement (SLA) between EITS and DPS and the Server Management Plan to address security patches.

Estimated Completion Date: November 13, 2020

Recommendation 3: Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.

Planned Corrective Action: Standing Order number 05/014/20 was created and put into effect on May 14, 2020. This policy establishes the minimum IT system patch and upgrade management standard for information systems and IT resources that support all DPS. Procedures have been established and will be maintained by the DPS ISO to include monthly reviews of the scanning.

Estimated Completion Date: May 14, 2020

Recommendation 4: Coordinate efforts with EITS to ensure operating system and database software are upgraded timely to current supported versions.

Planned Corrective Action: Standing Order number 05/014/20 was created and put into effect on May 14, 2020. This policy establishes the minimum IT system patch and upgrade management standard for information systems and IT resources that support all DPS. Procedures have been established and will be maintained by the DPS ISO. The SLA between EITS and DPS has also been updated to require all software and operating systems versions to be upgraded in a timely manner.

Estimated Completion Date: May 14, 2020

I am available to answer questions and provide additional data, if necessary. I appreciate everyone's assistance, cooperation, and patience throughout this audit cycle.

Respectfully,

Mindy McKay
Division Administrator

Cc: Shannon Riedel, Chief Deputy Legislative Auditor
Sarah Gasporra, Deputy Legislative Auditor
Shirlee Eitel-Bingham, Deputy Legislative Auditor
George Togliatti, DPS Director
Sheri Brueggemann, DPS Deputy Director
Shaun Rahmeyer, DPS Office of Cyber Defense Coordination Administrator
Charlene Boegle, DPS Administrative Services Officer
Tom Dorsey, DPS Information Security Officer
Suzie Block, EITS Chief IT Manager

Elected Officials

Audit Highlights

Highlights of performance audit report on the Unclaimed Property Program issued on September 3, 2020.

Legislative Auditor report # LA20-16.

Background

The Unclaimed Property Program (Program) is responsible for collecting unclaimed property, locating property owners, and auditing businesses to ensure they have reported unclaimed property in their possession. The primary mission of the Program is to return abandoned property to the original owners or their heirs. According to the Treasurer's annual report, the State held about $853 million in unclaimed property at the end of fiscal year 2019.

Unclaimed property can include anything of value owed to an individual or a business. Property is considered unclaimed when there has been no activity or contact with the owner for a specific period. Any entity or person in possession of property that belongs to a Nevada resident is considered a holder of unclaimed property. After unsuccessful attempts to contact the owner, the property must be turned over to the State.

The Program maintains a searchable database of unclaimed property available to the public on the Treasurer's website. The reported owner, an estate, a lawful heir, or a duly authorized representative may file a claim for unclaimed property.

All unclaimed property received by the Program is recorded in the Abandoned Property Trust Account. Money is used to pay claims and fund the Program. Remaining balances in the Account are distributed to the Millennium Scholarship Trust Fund, Educational Trust Fund, and General Fund.

Purpose of Audit

The purpose of the audit was to evaluate the Program's processes for collecting, administering, and returning unclaimed property. Our audit focused on Program activities for fiscal year 2019, and included some information from fiscal year 2018.

Audit Recommendations

This audit report contains ten recommendations to strengthen the processes for collecting, administering, and returning unclaimed property. The State Treasurer accepted the ten recommendations.

Recommendation Status

The Program's 60-day plan for corrective action is due on December 3, 2020. In addition, the 6-month report on the status of audit recommendations is due on June 3, 2021.

Unclaimed Property Program

Office of the State Treasurer

Summary

The Unclaimed Property Program can strengthen certain processes over entities reporting abandoned property and claims to recover assets. Internal controls over the reporting process do not ensure unclaimed property reports and payments are processed timely. The Program's lack of enforcing policy for submitting unclaimed property payments via its online reporting system contributed to unprocessed reports and payments. Further, the Program lacked sufficient oversight of its automated claims system to ensure system reports were monitored for fraud and that the system was functioning properly. Stronger controls can help the Program ensure unclaimed property is promptly processed.

The Program can improve controls over the unclaimed property system and inventory. Specifically, controls are needed to ensure edits to critical data documenting ownership of unclaimed property are appropriate. Additionally, the Program should segregate duties over system and user access. Finally, inventory controls are needed for processing and recording safe deposit box contents in the unclaimed property system. Strong controls will help protect system data from unauthorized use and modifications and ensure safe deposit box contents are safeguarded.

Key Findings

We identified a backlog of 397 unclaimed property reports received between fiscal years 2016 and 2019. We tested 37 of the 397 unprocessed unclaimed property reports and found for 16 or 43% of the reports, Program staff did not perform timely research to identify why the report was not processed, and 7 or 19% of the reports reappeared in the system after being processed and removed by staff. Timely processing of unclaimed property reports is important to ensure collection of payments from the holders. (page 6)

The Program needs to revise internal controls to segregate duties and maintain appropriate documentation for the deletion of holder reports from the unclaimed property system. Eight of ten reports revealed the same person deleted the report and approved the transaction. Additionally, most lacked sufficient documentation to substantiate the reason for deleting the report. (page 7)

The Program did not ensure payments were received and posted timely in the unclaimed property system. The Program did not post 358 payments totaling $374,000 in property, dividends, and sales of unclaimed securities collected between fiscal years 2016 and 2019. The time frame payments were unposted ranged between 128 days to about 4 years. When unclaimed property payments are not posted, the property is not assigned to its rightful owner in the state's unclaimed property system. (page 8)

The Program's manual review of fast track claims was insufficient. Policies were not detailed or sufficient to ensure automatic processes were functioning as intended. The Program strengthened its process in April 2019 after our inquires. The revised review process identified one instance when the system inappropriately released a claim to the wrong person and two instances where criteria used by the fast track system was inappropriate. (page 11)

The Program was not reviewing fast track claims reports developed in response to our prior audit. The Program developed two reports to monitor fast track claims in response to the fraud identified. However, the Program did not sustain implementation of the recommendation and could not provide evidence the reports were being generated or reviewed. (page 11)

Property data edits in the unclaimed property system were not reviewed as recommended in our 2010 and 2015 audits. The purpose of reviewing edits is to verify inappropriate changes are not being made to data in the system. (page 13)

The Program did not adequately monitor access to its unclaimed property system. Routine reviews of system access were not performed and a current list of authorized users was not maintained. (page 14)

The Program did not maintain accurate and complete inventory records for the contents of unclaimed safe deposit boxes. We tested 35 safe deposit boxes and were unable to locate 14 items from 4 of the 35 boxes tested. Additionally, our observation of the Program's vault identified 6 of 20 savings bonds not recorded in inventory. (page 15)

Cash submitted with the contents of safe deposit boxes was not deposited in accordance with statute. In fiscal year 2019, a total of $84,000 in cash was recovered from unclaimed safe deposit boxes. We found the cash deposits associated with these safe deposit boxes were made between 28 to 132 days late. Additionally, it took the Program between 27 and 163 days to record tangible items contained in safe deposit boxes. (page 16)

Zach Conine
State Treasurer

STATE OF NEVADA
OFFICE OF THE STATE TREASURER

November 25, 2020

Daniel Crossman, CPA
Legislative Auditor
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89701

Dear Mr. Crossman:

The attached document represents the State Treasurer's Office Unclaimed Property Division Performance Corrective Action Plan in response to the Legislative Counsel Bureau Audit conducted for fiscal year 2019 and some information from fiscal year 2018. The document details the Corrective Action Plan and provides the status of each Corrective Action to date.

If you have any questions regarding this response please contact Chief Deputy Tara Hagan at (775) 684-5753, or Unclaimed Property Division Deputy Linda Tobin at (702) 486-4354.

Sincerely,

Zach Conine
Nevada State Treasurer

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STATE TREASURER PROGRAMS
Governor Guinn Millennium Scholarship Program
Nevada Prepaid Tuition Program
Unclaimed Property
College Savings Plans of Nevada
Nevada College Kick Start Program

LAS VEGAS OFFICE
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(702) 486-3246 Fax

Website: NevadaTreasurer.gov E-mail: StateTreasurer@NevadaTreasurer.gov

1. **Develop policies and procedures for the timely processing of unclaimed property holder reports and payments.**
   Corrective Action:
   - Assign additional resources to clear the backlog of older, uncleared holder reports and resolve outstanding receipt issues.
   - Utilize the penalties and interest program to encourage Holder responses and engagement in resolving report and/or payments issues.
   - Draft updated policies and procedures, requiring timely processing of reports and payments and outlining documentation method to substantiate follow up to resolve any issue.

   Corrective Action Status:
   - The backlog of reports and payments has been resolved. All reports received prior to fiscal year 2021 have been cleared, processed, and payments resolved and attached.
   - Reports and payments for the current fiscal year have all been processed or followed up on within 30 days of receipt, with proper documentation addressing any problems with the reports.
   - An updated policy and procedure addressing the timely processing of reports and payments has been drafted and is pending final approval. by the Treasurer.

2. **Ensure proper segregation of duties and documentation is maintained when deleting holder reports from the unclaimed property system.**
   Corrective Action:
   - Draft updated policies and procedures and desk manual defining the process for deleting a report, including adequate documentation and audit function.
   - Remove system access to delete reports from all staff other than the Deputy Treasurer and Management Analyst IV.
   - Assign the Auditor III, who does not have system permission to delete reports, to complete monthly audits of deleted reports to ensure all are properly documented and justified.
   - Work with the system vendor to modify Audit Deleted Report to ensure all information necessary to track and review deleted reports is documented and maintained.

   Corrective Action Status:
   - An updated policy and procedure addressing the procedures for deleting reports has been drafted and is pending final approval. by the Treasurer.
   - Updated desk manuals addressing deleting reports has been drafted and implemented.
   - System access has been restricted to allow access to the application which allows a report to be deleted to only the Deputy Treasurer and Management Analyst IV
   - Auditor III has implemented a monthly audit for deleted reports. All exceptions noted are sent to both the Deputy Treasurer and Management Analyst IV for remediation and explanation.
   - The system vendor has made the requested report changes. The updated report is used during the monthly audit.

3. **Develop, update, and implement policies and procedures over the fast track claims review process, including monitoring claim reports.**
   Corrective Action:
   - Draft updated policies and procedure for all required internal audit functions regarding all claims, including Fasttrack.
   - Assign the audit group to test a sample of Fasttrack claims each week prior to processing the claimant payments to ensure claims were properly approved through the automated system, in accordance with the business rules.
   - Assign the audit group to generate and review the "Multiple Claims Paid to the Same Address" report and "Multiple Claims Generated from the Same IP Address" report quarterly for any unusual trends and transactions.

   Corrective Action Status:
   - Updated policies and procedure addressing internal auditing process regarding claims review has been drafted and is pending final approval. by the Treasurer.
   - Weekly audits of Fasttrack claims have been fully implemented and are performed prior to issuance of claims payments.
   - Quarterly audits of reports to monitor for unusual trends and transactions have been fully implemented.

4. **Ensure policies and procedures regarding the monitoring of system edit reports are followed, and the editing and review functions are properly segregated.**
   Corrective Action:
   - Draft updated policies and procedures and desk procedures addressing the performance of data edits and the internal auditing process for reviewing edits.
   - Draft updated desk manual for the Management Analyst IV outlining the process of performing and documenting system edits.
   - Modify system access to allow only specified office personnel the system access to edit properties.
   - Assign the function of reviewing system edits to personnel who cannot perform edits in the system.

   Corrective Action Status:
   - Updated policies and procedures addressing the performance of data edits and the internal auditing process for reviewing edits has been drafted and is pending final approval. by the Treasurer.
   - An updated desk manual for the Management Analyst IV has been completed and includes the detailed process for edits and ensuring proper documentation is maintained.
   - System access has been restricted to allow only three (3) authorized staff the permission to perform edits.
   - Quarterly audits of system edits have been fully implemented, using the three revised reports and the fourth "old" report until final report revision has been completed.

5. **Work with the system vendor to improve edit reports to provide sufficient information to ensure oversight and monitoring activities can be performed efficiently**

   Corrective Action:

   - Work with the system vendor to modify reports to ensure that any system edits of sensitive information is adequately documented on the audit reports and includes all pertinent information, including the "before" and "after" of edited data.

   Corrective Action Status:

   - The vendor has completed modifications on three (3) of the four (4) requested reports. The fourth report modification is in process and will be completed prior to the six-month report deadline.

6. **Develop policies and procedures to ensure system access privileges are periodically reviewed for appropriateness, changes are adequately documented, and a current access listing is properly maintained.**

   Corrective Action:

   - Draft a new policy and procedure to address system access review, including frequency of list generation and review, and the criteria and method of documentation.
   - Work with vendor to modify and/or develop system database audit tables to track and capture all user provisioning changes within the system.
   - Work with vendor to develop reports based on user change audit tables to give the STO Information Technology Professional III position (IT Pro III) information necessary to review changes for appropriateness.
   - Develop template for all personnel positions and document proper roles to be assigned.

   Corrective Action Status:

   - A new policy and procedure to address system access review, including frequency of list generation and review, and the criteria and method of documentation is in development.
   - IT Pro III is working with the vendor to ensure all tables are being archived and developing reports to review access easily.
   - The IT Pro III is having ongoing discussions with the vendor to ensure our Office has adequate training and knowledge of the system to be able to appropriately draft the policy and perform a quality review.
   - A template used to determine proper roles assigned to each personnel position is in development.
   - All actions noted above will be completed prior to the six-month report deadline.

7. **Segregate Duties over user access privileges.**

   Corrective Action:

   - Ensure STO IT staff has adequate training and understanding of the software platform, bifurcation of user provisioning, user roles, security groups and SQL roles.
   - Assign IT department responsibility of SQL Role provisioning.
   - Assign the Deputy Treasurer responsibility to assign and control User Roles and Security Groups and require IT to review for changes and documentation as outlined in #6 above.
   - Revise new hire/change request form to adequately document needs of user SQL roles and support changes made by the IT staff.

- Develop forms to document changes to User Roles and Security Groups made by the Deputy Treasurer.

Corrective Action Status:

- Initial training by the vendor has been completed and will remain ongoing until IT staff is confident and thoroughly versed in system functionality.
- Change request forms have been created and will be used and maintained for all future changes.
- Segregation of assignment of user provisioning has been fully implemented.

8. **Establish controls to ensure an accurate inventory of safe deposit box contents is maintained, including following up on property inventory reconciliation discrepancies.**

Corrective Action:

- Modify timing of annual inventory testing to include both years of inventory in the sample which allows each safe deposit box two opportunities to be selected for testing.
- Make corrections to inventory records to account for any discrepancies found during testing or otherwise discovered.

Corrective Action Status:

- The 2020 inventory test was performed in August 2020 after intake was completed for FY20 safekeeping and prior to auction prep for properties received in FY19, which allowed both years of property the opportunity to be sampled.
- Errors noted in the testing were corrected in the system and management responses were drafted and included in the inventory reports.

9. **Comply with statute when processing cash received in unclaimed safe deposit boxes.**

Corrective Action:

- Revise the Holder Manual to highlight the requirement that Holders must indicate when cash is contained in a safe deposit box.
- Revise the inventory form that is used by Holders to document inventory being remitted, to highlight when cash is being remitted in a safe deposit box.
- Draft a new policy and procedure addressing cash received in safe deposit boxes, including allowing staff access to a safe deposit box's inventory in order to remove and deposit cash without having to complete in intake process for all contents of the box.

Corrective Action Status:

- Revision to the Holder Manual to address cash in safe deposit boxes was completed and posted in August 2020.
- Inventory form revisions were made and posted to the Unclaimed Property Division's webpage for use to report safekeeping for FY21 (which was reported prior to November 1, 2020).
- A new policy and procedure addressing the process to ensure that cash received from a safe deposit box is properly deposited as required under statute has been drafted and is pending final approval by the Treasurer.

10. Develop policies and procedures to ensure processing and recording of safe deposit boxes is done as soon as practicable.

Corrective Action:

- Draft a new policy and procedure to better define balancing the workload of the claims team to outline priorities and set timeframe benchmarks for the completion of certain duties.
- Revise NRS 120A to allow for more timely delivery of safekeeping.
- Reassign one safekeeping team member from a group other than the claims processing team, which allows for more flexibility in staff resources to process safekeeping

Corrective Action Status:

- A new policy and procedure defining the workload of the claims team which outlines priorities and sets timeframe benchmarks for the completion of certain duties has been drafted and is pending final approval by the Treasurer.
- A revision to NRS 120A addressing the delivery of safekeeping has been proposed and is included in Senate Bill 71 to be considered during the 2021 Legislative session.
- The Accountant Technician I position has been reassigned as the second member of safekeeping team and has completed initial training to perform the role.

Special Purpose Agency

Audit Highlights

Highlights of performance audit report on the Public Employees' Benefits Program, Contract Management issued on September 3, 2020.

Legislative Auditor report # LA20-15.

Background

The Public Employees' Benefits Program (PEBP) is a state agency that is legislatively mandated to provide group health, life, and accident insurance for state and other eligible public employees and retirees. PEBP's mission is to provide employees, retirees, and their families with access to high quality benefits at affordable prices.

PEBP currently administers various benefits and is responsible for designing and managing a quality health care program for approximately 44,000 primary participants and 27,000 covered dependents, totaling over 70,000 individuals.

PEBP enters into contracts with vendors to provide services to its participants. In fiscal year 2019, PEBP paid over $114 million to 19 vendors under contract with the agency. Vendor payments included things like actuarial services and medical, dental, and pharmaceutical administrator services.

A 10-member board oversees PEBP's operations. Nine board members are appointed by the Governor, and the 10th member is the Director of the Department of Administration or a designee approved by the Governor. The Board appoints an Executive Officer to direct the day-to-day operations.

Purpose of Audit

The purpose of the audit was to determine if PEBP has adequate controls to ensure vendor selection and payments complied with state laws, policies, and contract terms; and expenses related to contracts, awards, and accreditations were appropriate. Our audit included a review of contract procurement and payment practices, and award and accreditation expenditures for fiscal year 2019, and prior years for some activities.

Audit Recommendations

This audit report contains four recommendations to improve PEBP's contracting practices and one recommendation to ensure the proper use of PEBP's resources.

PEBP accepted the five recommendations.

Recommendation Status

PEBP's 60-day plan for corrective action is due on December 3, 2020. In addition, the 6-month report on the status of audit recommendations is due on June 3, 2021.

Contract Management

Public Employees' Benefits Program

Summary

The Public Employees' Benefits Program's (PEBP) contracting practices changed over the past several years, focusing more on amending and extending contracts through private negotiations instead of competitive procurements. While contract amendments may be appropriate in some circumstances, for the most part, amendments should be infrequent and not utilized as a default to extend contracts and procure services worth hundreds of millions of dollars. State law creates the PEBP board giving it responsibility for ensuring contracting practices comply with laws and policies, and to help ensure the proper use of agency resources. However, PEBP's contracting practices did not always follow state laws and policies as some amendments significantly modified contracts' scopes of work and contracts were extended without proper approvals. Furthermore, some wasteful spending of agency resources occurred. Without proper contracting practices and agency oversight, there is increased risk the best interests of the State and PEBP participants will not be realized, and agency resources will not be used appropriately.

Key Findings

Between fiscal years 2015 and 2019, PEBP authorized nearly $96 million in contract services that were not competitively bid through a Request for Proposal (RFP) process, as PEBP began to focus more on extending contracts. For 14 of 19 active service contracts in fiscal year 2019, PEBP amended these contracts to extend them beyond the original contract term, with some extended more than once. As a result, the average contract term increased from almost 5.5 years to over 8.5 years, with two contracts having 11-year terms. Under PEBP's management of the past 5 years, 23 contract extensions were performed and only 12 RFPs. State policy indicates contracts should be competitively solicited at least every 4 years. While PEBP claims a longer contract term is more desirable for some contracts, amending and extending contracts indefinitely does not help ensure the State and PEBP participants receive the best value. (page 6)

Private negotiations became a standard practice as PEBP's management extended vendor contracts for multiple years. Some negotiations took place through direct contact with vendors or by emails. For one contract, negotiations included two vendor paid trips, at the request of PEBP management, in which PEBP employees received transportation, lodging, and meals worth more than $7,000. Following the second trip, a significant scope modification occurred and the contract was extended 2 years. The amendments and contract extension occurred despite PEBP management and staff dissatisfaction with the vendor's performance. Not only does accepting gifts violate state ethics laws and policies, but it increases the risk of fraud and that contracting decisions will not be in the best interests of the State or PEBP's participants. (page 10)

PEBP management claimed that competitive bidding for contracts was unnecessary as they performed regular market checks to determine the value of the services their current vendors were providing. However, market checks were only performed multiple years for one vendor, and showed PEBP was paying more than other plans of similar size. In addition, cost savings was used to justify several contract extensions, after vendors agreed to lower pricing in exchange for added years to their contract terms. Market checks and cost savings should not be used to supplant bidding processes since additional value and savings may be received through competition. (page 12)

PEBP's board did not provide adequate oversight of contracting practices as it approved significant modifications to contracts' scopes of work and changes to PEBP's policies and procedures that placed less emphasis on competitive procurement. In addition, 6 of 18 contract extensions took place without State Purchasing's approval or being discussed at a PEBP Board meeting; thereby, circumventing state policy and law. (page 14)

During our testing, we observed some agency expenditures were unnecessary and not an efficient use of agency resources. For instance, PEBP allocated over 620 hours and nearly $51,000 to obtain business awards and an accreditation. It is the responsibility of PEBP's Board and management to ensure funds are spent appropriately. (page 21)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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ACCREDITED
CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

Date: November 28, 2020

To: Susan Brown, Director Governor's Finance Office

CC: Daniel Crossman, Legislative Auditor
Warren Lowman, Division of Internal Audits

From: Laura Rich, Executive Officer, Public Employees' Benefits Program

Subject: PEBP Legislative Audit Corrective Action Plan

NRS 218G.250 requires the submission of a corrective action plan to be submitted to the Director of the Office of Finance within 60 working days after receipt of notification.

Attached is PEBP's response indicating acceptance and the PEBP Board approved correction action plan.

Sincerely,

Laura Rich
Executive Officer

On September 23, 2020, the Board of the Public Employees' Benefits Program approved the following corrective action plan:

Recommendation 1:
The PEBP Board should develop policies and procedures to ensure:

- *Competitive procurement of contracted services once the original term of the contract ends, in compliance with state policies*
- *Contracts and contract amendments have supporting documentation, including proper approvals by the Board and State Purchasing Division; and*
- *Changes to a contract's original scope of work are competitively bid*

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
The PEBP Board shall form a subcommittee with the purpose of editing existing and/or developing new policies and procedures to address PEBP procurement practices.

Recommendation 2:
Comply with state law and agency policy concerning gifts and include periodic training and documented attestations of Board member and employee acceptance of policies.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
PEBP will coordinate with the Department of Human Resource Management to ensure PEBP policies and Procedures are updated to reflect state gifting policies and ensure all employees sign updated attestations. Additionally, PEBP will continue to request ethics training be provided to staff and Board members on an annual basis.

Recommendation 3:
Establish formal policies and procedures regarding the Request for Information process and compliance with State Purchasing guidelines.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
PEBP staff will edit existing and/or develop new policies and procedures addressing procurement practices that align with State Purchasing guidelines.

Recommendation 4:
Develop policies and procedures that require accurate information be provided to the Board and other governing bodies when seeking to amend contracts and supporting documentation to be provided.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:

1. The PEBP Board shall form a subcommittee with the purpose of creating criteria and/or guidelines to be met by staff before any contract amendments are brought to the Board for consideration.
2. Once Subcommittee recommendations have been approved by the Board, PEBP staff will update its policies and procedures accordingly.

Recommendation 5:
Develop policies and procedures, in consultation with PEBP's Board, to ensure the use of funds and resources directly relate to the purpose of the agency and the statutory intent for the use of those resources.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:

1. The PEBP Board shall form a subcommittee with the purpose of creating criteria and/or guidelines to address NRS 287.0434(1) regarding authorized expenditures to be met by staff before any proposed expenditures are brought to the Board for consideration.
2. Once Subcommittee recommendations have been approved by the Board, PEBP staff will update its policies and procedures accordingly.

Audit Highlights

Highlights of performance audit report on the Public Employees' Benefits Program, Information Security issued on February 18, 2020.

Legislative Auditor report # LA20-13.

Background

The Public Employees' Benefits Program (PEBP) is a state agency that is legislatively mandated to provide group health, life, and accident insurance for state and other eligible public employees.

PEBP currently administers various benefits and is responsible for designing and managing a quality health care program for approximately 43,000 primary participants and 27,000 covered dependents, totaling over 70,000 individuals. PEBP's mission is to provide employees, retirees, and their families with access to high quality benefits at affordable prices.

A 10-member Board oversees PEBP's operations. Nine Board members are appointed by the Governor, and the 10th member is the Director of the Department of Administration or his designee approved by the Governor. The Board appoints an Executive Officer to direct the day-to-day operations.

Funding for PEBP operations and insurance plans comes primarily from participant and employer contributions. PEBP submits its funding and operational requirements to the Legislature as part of the biennial budget. Upon approval, each state agency is assessed an amount to contribute toward both the active-employee and retiree health plans. For fiscal year 2019, PEBP had revenues of more than $376 million.

Purpose of Audit

The purpose of the audit was to determine if PEBP has adequate information security controls in place to protect the confidentiality, integrity, and availability of its information and information systems. Our audit focused on the systems and practices in place during calendar year 2019 and included a review of security awareness training rosters from prior years.

Audit Recommendations

This audit report contains 14 recommendations to improve the security of PEBP's information systems.

PEBP accepted the 14 recommendations.

Recommendation Status

PEBP's 60-day plan for corrective action is due on May 12, 2020. In addition, the 6-month report on the status of audit recommendations is due on November 12, 2020.

Information Security

Public Employees' Benefits Program

Summary

The Public Employees' Benefits Program (PEBP) needs to strengthen its information system controls to ensure adequate protection of information systems and information processed therein. By taking action to address these control weaknesses, PEBP can better protect its physical resources, minimize security vulnerabilities, and ensure continuation of critical services.

Control weaknesses included: 1) inadequate security over computers and network devices, such as computers missing operating system and anti-virus updates; 2) not adequately managing users, including lack of account review and non-compliance with background check and security awareness training requirements; and 3) incomplete security related plans, such as lack of a current IT contingency plan and documentation of data recovery process.

Key Findings

PEBP is not monitoring the status of operating system updates on its computers and laptops. The application which PEBP utilizes to automate operating system updates did not successfully deploy updates to 13 of the 20 computers and laptops we tested. This problem went undetected as staff were not routinely verifying whether updates were installed successfully. Staff acknowledged additional training in the administration of the systems management application is needed to gain more familiarity with the system and its capabilities. (page 4)

PEBP is not ensuring its computers and laptops are current with anti-virus software. The application which automates anti-virus deployment was not successfully deploying virus definition updates to 24 of the 55 computers we tested. This problem went largely undetected as staff were not routinely verifying updates were installed successfully and were not familiar with the anti-virus management application. (page 5)

Weaknesses exist in managing PEBP's network accounts. Of PEBP's 110 network accounts, we identified 64 active user and service accounts that should be reviewed to determine their need. PEBP was disabling user accounts upon employee departure; however, it did not perform routine account maintenance to remove obsolete accounts. (page 8)

PEBP is not routinely reviewing user access privileges in five of its critical applications and user access is not removed in a timely manner. These applications contain personal identifying information. During our analysis of the critical applications, we determined that although PEBP had established a procedure for revoking user access upon employee termination, it was not being followed. (page 9)

Background checks were not completed for PEBP's IT contractors. During our system account review, we identified three IT contractor accounts. We determined none of these IT contractors had background checks conducted as part of their hiring process, although PEBP conducted routine background checks on employees. These IT contractors had access to important information systems containing sensitive information. (page 10)

Fourteen of PEBP's thirty-three employees have not received their annual security awareness training. Seven had no record of ever taking the training. During the course of the audit, we determined none of PEBP's three IT contractors received security awareness training as required by state security standards. Security awareness training helps ensure employees, consultants, and contractors are aware of their responsibilities in protecting state information. (page 10)

PEBP's system recovery and business continuity plan does not include sufficient information to enable its management to restore its critical services due to a system, application, or hardware malfunction. We determined PEBP's plan is not reviewed annually and has not been kept up to date. The plan references obsolete equipment and software inventory listings. Staff indicated the plan has been in place for some time and is outdated. PEBP must be able to continue to provide critical services should a situation occur that renders resources inaccessible. (page 12)

PEBP's data recovery procedures have not been adequately documented. Without adequate documentation, PEBP cannot develop comprehensive recovery procedures for each system, application, and associated data. (page 12)

Steve Sisolak
Governor

Susan Brown
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: Susan Brown, Director
Governor's Finance Office

Date: November 12, 2020

Subject: Legislative Audit of the Public Employees' Benefits Program, Information Security

On February 18, 2020, your office released an audit report (LA 20-13) on the Public Employees' Benefits Program (PEBP), Information Security. PEBP subsequently filed a corrective action plan on March 31, 2020. NRS 218G.270 requires the Director of the Governor's Finance Office to report to the Legislative Auditor on measures taken by PEBP to comply with audit findings.

There were 14 recommendations contained in the report. The extent of PEBP's compliance with the audit recommendations is as follows:

Recommendation 1

Obtain additional training to utilize the full capabilities of the operating system and anti-virus management applications to improve computer administration.

Status – Fully Implemented

Agency Actions – PEBP's information technology staff obtained additional training from the state's Enterprise Information Technology Services (EITS) staff to utilize the full capabilities of the operating system and anti-virus management applications to improve computer administration on September 1, 2020. We interviewed EITS staff to confirm this training was provided to PEBP. This recommendation is no longer applicable because management of PEBP's operating system and anti-virus applications have been transferred to EITS.

Recommendation 2

Develop procedures to routinely detect and correct failed computer operating system and anti-virus update installations.

Status – Fully Implemented

Agency Actions – EITS is now managing PEBP's computer operating systems and anti-virus update installations. EITS software has been deployed to routinely detect and correct failed computer operating system and anti-virus update installations. EITS staff submits a monthly exception report to PEBP that shows failed update installations. We reviewed the October 2020 exception report and noted it accurately identified failed update installations, the computer name and domain, and the reason for the failure (e.g., computer restart required).

Recommendation 3

Install and configure encryption software on laptops.

Status – Fully Implemented

Agency Actions – PEBP installed and configured encryption software "BitLocker," a Microsoft encryption program, on all laptops to encrypt software on these laptops. We reviewed PEBP's "PC/Laptop Checklist" and the asset inventory spreadsheet and confirmed encryption activation. In addition, this internal checklist serves as a requirement for PEBP's IT staff to check installation and configuration of encryption software on all laptops.

Recommendation 4

Update existing policies and procedures to ensure mobile device agreements are signed and kept on file.

Status – Fully Implemented

Agency Actions – PEBP updated existing policies and procedures to ensure mobile device agreements are signed and kept on file. The procedures require all staff that use mobile devices (Laptops, Tablets, and Smartphones) to complete and sign a Mobile Device Agreement (MDA). The signed MDAs are stored in PEBP's "Smartsheet" software which is used to track employee MDAs. We reviewed the updated policies and procedures, signed MDAs, and the Smartsheet report and substantiated PEBP's actions.

Recommendation 5

Modify the overwrite settings of the multifunction device to ensure data is adequately erased.

Status – Partially Implemented

Agency Comments – PEBP reports it modified the overwrite settings of the multifunction device to ensure data is adequately erased. According to PEBP, the change will ensure print jobs, document scans, and other data are erased from the multifunction device's memory.

Auditor Comments – We are unable to confirm the modification of the overwrite settings of the multifunction device due to the closure of state offices as a result of the COVID-19 pandemic.

Recommendation 6

Review the existing multifunction device configuration and determine a viable method to manage faxes.

Status – Fully Implemented

Agency Actions – PEBP reviewed the existing multifunction device configuration and determined a viable method to manage faxes. PEBP discontinued the use of a multifunction device to manage faxes and instead purchased a standalone fax machine and a secure cabinet to meet state security standards. In addition, PEBP removed all but one dedicated fax line that is now used exclusively for the standalone fax machine. We reviewed the invoice for the standalone fax machine and secure cabinet and confirmed with EITS staff that all but one dedicated fax line was removed.

Recommendation 7

Periodically review the multifunction device for firmware and software updates.

Status – Fully Implemented

Agency Actions – PEBP periodically reviews the multifunction device for firmware and software updates and uses Smartsheet software to set quarterly reminders to check for these updates. We reviewed a copy of the PEBP Asset Printer Report exported from the Smartsheet software and noted reminders are set quarterly to review multifunction device firmware and software updates. We also noted multifunction devices were updated with current firmware versions.

Recommendation 8

Configure encryption on the wireless access point.

Status – Fully Implemented

Agency Actions – PEBP configured encryption on the wireless access point (WAP) to include encryption. Although a guest password was required to connect to the WAP, there was no administrative password established which left the WAP vulnerable to unauthorized access. PEBP set an administrative password to address this recommendation and secure the WAP. We reviewed the login settings and noted an administrative password is now required for access.

Recommendation 9

Develop policies and procedures to ensure quarterly review of: 1) network user and service accounts; 2) critical business application user access; and 3) accounts within the building access system.

Status – Fully Implemented

Agency Actions – PEBP developed policies and procedures to ensure quarterly review of network user and service accounts; critical business application user access; and accounts within the building access system. Additionally, PEBP uses a personnel access tracker to quarterly review account access and ensure account privileges are revoked when necessary. We reviewed the updated policies and procedures and personnel access report and noted account access is tracked by employee and quarterly reminders have been established to review account access.

Recommendation 10

Follow the established procedure for revoking system access by disabling accounts immediately upon termination or a change in responsibilities of an employee or contractor.

Status – Fully Implemented

Agency Actions – PEBP is following procedures for revoking system access by disabling accounts immediately upon termination or a change in responsibilities of an employee or contractor. Additionally, PEBP tracks system access by user on a personnel access tracker spreadsheet. We reviewed this spreadsheet and PEBP's term/transfer analysis report and noted one employee was transferred to another agency and the employee's system access was disabled on the employee's final day working for PEBP.

Recommendation 11

Enhance the existing process to ensure IT contractors with access to PEBP's systems have background checks.

Status – Fully Implemented

Agency Actions – PEBP enhanced its existing process to ensure IT contractors with access to PEBP's systems have background checks. PEBP now uses Smartsheet software to track IT contractors with access to PEBP's systems. We reviewed the newly developed contractor checklist, Smartsheet report, and updated procedures and confirmed that IT contractors with access to PEBP's systems must pass background checks prior to being given access to PEBP's systems.

Recommendation 12

Update existing policy to define roles and responsibilities of individuals to monitor and ensure all employees, consultants, and IT contractors take initial and annual security awareness training.

Status – Fully Implemented

Agency Actions – PEBP updated its existing policy (Security Awareness Training Policy) to define roles and responsibilities of individuals to monitor and ensure all employees, consultants, and IT contractors take initial and annual security awareness training through "KnowBe4," a security awareness training platform authorized by EITS. To monitor ongoing compliance with these training requirements, PEBP uses Smartsheet software to track employees, consultants, and IT contractors that have taken the training. This software automatically alerts staff via email when training is coming due, is currently due, and is past due. We reviewed the updated security awareness training policy and the Smartsheet training report and noted PEBP is compliant with state security awareness training requirements.

Recommendation 13

Ensure the system recovery and business continuity plan is reviewed and kept up to date at least annually.

Status – Partially Implemented

Agency Comments – PEBP represents it is working on ensuring the system recovery and business continuity plan is reviewed and kept up to date at least annually. PEBP's former Chief Information Officer (CIO) was working with EITS staff to ensure the system recovery and business continuity plan was reviewed and kept up to date at least annually. This position has been vacated and PEBP does not anticipate revision of the system recovery

and business continuity plan until the CIO position is filled in the near future. PEBP anticipates full implementation of this recommendation in January 2021.

Recommendation 14

Update existing policies and procedures to define scheduling, testing, and documenting of the recovery processes at least semiannually.

Status – Partially Implemented

Agency Comments – PEBP represents it is working on updating existing policies and procedures to define scheduling, testing, and documenting of the recovery processes at least semiannually. PEBP's former CIO was working with EITS staff to update existing policies and procedures to define scheduling, testing, and documenting of the recovery processes at least semiannually. The CIO position is currently vacant and existing policies and procedures have not been updated. PEBP reports progress on this recommendation will start when the CIO position is filled in the near future and anticipates full implementation of this recommendation in January 2021.

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

Susan Brown, Director
Governor's Finance Office

cc: Michelle White, Chief of Staff, Office of the Governor
Laura Rich, Executive Officer, Public Employees' Benefits Program
Warren Lowman, Administrator, Division of Internal Audits

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January 6, 2021

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

In February 2020, we issued an audit report on the Public Employees' Benefits Program (PEBP), Information Security. PEBP filed its plan for corrective action in March 2020. 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 14 recommendations contained in the audit report. As of November 12, 2020, the Office of Finance indicated 11 recommendations were fully implemented and 3 recommendations were partially implemented. The partially implemented recommendations are shown below.

	Recommendation	Status
Recommendation No. 5	Modify the overwrite settings of the multifunction device to ensure data is adequately erased.	Partially Implemented
Recommendation No. 13	Ensure the system recovery and business continuity plan is reviewed and kept up to date at least annually.	Partially Implemented
Recommendation No. 14	Update existing policies and procedures to define scheduling, testing, and documenting of the recovery processes at least semiannually.	Partially Implemented

In November 2020, we discussed the status of the three partially implemented recommendations with PEBP management and reviewed relevant documentation. Our review indicated PEBP has now fully implemented Recommendation No. 5. However, PEBP indicates the business continuity plan review and recovery process updates will be completed when the Chief Information Officer position at PEBP is filled. PEBP anticipates full implementation of these two recommendations in January 2021.

Questions

1. Has a review of the business continuity plan been conducted?

2. Has the Agency completed updates to existing policies and procedures to define scheduling, testing, and documenting of the recovery process?

Respectfully Submitted,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:smy
cc: Michelle White, 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
Laura Freed, Director, Department of Administration
Laura Rich, Executive Officer, Public Employees' Benefits Program

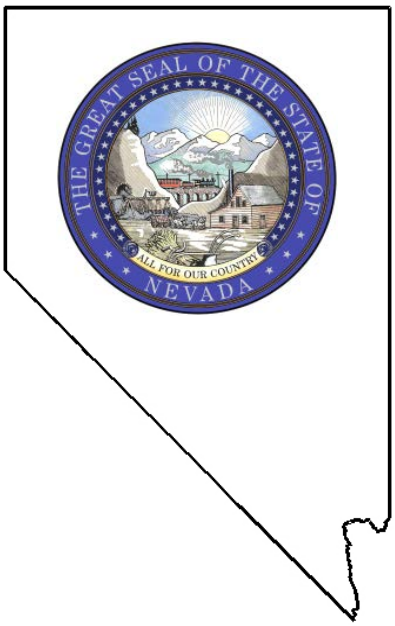
STATE OF NEVADA

Performance Audit – Addendum

Public Employees' Benefits Program

Information Security – Servers
LA20-13A

Operating System and Database Application Software



Legislative Auditor
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This report addendum LA20-13A contains supplemental findings, conclusions, and recommendations from our performance audit of the Public Employees' Benefits Program, Information Security (LA20-13). We issued that report on February 18, 2020. The audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to provisions of NRS 218G.010 and 218G.350.

An addendum to report LA20-13 was necessary because security vulnerabilities existed in certain information systems within the Public Employees' Benefits Program. Providing details regarding those vulnerabilities, at the time we made the original report public, would have unnecessarily exposed those information security weaknesses. Since the agency has performed sufficient corrective actions, we are issuing this addendum as a supplement to our original report. Readers are encouraged to refer to report LA20-13 and this report addendum to gain a complete and comprehensive understanding of the audit's scope and objective, findings, recommendations, and methodology.

This addendum includes four additional recommendations to improve the security of the agency's servers. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Daniel L. Crossman, CPA
Legislative Auditor

November 5, 2020
Carson City, Nevada

Addendum to Audit Report LA20-13

Server Software Lacked Critical Security Updates

Many of the Public Employees' Benefits Program's (PEBP) servers had critical security vulnerabilities due to outdated and unsupported software. PEBP did not ensure that operating systems and database application software were upgraded to supported versions in a timely manner. Knowing key dates in a software asset lifecycle plan ensures an organization makes informed decisions about when to upgrade or make other changes to its software. Without proper software upgrade planning, PEBP compromises security, performance, and overall efficiency.

We determined all servers were not current with Microsoft Windows operating system security updates. PEBP's designated server for update deployment was not issuing Windows operating system updates successfully. Furthermore, updates were not routinely verified for successful installation. In addition, we determined adequate documentation of procedures for administering the server was not maintained. State security standards require agencies to implement a process to deploy critical or actively exploitable security patches.

Further, we determined one server was running outdated Windows operating system software as well as outdated database software. There were no current security updates available, as the vendor no longer supported the operating system and database versions of software installed. State security standards indicate operating systems or commercial applications that have reached end-of-support from the vendor must be upgraded to a currently supported version.

PEBP was also not conducting vulnerability scanning on its servers. PEBP could have identified outdated software and security update issues earlier had they performed vulnerability scanning and maintained a software inventory. Conducting scans on a frequent basis identifies and prioritizes vulnerabilities. State Information Security Program Policies require all systems have vulnerability scans to identify security threats at least annually.

Some Servers Lacked Virus Protection Software

Controls over virus protection for PEBP's servers were deficient. The server, which automates antivirus deployment, was not updating 9 of the 22 Windows servers. Four did not have the antivirus client software installed and five did not have current antivirus updates. In addition, the system administrator was not routinely verifying antivirus updates were successfully installed and did not have documentation of procedures for administering the server. State security standards state each agency shall update virus protection software and definition files as new releases and updates become available.

Linux Servers Lacked Oversight

Some of the agency's Linux servers were not adequately maintained. Of the nine Linux servers at PEBP, we determined only three were running a current distribution of Linux. However, the system administrator could not identify the distribution or version of the remaining Linux servers. Through discussions with staff as well as our observations, we determined the system administrator had not maintained adequate password documentation nor sufficient server documentation to ensure server maintenance was occurring.

Recommendations

1. Develop and maintain an agency-wide server software asset lifecycle plan.
2. Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates and ensure they are successfully installed.
3. Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.
4. Ensure existing server inventory and password management software is maintained.

Actions Taken by the Agency to Resolve the Security Vulnerabilities

After the security vulnerabilities were identified in the servers, the agency established a plan to mitigate them. The plan involved utilizing the Division of Enterprise Information Technology Services' software update and antivirus management services, as well as a full documentation and system review of PEBP's information technology environment.

Beginning in February 2020, we conducted monthly meetings to obtain status reports and monitor the progress of system and software upgrades. We continued to monitor PEBP's progress until successful upgrading, patching, or decommissioning of all servers was complete.

Methodology

To assess the logical security controls of all of PEBP's servers, we tested to ensure they were protected with current antivirus, operating system, and database software updates. Based on the results of this test work and identifying outdated software, we conducted monthly meetings with PEBP's IT staff and management regarding resolution of these issues.

Our audit work was conducted from January 2019 to August 2020. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Statutorily Required Corrective Action and Follow-Up
The 4 recommendations on page 3 are in addition to the 14 issued in the original report LA20-13 and are subject to the corrective action and follow-up requirements outlined in NRS 218G.250 and 218G.270. The Agency's 60-day plan for corrective action on the four recommendations in this addendum is due on April 9, 2021 and the 6-month report on the status of audit recommendations is due on October 9, 2021.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report addendum to the Public Employees' Benefits Program. On October 19, 2020, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report addendum. That response is included on page 6.

Contributors to this report included:

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Response From the Public Employees' Benefits Program

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

October 29, 2020

Daniel L. Crossman, CPA
Legislative Council Bureau
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Carson City, NV 89701

Dear Mr. Crossman,

Thank you for the information provided in your audit report dated October 9, 2020. We appreciate the Legislative Council Bureau's professionalism during this audit process and the opportunity to improve the security of PEBP's IT systems. Please see the agencies' responses to your recommendations below. We have also attached PEBP's "Response to the Audit Recommendations" indicating our acceptance of the recommendations.

Recommendation 1: Develop and maintain an agency-wide server software asset lifecycle plan.

Response: PEBP accepts this recommendation.
In response to this finding, PEBP has developed an asset lifecycle plan and has implemented a system to track and monitor replacement schedules. Additionally, PEBP has purchased new servers to replace existing servers with past due end-of-life replacement dates.

Recommendation 2: Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates and ensure they are successfully installed.

Response: PEBP accepts this recommendation.
PEBP has taken appropriate measures to ensure routine updates are managed automatically through Enterprise IT Services (EITS) and that proper oversight occurs on the agency level. Policies and Procedures will be updated accordingly.

Recommendation 3: Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.

Response: PEBP accepts this recommendation.
In coordination with EITS, PEBP has already taken appropriate measures to reduce server vulnerability. Some existing servers were decommissioned and transitioned to EITS while other older servers have been replaced.

Recommendation 4: Ensure existing server inventory and password management software is maintained.

Response: PEBP accepts this recommendation.

As a result of this finding, PEBP IT staff have taken proper measures to ensure this recommendation is accomplished both externally through existing EITS processes and internally via a newly implemented tracking and oversight system. Additionally, the appropriate updates to agency policies and procedures will be made.

Thank you again for the recommendations to improve the Public Employee Benefits Program's IT operations and security.

Sincerely,

X 

Laura Rich
Executive Officer, Public Employees' Benefits Progr...
Signed by: 8d3ae9d7-40c6-491d-85c0-7ec0133f30a0

Laura Rich, Executive Director
Public Employee Benefits Program

Public Employees' Benefits Program Response to Addendum Recommendations

	Recommendations	Accepted	Rejected
1.	Develop and maintain an agency-wide server software asset lifecycle plan	X	
2.	Develop policies and procedures to routinely verify servers are receiving operating system and database software critical updates and ensure they are successfully installed	X	
3.	Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk	X	
4.	Ensure existing server inventory and password management software is maintained	X	
	TOTALS	4	