Arizona Department of Health Services

Department failed to investigate or timely investigate some long-term care facility complaints, did not comply with some conflict-of-interest requirements, and has some gaps in 4 IT security areas

Performance Audit and Sunset Review

September 2019
Report 19-112

A Report to the Arizona Legislature

Lindsey A. Perry
Auditor General

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September 26, 2019

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Dr. Cara Christ, Director
Arizona Department of Health Services

Transmitted herewith is the Auditor General's report, *A Performance Audit and Sunset Review of the Arizona Department of Health Services*. This report is in response to a September 14, 2016, resolution of the Joint Legislative Audit Committee. The performance audit and sunset review was conducted as part of the sunset review process prescribed in Arizona Revised Statutes §41-2951 et seq. I am also transmitting within this report a copy of the Report Highlights to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Health Services agrees with all but 2 of the findings and indicates that it will implement most of the recommendations directed to it.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Lindsey Perry, CPA, CFE
Auditor General


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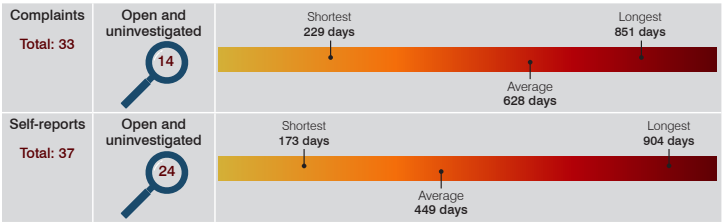
Performance Audit and Sunset Review
Report Highlights
September 2019

Arizona Department of Health Services

CONCLUSION: The Arizona Department of Health Services (Department) provides and coordinates public health services and programs for the State. Some of the Department's key responsibilities include regulating some health-related occupations, such as emergency medical care technicians; regulating childcare and healthcare facilities; responding to public health emergencies; and helping control public health epidemics. The Department failed to investigate, or timely investigate or resolve, some long-term care facility complaints and self-reports. In addition, it did not comply with some conflict-of-interest requirements. The Department is also responsible for safeguarding its information technology (IT) systems and data, and some gaps in its IT security processes resulted in an incident and additional IT security weaknesses. Finally, the Department is responsible for more than 30 boards, commissions, committees, councils, subcommittees, teams, and user or work groups that are subject to open meeting law requirements, and the Department did not consistently comply with open meeting law requirements for 3 meetings we reviewed.

Department's failure to investigate, or timely investigate or resolve, some long-term care facility complaints and self-reports may put residents at risk

As the State licensing agency and the State Survey Agency for the federal Centers for Medicare and Medicaid Services (CMS), the Department is required to investigate all complaints and long-term care facility self-reported incidents (self-reports) for the 147 State licensed/CMS certified long-term care facilities in the State. We reviewed 33 complaints and a judgmental sample of 37 self-reports the Department received in calendar years 2017 and 2018 for 5 judgmentally selected long-term care facilities and found that the Department did not investigate or did not timely prioritize, investigate, or resolve some long-term care facility complaints and self-reports. Specifically, we found that as of June 2019, 38 of the 70 complaints and self-reports were still open and uninvestigated. These uninvestigated complaints and self-reports included allegations of abuse and neglect of residents and unsanitary living conditions.



Additionally, for the 20 complaints and self-reports that the Department did investigate, we found that the Department did not timely initiate its investigation for 15 of them. For example, 12 of the 20 complaints/self-reports were assigned a priority B (alleges actual harm but does not rise to the level of an immediate and serious threat), and the Department did not timely initiate investigations for 11 of these 12 complaints/self-reports.

Recommendations

- The Department should ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner.
- The Legislature should consider forming a task force to study and propose policy options for addressing the Department's timely investigation and processing of long-term care facility complaints and self-reports to help ensure resident health and safety.

Department did not comply with some conflict-of-interest requirements

Arizona law requires employees of public agencies and public officers to avoid conflicts of interest that might influence or affect their official conduct and outlines several requirements for doing so. We identified several areas where the Department was not meeting statutory requirements or best practices. For example, although required by statute,

the Department lacked a special disclosure file that memorializes all disclosures and did not require members of the more than 30 Department-supported boards, commissions, and committees to complete disclosure forms. Also, the Department was not requiring employees to annually disclose conflicts, a best practice. These deficiencies increased the risk of Department employees and public officers not disclosing conflicts. However, the Department began addressing these deficiencies in July 2019.

Recommendation

The Department should continue its efforts to develop and implement a new conflict-of-interest disclosure process.

Some gaps in Department IT security processes resulted in a security incident and additional IT security weaknesses

To administer its programs, the Department uses many IT systems to store and process large volumes of sensitive and/or confidential data. Various federal and State laws and regulations and the Arizona Department of Administration's Strategic Enterprise Technology Office (ASET) policies specify the Department's responsibility for protecting this data. However, we identified an instance where confidential Department data was not properly protected by the Department and was therefore inappropriately available to the public. Specifically, a security weakness on a Department website allowed a member of the public to view confidential data such as birthdates, identification numbers, and other information as well as copy an authorized user's credentials and use them to log into a Department web application. As of August 2019, the Department reported that it had investigated and reported this incident to ASET, as required.

We also identified the following gaps in the Department's data classification, risk assessment, and IT security awareness training processes:

- Data classification helps to ensure sensitive data is protected from loss, misuse, or inappropriate disclosure. Although the Department reported that it treats all its data as confidential, it has not inventoried its data and documented the classification of that data.
- The Department has not conducted a formal Department-wide IT risk assessment since 2015. A risk assessment is a structured process recommended by credible industry standards and required by ASET policy that at least annually identifies IT risks within an organization—such as weak security practices, outdated systems, or the lack of a plan for restoring IT systems following a disaster.
- The Department requires all employees and contractors to complete basic security awareness training when initially hired and annually thereafter, but is not enforcing this requirement. Specifically, only 20 percent of the Department's 1,128 employees completed both trainings in 2018.

Recommendations

The Department should:

- Develop and implement web application development policies and procedures that incorporate security into the development and modification process.
- Develop and implement revisions to its data classification, risk assessment, and security awareness training policies and procedures to align with ASET requirements and credible industry standards.

Other Department actions needed

As reported in the Sunset Factors, we identified additional areas where the Department should improve:

Open meeting law—The Department is responsible for more than 30 boards, commissions, committees, councils, subcommittees, teams, and user or work groups that are subject to open meeting law requirements. We reviewed 3 meetings for a Department-supported committee and council and found that the Department did not consistently comply with open meeting law requirements.

Recommendation

The Department should develop and implement policies, procedures, training, and an oversight process to help ensure that the boards, commissions, and councils it supports comply with open meeting law requirements.

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INTRODUCTION

This is the fourth of 4 performance audit reports released as a part of the sunset review of the Arizona Department of Health Services (Department). The first report (Report 19-107) focused on the Department's administration of the Medical Marijuana Program. The second report (Report 19-109) addressed the Department's processes for procuring goods and services through contracts, monitoring contracts and agreements to ensure requirements are met, and processing payments for contracts and agreements. The third report (Report 19-111) addressed the Department's administration of the Arizona State Hospital (State Hospital). This fourth report addresses the statutory sunset factors and includes findings on the Department's long-term care facility complaint- and self-report-handling processes, its conflict-of-interest practices, and 4 information technology (IT) security areas.

Mission and purpose

The Department was established to provide and coordinate public health services and programs for the State. Its mission is to promote, protect, and improve the health and wellness of individuals and communities in Arizona. Some of the Department's key responsibilities include regulating some health-related occupations such as emergency medical care technicians and speech-language pathologists; regulating childcare facilities and healthcare facilities such as daycare centers and hospitals; responding to public health emergencies and helping control public health epidemics; administering the Women, Infants and Children (WIC) program, which offers nutrition education and breastfeeding support services along with access to supplemental nutritious foods; and operating the State Hospital, which provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

Organization, staffing, and responsibilities

The Department comprises several programs, divisions, and offices that provide a variety of services that address matters of public health and wellness or support the Department's operations. As of June 14, 2019, the Department reported 1,351.75 filled full-time equivalent (FTE) positions and 212.75 vacancies. In addition to the director and her administrative assistant, the Department's responsibilities and staffing are as follows:

- **State Hospital (587.25 filled FTE positions; 141.50 vacancies)—**At the State Hospital, the Department operates its Civil and Forensic Hospitals, which have a total of 260 beds. The Civil Hospital treats court-ordered persons with serious mental illness, and the Forensic Hospital treats persons adjudicated through the criminal justice system that must be restored to competency or are found guilty-except-insane. The Department also operates the Arizona Community Protection and Treatment Center, a 100-bed facility that houses and treats court-ordered sexually violent persons. (See Auditor General Report 19-111 for more information.)

- **Office of Continuous Improvement (4 filled FTE positions; 1 vacancy)—**This office performs several functions, including strategic planning and State health assessment and improvement planning, and supports the Department's efforts to maintain its public health accreditation, a voluntary accreditation program that measures a health department's performance against a set of nationally recognized, practice-focused, and evidence-based standards.[1] It also helps the Department deploy the Arizona Management System, the Arizona Governor's Office's results-driven management system through which State agencies track and improve their performance.

[1] This accreditation is through the Public Health Accreditation Board, a nonprofit organization.

- **Planning and Operations (150 filled FTE positions; 19 vacancies)—**This division performs various operational functions, including business and financial services, human resource management, information technology services, internal and external audits, and facilities management. This division includes the Department's procurement office, which helps Department programs identify and develop contract scopes of work and terms, and comply with procurement requirements when the goods and services the Department needs are not available through State-wide contracts (see Auditor General Report 19-109 for more information).

- **Policy and Intergovernmental Affairs (16 filled FTE positions; 6.5 vacancies)—**This division provides legal support to the Department's director and executive team and acts as a liaison between the Department and the Attorney General's Office. Additionally, this division conducts rulemakings and develops substantive policy statements and guidance documents.

- **Public Health Licensing (239.75 filled FTE positions; 16.50 vacancies)—**This division regulates health and childcare facilities and providers in Arizona, including nursing homes, daycare centers, and assisted living facilities. Its responsibilities include inspecting facilities to ensure that they remain in compliance with regulatory standards and investigating complaints about regulated facilities or professions. Laws 2019, Ch. 133, requires the Department to license and regulate intermediate care facilities, which provide long-term residential and medical care services for individuals with intellectual disabilities.[2] These facilities are required to obtain State licensure on or before January 1, 2020.[3] Although these facilities were federally certified through the federal Centers for Medicare and Medicaid Services (CMS) and the Department conducted annual inspections on behalf of CMS, these facilities were previously exempt from State licensure requirements.

- **Public Health Preparedness (238 filled FTE positions; 12.25 vacancies)—**This division is responsible for ensuring that the public health system is prepared for public health emergencies. For example, it coordinates a State-wide system of emergency medical services and provides education to and certification of first responders. This division also works to prevent and control infectious disease outbreak through programs such as the Arizona Immunization Program, which offers resources and information on vaccinations. Additionally, the State Laboratory analyzes infectious and communicable diseases and operates the Newborn Screening Program, which tests Arizona newborns for over 30 congenital disorders. This division also helps fulfill the Department's statutory responsibility to prescribe reasonably necessary measures to ensure that all retail food or drink in the State is safe for consumption.[4] For example, the Department has established licensure and other regulatory requirements for food establishments as well as food safety requirements. In addition, although the Department generally delegates the licensure and regulation of food establishments in the State to the counties, registered sanitarians from this division perform preoperational inspections of food establishments.

- **Public Health Prevention (114.75 filled FTE positions; 16 vacancies)—**This division promotes and supports the health and wellness of Arizonans through various programs and policy development. For example, the WIC program is a nutrition program that helps families learn about eating well and staying healthy. The division also works to advance policies that impact chronic disease risk factors and helps develop approaches for HIV prevention. Through this division, the Department also addresses health systems development to improve access to primary healthcare.

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[2] There are 10 State-operated intermediate care facilities and 1 privately operated facility, Hacienda Healthcare (Hacienda).

[3] As of August 16, 2019, of the 11 intermediate care facilities, the Department has only licensed Hacienda, which received its license on April 26, 2019. However, on June 25, 2019, the State had issued an intent to revoke Hacienda's license, and CMS provided notice that it would terminate the provider agreement with the facility as of July 3, 2019, because of noncompliance with basic health and safety requirements. On August 5, 2019, the Department reported that Hacienda requested a hearing regarding the termination of the CMS provider agreement and was also working with the Department on an informal settlement agreement. As of August 5, 2019, the Department had yet to revoke the State license, and the CMS provider agreement had not been terminated.

[4] A.R.S. §36-136(I)(4).

Department-supported boards and commissions

The Department provides support for more than 30 boards, commissions, committees, councils, subcommittees, teams, and user or work groups. For example, the Department is responsible for:

- The Arizona State Hospital Governing Body, which meets regularly regarding the operation of the State Hospital.
- The Tobacco Trust Commission, established pursuant to Arizona Revised Statutes (A.R.S.) §36-779, which serves as an advisory board to the Department on the goals, objectives, and activities of tobacco control programs that receive tobacco revenue monies from the Department.
- The Emergency Medical Services Council, formed to provide recommendations to the Department regarding the adoption of standards for training and certification relative to emergency medical services within the State.

Revenues and expenditures

As shown in Table 1 (see pages 4 through 5), the Department has various revenue sources, including the State General Fund and intergovernmental revenue, such as federal grants, to cover program expenditures. For fiscal year 2019, the Department's net revenues totaled more than $453 million, while its expenditures and transfers totaled approximately $442 million. Its largest expenses were for payroll and related benefits and aid to individuals and organizations for various State and federal grants and agreements. For example, the Department entered into agreements for distributing benefits from and administering the federal WIC program.

Table 1
Schedule of revenues and expenditures
Fiscal years 2017 through 2019
(Unaudited)

	2017 (Actual)	2018 (Actual)	2019 (Actual)
Revenues			
Intergovernmental[1]	$287,341,251	$276,451,848	$260,752,045
State General Fund appropriations	77,953,264	92,379,360	88,781,663
Licensing and fees	37,063,417	43,690,328	49,599,519
Tobacco sales taxes	28,141,365	27,496,044	25,298,339
Charges for goods and services	11,549,760	10,078,064	10,844,495
Lottery proceeds	9,672,137	9,896,746	10,084,817
Institutional care[2]	5,352,048	6,207,658	3,173,980
Fines, forfeits, and penalties	2,189,470	5,549,498	5,593,647
Nuclear Emergency Management Fund[3]		789,663	789,663
Rental income	1,188,879	820,593	928,219
Consumer Restitution and Remediation Revolving Fund[4]		400,600	
Interest income	772,398	920,566	1,115,965
Other	2,516,935	2,664,577	1,981,774
Total gross revenues	463,740,924	477,345,545	458,944,126
Remittances to the State General Fund[5]	(5,383,793)	(6,530,392)	(4,909,320)
Net credit card fees	(581,928)	(759,528)	(622,799)
Total net revenues	**457,775,203**	**470,055,625**	**453,412,007**
Expenditures and transfers			
Payroll and related benefits	103,570,374	109,487,134	109,348,083
Professional and outside services	33,210,861	36,067,254	28,506,877
Travel	1,452,793	1,383,479	1,521,110
Food and related expenditures	2,718,787	2,920,588	2,997,963
Aid to individuals and organizations[6]	249,841,286	237,608,109	229,117,364
Other operating[7]	53,220,242	57,146,908	54,970,834
Furniture, equipment, and software	3,767,259	4,843,894	3,544,748
Total expenditures	447,781,602	449,457,366	430,005,979
Transfers to the State General Fund[8]	35,000,000	4,600,000	1,000,000
Transfers to the other agencies[9]	14,054,964	10,662,957	10,815,303
Total expenditures and transfers	**496,836,566**	**464,720,323**	**441,821,282**
Excess of revenues over (under) expenditures	(39,061,363)	5,335,302	11,590,725
Department fund balance, beginning of year	142,252,081	103,190,718	108,700,420
Bureau of Radiation Control fund balance, beginning of year[10]		174,400	
Fund balance, end of year	**$103,190,718**	**$108,700,420**	**$120,291,145**

1 Intergovernmental revenues include a $1.2 million transfer from the Arizona Health Care Cost Containment System (AHCCCS) to the Department for the costs of prescription medications for persons with a serious mental illness at the State Hospital in both fiscal years 2017 and 2018, as required by Laws 2016, Ch. 117, §17, and Laws 2017, Ch. 305, §12.

2 Institutional care revenues are fees collected from government and/or individuals for services such as providing housing, food, and health. For example, the State Hospital receives reimbursements from AHCCCS (a federal Title XIX Medicaid Waiver program) for services provided to AHCCCS-eligible patients and from Arizona counties for services provided to persons after serving their sentences who the courts convicted of sexually violent crimes and committed to the State Hospital for further confinement and treatment. The institutional care revenues decreased between fiscal years 2018 and 2019 because the county share of the cost of daily care for sexually violent persons was eliminated. The decrease in revenues was compensated by an increase in State General Fund appropriations.

3 Nuclear Emergency Management Fund revenues were an appropriation the Department received from this fund for programs relating to off-site nuclear emergency response plans in accordance with Laws, 2017, Ch. 43, §3.

[4] Consumer Restitution and Remediation Revolving Fund revenues were an appropriation the Department received from this fund for the opioid abuse prevention campaign in accordance with Laws 2018, Ch. 1, §44.

[5] Remittances to the State General Fund are monies the Department remitted to the State General Fund in accordance with statutes. For example, the Department is required to remit 10 percent of certain license fees such as fees collected for childcare facility and audiologist licenses. The State Hospital is required to remit all monies collected for examination, evaluation, treatment, and maintenance of patients for voluntary admissions or federal, State, public, or private medical benefits in accordance with A.R.S. §36-545.02.

[6] Aid to individuals and organizations comprises payments for various State and federal grants and agreements. For example, the Department entered into agreements for distributing benefits from and administering the federal WIC program and Supplemental Nutrition Assistance Program. In addition, the Department awarded grants for Arizona Biomedical Research Center investigators and entered into an agreement to establish a smoker's helpline that were paid for by tobacco tax monies.

[7] Other operating expenditures comprise items such as rent, utilities, prescription drugs, medical supplies, and computer-related expenditures such as software support and maintenance.

[8] Transfers to the State General Fund in fiscal years 2017 and 2018 were required by Laws 2017, Ch. 305, §138; Laws 2018, Ch. 276, §139; and Laws 2018, Ch. 276, §140, to provide adequate support and maintenance for State agencies.

[9] Contracts or laws require various transfers to other agencies. For example, during fiscal years 2017 and 2018, the Department transferred monies to the Arizona Department of Child Safety and the Arizona Early Childhood Development and Health Board for services provided for the federal Maternal, Infant, and Early Childhood Home Visiting program. In addition, the Department transferred approximately $2.8 million in fiscal year 2018 from its lottery proceeds to the Arizona Department of Economic Security in accordance with Laws 2017, Ch. 305, §31.

[10] The Bureau of Radiation Control's beginning fund balance represents the Arizona Radiation Regulatory Agency's (ARRA) July 1, 2017, beginning fund balance. Effective January 1, 2018, Laws 2017, Ch. 313, eliminated ARRA and transferred its responsibilities to the Department. The table presents ARRA's financial activity for all of fiscal year 2018.

Source: Auditor General staff analysis of the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2017 through 2019 and Department-provided information.

Department's failure to investigate, or timely investigate or resolve, some long-term care facility complaints and self-reports may put residents at risk

Department required to investigate long-term care facility complaints and self-reports

The Department receives both complaints and self-reports that may contain regulatory violation allegations at long-term care facilities, including allegations of resident neglect and abuse (see textbox).[5] As the State licensing agency and the State Survey Agency for CMS, which requires the Department to enforce CMS standards and carry out the Medicare certification process, the Department conducts annual onsite long-term care facility inspections referred to as surveys.[6] In addition, the Department is required to investigate all complaints and self-reports for the 147 State licensed/CMS certified long-term care facilities in the State.[7] According to CMS guidelines, the mission of its complaint/incident process, which is generally performed by the State Survey Agency, is to protect residents from abuse, neglect, exploitation, and inadequate care or supervision.[8]

Key terms

Complaint—An allegation or concern about a long-term care facility regulatory violation, including resident abuse or neglect submitted by an individual or another State or federal agency through email, telephone, or the Department's online complaint reporting system.

Self-report—Also known as facility-reported incidents, all long-term care facilities that are CMS certified must report incidents that involve potential regulatory violations, including resident injuries of an unknown origin, allegations of resident neglect and/or abuse, and misappropriation of resident property.

Regulatory violation allegations—An allegation of noncompliance with the State's licensing requirements and/or CMS' certification standards.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and the Department's Division of Public Health Licensing's policies and procedures.

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[5] The Arizona Department of Economic Security (DES), consistent with Arizona Revised Statutes, investigates allegations of abuse, neglect, and exploitation of vulnerable adults in Arizona, which DES does through its Adult Protective Services program. Although both the Department and DES investigate allegations of abuse involving vulnerable adults at long-term care facilities, DES determines whether or not the abuse occurred, and the Department reviews the facility's practices and policies and procedures to determine if the facility has appropriate safeguards in place to mitigate the likelihood of abuse occurring. The Department's online complaint form asks complainants to indicate whether they contacted any other agencies, including DES Adult Protective Services. Additionally, Department staff are required to ask complainants during intake if they have contacted other appropriate agencies who could provide assistance, such as DES Adult Protective Services.

[6] To meet CMS' annual survey requirement, the Department's survey of a facility must be completed within 15.9 months after the last day of the previous survey for that facility, but the State-wide average for all facilities surveyed must not exceed 12.9 months. According to CMS guidance, annual surveys involve observations and/or review of areas including dining, infection-control protocols, administering medication, storage of medication, sufficiency and competency of nursing staff, and resident assessments.

[7] The Department is also required to investigate complaints and self-reports for 1 facility that has a State license only and the 10 Arizona Training Program Intermediate Care Facilities for Individuals with Intellectual Disabilities that have CMS certification only.

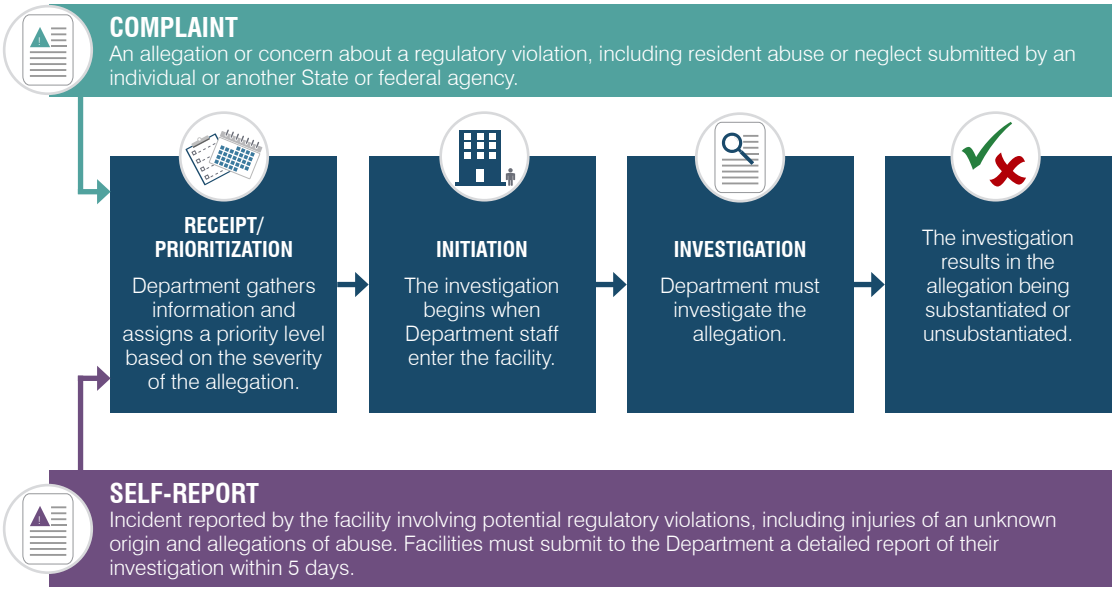
[8] According to the Department, CMS conducts certification surveys and complaint/incident investigations for long-term care facilities on Arizona's Native American Reservations.

We identified 2 complaint/self-report-handling areas where the Department was not meeting complaint/self-report-handling requirements. Specifically, the Department did not (1) investigate all complaints and self-reports as required and (2) prioritize, investigate, and resolve all complaints and self-reports timely.

Department has not investigated some long-term care facility complaints and self-reports, as required

We reviewed 33 complaints and a judgmental sample of 37 of the 172 self-reports the Department received in calendar years 2017 and 2018 for 5 judgmentally selected long-term care nursing facilities and found that 50 of the 70 complaints and self-reports were not investigated and/or did not contain any evidence that the Department had completed an investigation.[9,10] Specifically, these complaints and self-reports had not yet progressed to the initiation step in the long-term care facility complaint and self-report investigation process (see Figure 1), or were listed as "no action necessary." These uninvestigated complaints and self-reports included allegations of abuse and neglect of residents and unsanitary living conditions. Specifically:

Figure 1
Department's long-term care facility complaint and self-report process



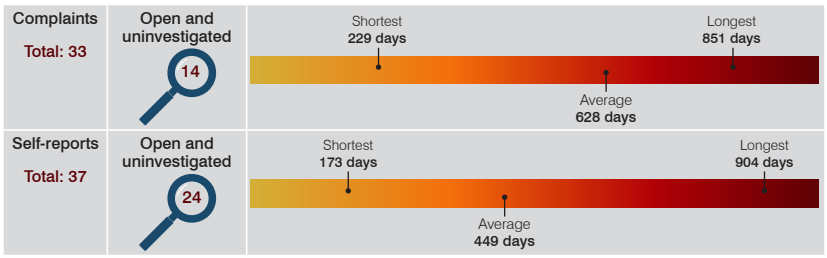
Source: Auditor General staff review of CMS' State Operations Manual Chapters 5 and 7 and the Department's Division of Public Health Licensing's policies and procedures.

[9] The Department received a total of 34 complaints for these 5 facilities in calendar years 2017 and 2018. However, we removed 1 complaint from our review because of inconsistencies in the reported data. For example, the date the complaint was received occurred after the documented date of investigation.

[10] Of the 147 facilities, we judgmentally selected 2 of the 5 facilities in our sample using information from a searchable database available through the Department's AZ Care Check website and CMS' website because of rating discrepancies in each facility's ratings on the 2 websites. Specifically, the Department's AZ Care Check website indicated that both facilities had been given an A rating, yet the CMS website indicated that the 2 facilities were rated overall as below average and much below average. We selected 3 facilities from a list of 39 facilities that had undergone and completed surveys (inspections) between December 2018 and May 2019 to ensure we captured facilities from across the State within our sample. Specifically, of the 5 total facilities selected, 2 were Phoenix area facilities, 1 was a Tucson facility, and 2 were facilities located in rural areas of the State. In addition, we judgmentally selected 37 of the 172 self-reports submitted by these 5 facilities to ensure our sample included self-reports from each of the 5 facilities, self-reports that were received throughout both calendar years 2017 and 2018, and self-reports at different stages of completion (such as closed, pending investigation, or not yet prioritized).

- **Uninvestigated complaints—**As shown in Figure 2, as of June 2019, 14 of the 33 complaints, or 42 percent, had been open between 229 days and 851 days without an investigation. The complaint that had been open and uninvestigated for 851 days was submitted by another State agency and alleged that inadequate staffing levels caused a resident, who was unable to feed or use the restroom without assistance, to be soaked in their own urine and have their clothes stained with dried food.

Figure 2
Time frames for 38 open and uninvestigated long-term care facility complaints and self-reports from calendar years 2017 and 2018
As of June 2019



Source: Auditor General staff analysis of 33 complaints and 37 self-reports the Department received in calendar years 2017 and 2018 for 5 judgmentally selected long-term care nursing facilities.

- **Uninvestigated self-reports—**As of June 2019, 24 of the 37 self-reports, or 65 percent, had been open between 173 days and 904 days without an investigation. Although in some cases there was evidence that the Department had conducted some preliminary work, such as reviewing information provided by the facility, these self-reports did not contain evidence that the Department had opened or completed a formal investigation as required by CMS. A self-report that had been open and uninvestigated for 652 days involved a resident attempting to strangle another resident. Another self-report that had been open and uninvestigated for 562 days involved a resident that struck their head on the floor and had to go to the hospital after being knocked out of their wheelchair by another resident.

- **Inappropriately prioritized and incomplete self-report investigations—**In addition to the 24 uninvestigated self-reports, we found that 12 of the 37 self-reports, or 32 percent, were prioritized as "no action necessary." These self-report files had evidence that Department staff had reviewed the facility's internal investigation report on the incident, but Department staff had not completed a formal investigation.[11] Once the Department has prioritized a self-report as no action necessary, the self-report is closed, and the Department does not take any further actions, such as a formal investigation. However, because facilities are required to self-report only items that are potential regulatory violations, which the Department must investigate to determine whether violations have occurred, the Department should not be classifying self-reports as no action necessary. For example, 1 "no action necessary" self-report was closed on the same day it was reported to the Department and involved allegations that a resident with ambulatory issues was being thrown around like a "rag doll" by a staff member.

The Department also provided us with unaudited data from its system in June 2019 showing that 2,767 of the total 4,958 complaints and self-reports the Department received in calendar years 2017 and 2018 for its long-term care facilities, or approximately 56 percent, were open and uninvestigated.[12]

Department has not investigated and resolved some long-term care facility complaints and self-reports in a timely manner

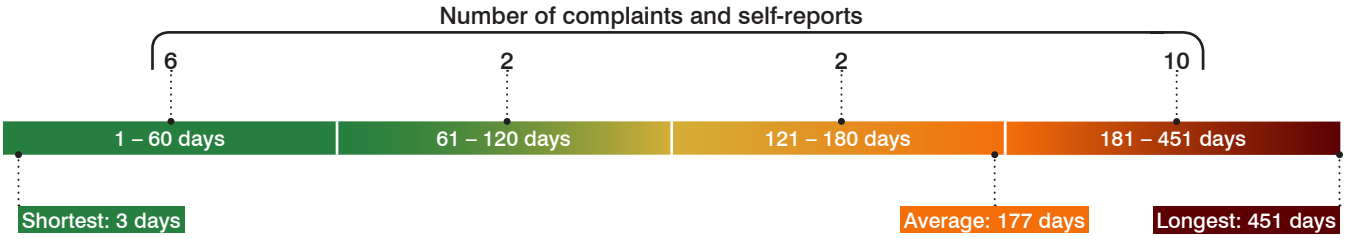
Federal guidance does not establish an overall time frame for complaint/self-report investigations, but it requires states to establish time frames to help ensure that complaints/self-reports are investigated in a timely manner.

[11] According to federal regulations, a report of the results of all investigations is required to be completed and submitted to the Department within 5 working days of the incident alleging abuse, neglect, exploitation, or mistreatment.

[12] The Department-provided data for calendar years 2017 and 2018 includes complaints and self-reports from all the State's long-term care facilities, including the facilities that were State licensed or CMS certified only, and the facilities that are both State licensed and CMS certified. The complaint numbers do not include the 1 open and uninvestigated complaint for the Arizona Pioneers' Home, which a legislative member requested the Department review, because the Home is not a State-licensed or CMS-certified long-term care facility.

Although the Department has not established time frames for completing investigations, we identified 1 western state, California, that has established a time frame for completing investigations in statute. California requires complaint investigations to be completed within 60 days of receipt of complaints received on or after July 1, 2018.[13] Based on our review of the 33 complaints and 37 self-reports, the Department had investigated 20 of the 70, or 29 percent, of the complaints and self-reports. For those 20 complaints and self-reports, the Department took between 3 and 451 days to investigate the complaint or self-report (see Figure 3).[14]

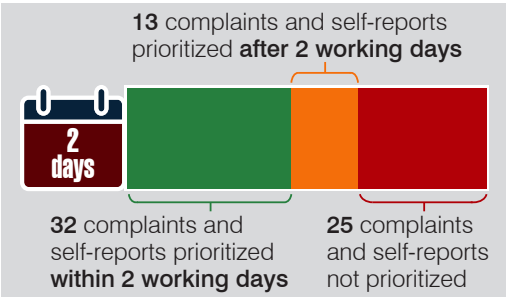
Figure 3
Investigation time frame for the 20 investigated long-term care facility complaints and self-reports from calendar years 2017 and 2018
As of June 2019



Source: Auditor General staff analysis of 33 complaints and 37 self-reports the Department received in calendar years 2017 and 2018 for 5 judgmentally selected long-term care nursing facilities.

Although neither the federal government nor the Department has established an overall time frame for investigating long-term care facility complaints, federal guidance sets time frames for 2 steps within the complaint/self-report-handling process—complaint/self-report prioritization and investigation initiation. For the 70 complaints and self-reports we reviewed, we identified some delays in the Department performing both of these complaint-handling steps. Specifically:

- **Department did not prioritize for investigation as required 38 of the 70 complaints and self-reports we reviewed—**According to federal guidance, the Department is required to assign an investigation priority level to all complaints and self-reports based on the complaint or self-report allegations. This priority level establishes how quickly the Department must begin its investigation. According to federal requirements, prioritization should occur within 2 working days from when the complaint or self-report was received, except those that allege the presence of an immediate jeopardy. Immediate jeopardy complaints and self-reports must be prioritized immediately for investigation. Even though the Department did not investigate all 70 complaints and self-reports in our sample, they all should have received a priority level. For the 70 complaints and self-reports in our sample, we found that 32, or 46 percent, were prioritized within 2 working days as required. The Department took longer than 2 working days to prioritize 13 complaints and self-reports, and as of June 2019 had not prioritized the remaining 25 complaints and self-reports for investigation between 173 and 904 calendar days after receipt.



- **Department did not timely initiate investigations for 15 of the 20 complaints and self-reports we reviewed—**Federal guidelines and State procedures establish time frames for initiating complaint and self-report investigations based on the priority level assigned (see textbox on page 11). Based on our review of

[13] In 2015, California passed a law that required investigations of long-term care facility complaints to be completed within 90 days of receipt. This time frame was shortened to 60 days effective July 1, 2018. Although the law indicates that an additional 60 days may be allowed to investigate a long-term care facility complaint, this extension must be documented by California's Department of Health.

[14] Number of days calculated from complaint/self-report receipt to investigation completion.

Priority levels and associated investigation initiation time frames[1]

Priority A—These complaints/self-reports allege that an immediate and serious threat to health and safety has caused or is likely to cause serious injury, harm, impairment, or death and the Department must start its investigation within 2 working days of the complaint's or self-report's receipt.

Priority B—These complaints/self-reports allege actual harm that impairs mental, physical, and/or psychosocial status, but it does not rise to the level of an immediate and serious threat, or allege that hazards to health and safety may exist and are likely to cause a significant problem in care and treatment. For these allegations, the Department must start its investigation within 10 working days of prioritization.

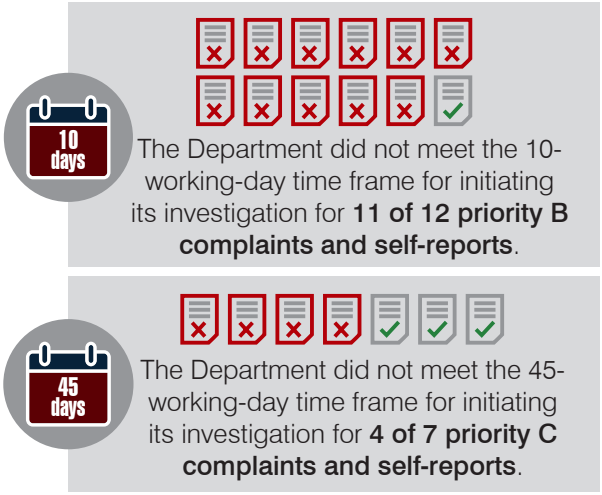
Priority C—These complaints/self-reports allege a situation that harms or may cause harm of limited consequences, but it does not significantly impair mental, physical, and/or psychosocial functions. These complaints/self-reports also include those situations negatively impacting care and treatment that may not include actual harm. For these allegations, the Department must start its investigation within 45 working days of prioritization.

[1] Federal and State guidance also establishes priorities D through H for complaints/self-reports that are of a less serious nature or outside of the Department's jurisdiction. Priority D complaints/self-reports are required to be investigated during the next survey. The other categories do not have a specific time frame for beginning investigations.

Source: Auditor General staff review of CMS' State Operations Manual Chapter 5 and the Department's Division of Public Health Licensing's policies and procedures.

the 20 complaints and self-reports where the Department initiated an investigation, the Department did not timely initiate its investigations for 15 of these complaints and self-reports (75 percent). Specifically:

- Twelve of the 20 complaints/self-reports were assigned a priority B. The Department did not initiate its investigation within 10 working days as required for 11 of the 12 complaints and self-reports. Instead, the Department took between 23 and 306 working days to initiate an investigation after prioritization.
- Seven of the 20 complaints/self-reports were assigned a priority C.[15] The Department did not initiate its investigation within the 45 working days as required for 4 of these complaints and self-reports. Instead the Department took between 78 and 166 working days to initiate an investigation after prioritization.



Finally, there are no overall State or federal time frames for how quickly the Department should resolve and close its long-term care facility complaints and self-reports after completing its investigation, including notifying the complainant of the results. However, for the 20 investigated complaints and self-reports in our sample, the Department has not always done so shortly after completing its investigation. Specifically, the Department took between 42 and 110 calendar days to resolve and close 17 of the 20 investigated complaints and self-reports. In addition, as of June 2019, the remaining 3 investigations had been open between 19 and 117 calendar days after the investigation was completed.

[15] The Department assigned a priority D to 1 remaining self-report. Federal guidance requires that the complaints and self-reports given a priority D be done in conjunction with the facility's next annual survey. The Department met this time frame for this self-report.

Uninvestigated and untimely long-term care facility complaint and self-report investigations may put residents at risk

Not investigating complaints and self-reports can put long-term care facilities' residents at risk of a variety of negative circumstances, including continued abuse, exploitation, or unsanitary conditions. For example, 1 complaint in our sample that had been open and uninvestigated for 229 days was made by a nursing student on rotation at a long-term care facility who alleged residents were being subjected to abuse, neglect, unsanitary conditions, and inappropriate quality of care/treatment. By not initiating an investigation of this complaint, the Department had yet to determine whether the allegations were substantiated/unsubstantiated and, if substantiated, also taking necessary action to address the violation(s), which might include issuing a Statement of Deficiencies and requiring the facility to develop and implement a Plan of Correction to help ensure the facility addressed the problems to protect the health and safety of its residents or revoking a facility's license.

In addition, the longer a complaint or self-report remains uninvestigated, the more likely potential problems or violations will remain unaddressed. For example, the Department did not begin its investigation for 1 of the complaints in our sample until 121 working days after it was received. This complaint, which was submitted by a resident's mother after the resident was hospitalized following a stroke at the facility, alleged that the resident did not receive proper medical care including proper medication. Although the Department eventually substantiated that the facility failed to provide proper medication, by not investigating the complaint in a timely manner, the Department was unable to ensure the facility timely resolved the specific concern with this patient before the patient was moved to a different facility. Further, the Department was unable to ensure that the facility timely established safeguards to prevent this situation from occurring with other residents. Timely investigations may not only prevent problems from escalating but may also deter future incidents from occurring because preventative safeguards are more likely to be in place due to the Department's presence. Additionally, by not investigating in a timely manner, complainants may question the status of their complaints and the Department's efforts to resolve the complaint. For the complaint previously discussed, the resident's mother called the Department twice to check on the status of her complaint, once 49 days after submitting the complaint and the other 19 days after the first call.

Several factors contributed to Department's uninvestigated and untimely long-term care facility complaint and self-report investigations and resolutions

Specifically:

- **Department has placed priority on annual site surveys—**State and federal laws and regulations require the Department to conduct onsite surveys of long-term care facilities annually.[16] These surveys assess a facility's compliance with State licensing and federal certification requirements through observation, file reviews, and interviews, including ensuring that policies are in place to safeguard resident well-being, such as receiving proper care and medication. According to the Department, it has placed a high priority on performing these surveys and a lower priority on complaint investigations, in part, because its federal funding is reduced when it does not meet the annual survey time frame. CMS conducts an annual formal assessment, known as the State Performance Evaluation, to determine whether State Survey Agencies fulfill their responsibilities, such as timely conducting site surveys. Based on our review of the Department's annual CMS State Performance Evaluations for federal fiscal years 2015 through 2018, the Department met its annual survey time frame in 2017 and nearly met the time frame in 2018.[17]

  Although the Department can complete some complaint and self-report investigations during the annual recertification survey, CMS guidance states that the Survey Agency (i.e., the Department) should generally take only 5 complaints on a survey to prevent the survey from becoming an abbreviated complaint investigation.

[16] For more information about CMS' annual survey requirement, see footnote 6, page 7.

[17] In federal fiscal year 2018, the Department's average was 13 months; see footnote 6 for more information about survey requirements.

In addition, we were told by CMS officials that the Department should be investigating complaints and self-reports outside of the annual recertification surveys in accordance with the initiation time frame associated with the assigned priority level. However, the Department reported that it investigates complaints and self-reports outside of the annual recertification survey only for priority level A complaints and self-reports and some priority level B complaints and self-reports if there are multiple complaints or self-reports that include very similar allegations at the same facility. The rest of the complaints and self-reports would likely not be investigated at all. For example, we found that only 4 of the 20 investigated complaints and self-reports in our sample were investigated outside of an annual recertification survey.

- **Department has yet to allocate the additional staff to complaint-handling activities that it indicated it would—**According to the Department's 4 annual CMS State Performance Evaluations for federal fiscal years 2015 through 2018, the Department did not meet the federal time frame for initiating its complaint and self-report investigations for priority level B complaints and did not meet the federal time frame for priority level A complaints in 2016 and 2017. The Department is required to develop a plan of improvement for any deficiencies CMS notes in its review. In its response to the 2015, 2016, 2017, and 2018 reviews sent to CMS in calendar years 2016, 2017, 2018, and 2019, the Department indicated that it planned to meet the federally required time frames for priority level B complaints by dedicating 2 staff full time to complaint-handling activities, including prioritizing and investigating complaints.[18] The Department has yet to take this action. However, during the audit, the Department indicated that it may be able to hire some additional staff and/or reallocate some staff from another area to specifically handle its long-term care facility complaints.

- **Department lacks some complaint-/self-report-handling time frames—**Although CMS guidelines require states to establish time frames for appropriately responding to complaints and self-reports, the Department does not have some time frames. Specifically, the Department has not established time frames for completing investigations and closing complaints and self-reports. Doing so could help ensure complaints and self-reports move through each complaint-handling step and the entire process in a timely manner.

- **Department lacks updated policies and procedures—**CMS requires that the Department document in policies and procedures the process it will take to respond to complaints. The Department has established complaint-handling policies and procedures. However, they were last updated in 2011 and do not reflect the Department's most up-to-date complaint-handling practices. For example, the Department's policies and procedures contain contradictory information about the time frame for initiating priority level C complaint and self-report investigations. Specifically, in one place, the policies and procedures require these investigations to begin within 45 days and in another place within 45 working days. Further, our review of the Department's data for the priority level C complaints and self-reports in our sample found that the Department had calculated the due date for initiating these investigations using both 45 calendar days and 45 working days.

- **Department lacks sufficient management reports—**The Department has not developed management reports that could help it effectively identify complaints and self-reports that are not being investigated or resolved timely. Although the Department provided us with one bimonthly management report, which can be broken out by priority level, it provides information for complaints only where the Department has made some type of change, such as entering a date or other information, in the previous 6 months. Any complaint that has not had any type of change in more than 6 months would not be reflected on the report. In addition, it does not provide any information on self-reports or other important information on the status of complaint investigations, such as the total number of complaints in each step of the complaint-handling process or how long they have been open. Further, the report does not help the Department effectively identify complaints that have been investigated and are awaiting final resolution, such as preparing a Statement of Deficiencies, the facility submitting a Plan of Correction, or closure in the system.

[18] The Department indicated in the 2015 plan of improvement that it would assign 5 staff to investigate complaints, but subsequent plans indicated only 2 staff members would be assigned to complaints.

- **Federal requirement issues—**The Department indicated that the directions it has received from CMS have had some impact on the effective processing of its long-term care complaints and self-reports. Specifically:

    - **Department believes that self-reports do not need to be investigated—**The Department indicated that based on its interpretation of CMS-provided direction, facility self-reports do not generally need to be separately investigated by the Department. We found that the Department did not investigate 36 of the 37 self-reports in our sample or had given them a priority code of "no action necessary" and closed them. However, our review of CMS guidance and interview with CMS officials determined that self-reports should be treated the same as complaints and investigated. The Department indicated that CMS is updating its guidance on self-reports, which the Department stated may clarify how it should handle some lower-priority self-reports and modify the requirements for what is considered an incident a facility must self-report to the Department. However, the Department was not sure when the guidance would be finalized.

    - **Department believes that self-reports do not need to be prioritized for investigation until after the Department receives a facility's required 5-day report—**The Department indicated that based on its interpretation of CMS-provided direction, it could wait to decide what priority level to assign to the self-report, which would determine how quickly it needed to initiate an investigation, until after it received a facility's 5-day report. This 5-day report provides information about the incident and the steps the facility is taking or has taken to address the incident. However, we were told by CMS officials that the Department should determine a priority level within 2 working days and should not wait until receiving the facility's 5-day report. Further, CMS guidance does not make a distinction between the handling of self-reports and complaints and does not state that the Department can wait to receive a facility's 5-day report before prioritizing self-reports for investigation.

Recommendations:

1. To help ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner, the Department should:

    a. Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

    b. Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

    c. Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

    d. Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

    e. Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

2. The Legislature should consider forming a task force to study and propose policy options for addressing the Department's timely investigation and processing of long-term care facility complaints and self-reports to help ensure resident health and safety. Options to consider include establishing requirements for investigating all complaints and self-reports, appropriate time frames for conducting investigations of and closing out long-term care facility complaints and self-reports, and reporting performance metrics to the Legislature. Task force members should include appropriate stakeholders, such as legislators, Department representatives, Arizona Department of Economic Security representatives, industry members (i.e., long-term care facility owners or licensed administrators), patient advocates, and if appropriate, a federal CMS

representative. Legislation forming the task force should identify task force membership, its overall purpose and expected outcomes, and deadlines for reporting recommendations to the Legislature.

Department response: As outlined in its **response**, the Department disagrees with the finding, but will implement the recommendations directed to it.

Department did not comply with some conflict-of-interest requirements

Statute addresses conflicts of interest for public-agency employees and public officers

Arizona law requires employees of public agencies and public officers to avoid conflicts of interest that might influence or affect their official conduct. To determine whether a conflict of interest exists, employees/public officers must first evaluate whether they or a relative has a "substantial interest" in (1) any contract, sale, purchase, or service to the public agency, or (2) any decision of the public agency.

If an employee/public officer or a relative has a substantial interest in either circumstance, the employee/public officer is required to fully disclose the interest and refrain from voting upon or otherwise participating in the matter in any way as an employee/public officer.[19] The interest must be disclosed in the public agency's official records, either through a signed document or the agency's official minutes. In addition, A.R.S. §38-509 requires public agencies to maintain a special file of all documents necessary to memorialize all disclosures of substantial interest—including both signed disclosure statements and official minutes disclosing substantial interests—and to make this file available for public inspection.

Ensuring compliance with these statutes can help deter self-dealing by employees/public officers and promote transparency and public confidence in an agency's official conduct.

Key terms

- **Substantial interest—**Any direct or indirect monetary or ownership interest that is not hypothetical and is not defined in statute as a "remote interest."
- **Remote interest—**Any of several specific categories of interest defined in statute that are exempt from the conflict-of-interest requirements. For example, an employee or public officer may participate in a decision that indirectly affects a relative who is an employee or an officer of another public agency or political subdivision, as long as the decision does not confer a direct economic benefit or detriment to the relative (such as a decision that would affect the relative's employment).
- **Relative—**An employee's/public officer's spouse, child, grandchild, parent, grandparent, full or half siblings and their spouses, and the parent, brother, sister, or child of the employee's/public officer's spouse.

Source: Auditor General staff review of A.R.S. §38-502 and Arizona Office of the Attorney General. (2018). Arizona agency handbook. Phoenix, AZ. Retrieved 4/9/2019 from https://www.azag.gov/outreach/publications/agency-handbook.

Deficiencies in Department's process increased risk of nondisclosure

Although the Department has a disclosure process and uses a conflict-of-interest disclosure form, we identified several deficiencies in its process and form. These deficiencies resulted in the Department's noncompliance with

[19] See A.R.S. §§38-502 and 38-503(A)&(B).

statutory conflict-of-interest requirements and best practices and increased the risk of Department employees and public officers not disclosing substantial interests. Specifically, the Department:

- **Lacked a special disclosure file as required by statute and a remediation process to address disclosed conflicts—**The Department housed its completed forms in each individual employee's personnel file or the State's online Hiring Express system instead of in a special disclosure file. As a result, the Department lacked a method to track how many employees—and which employees—disclosed an interest and make this information available in response to public requests. In addition, the Department had not established a process to review and remediate any disclosed conflicts.

- **Did not require board/commission/committee members to disclose conflicts—**According to A.R.S. §38-501(A), the State's conflict-of-interest statutes apply to all employees and public officers of any of the State's departments, commissions, agencies, bodies, or boards.[20] However, the Department did not require members of the more than 30 Department-supported boards, commissions, and committees to complete the forms (see the Introduction, page 3, for more information on the boards, commissions, and committees the Department supports).

- **Did not require disclosure of decision-making interest or an affirmative no statement—**According to A.R.S. §38-503, all employees and public officers must disclose their "substantial interest" in (1) any contract, sale, purchase, or service to the public agency, or (2) any decision of the public agency. The form used by the Department, a State form provided by the Arizona Department of Administration State Personnel System, required employees to disclose only their substantial financial interest; it did not require employees to disclose their substantial interest in any Department decisions. In addition, the form did not include a field for the employee to attest that she/he does not have any substantial interests, also known as an "affirmative no." To more clearly document that an employee has no known conflicts, a better practice would be that they check or initial a statement stating such. Understandably, the Department indicated that it considered the State's form to be sufficient and appropriate.

- **Did not require annual disclosures—**The Department required only new employees to complete the form at the time of their hire with the State if the employee indicated that they had a potential conflict in their onboarding paperwork and any time there was a change, as determined by the employee; it did not require employees to complete the form annually. Although annual disclosures are not required by statute, doing so regularly reminds employees/public officers of the importance of complying with conflict-of-interest laws and helps ensure that potential conflicts of interest are disclosed if an employee's or public officer's circumstances change. For example, several Department employees participated in the Department's medical marijuana Dispensary Registration Certificate allocation process, which determines individual(s) authorized to open a medical marijuana dispensary. Although we did not identify any conflicts of interest listed on employees' forms who worked on this process, many of the disclosures were from the early 2000s before medical marijuana was legal and the Department had implemented the Dispensary Registration Certificate allocation process. In addition, 2 of the employees' forms were signed when they worked for other State agencies prior to being employed by the Department.

- **Lacked policies and procedures—**Department staff reported that they did not have any Department-wide policies and procedures related to the State's conflict-of-interest requirements. Rather, they used the *Arizona State Personnel System Employee Handbook* (handbook). However, this handbook has very limited information regarding conflicts of interest and did not include guidance pertaining to the deficiencies we noted in the Department's processes. A better practice would be establishing its own policies and procedures, which provide employees with an understanding of the Department's specific processes for meeting the State's conflict-of-interest requirements.

[20] A.R.S. §38-502(8) defines "public officer" as all elected or appointed officers of a public agency established by charter, ordinance, resolution, State constitution, or statute. According to the *Arizona Agency Handbook*, public officers include directors of State agencies and members of State boards, commissions, committees—whether paid or unpaid.

- **Lacked Department-specific training—**Department staff reported that they did not have any Department-wide initial or periodic refresher training related to conflict-of-interest requirements. Rather, they used the State's online training courses. However, Department training would provide employees with an understanding of how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities.

Department implementing a new disclosure process to address deficiencies

Department staff reported that, prior to our interviews, they were not aware of all the State's conflict-of-interest requirements. However, after we completed our review of the Department's practices and reported the identified deficiencies, it developed and implemented new conflict-of-interest policies and procedures that were approved on July 9, 2019. The new policies and procedures are comprehensive and address most of the deficiencies we noted. The policies and procedures apply to all Department officers and employees and clearly establish a review and remediation process, requirements for a special file, and an annual disclosure requirement, and define conflicts-of-interest as both substantial financial and decision-making interests. As of July 2019, the Department indicated that it was still in the process of addressing the form and training deficiencies we noted in our review.

Recommendation:

3. The Department should continue its efforts to develop and implement a new conflict-of-interest disclosure process and form that will help it comply with the State's conflict-of-interest requirements and best practices, such as having public officials and employees annually disclose whether or not they have any substantial financial and/or decision-making conflicts, and train employees on how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities.

   Department response: As outlined in its **response**, the Department agrees with the finding, and will implement the recommendation.

Some gaps in Department IT security processes resulted in a security incident and additional IT security weaknesses

Department responsible for safeguarding its IT systems and data

The Department provides health-related services through various programs, such as the WIC and Medical Marijuana programs, and the State Hospital. It also provides other services, such as issuing birth and death certificates, regulating some health-related occupations, and regulating childcare and healthcare facilities. According to the Department, to administer these and various other programs, it uses many IT systems to store and process large volumes of sensitive and/or confidential data. For example, when individuals apply for a birth certificate through the Department's website, they must enter their name, date of birth, mailing address, and other information for the Department to process the application. Because of the volume and nature of the sensitive data the Department maintains, it has a significant responsibility to safeguard its IT systems and data from misuse, attack, or loss. Various federal and State laws and regulations and the Arizona Department of Administration's Strategic Enterprise Technology Office (ASET) policies specify the Department's responsibility in protecting this data.

Although the Department has established some ASET-required policies and procedures, we identified gaps in the Department's IT security processes in the following 4 areas: (1) web application development, (2) data classification, (3) risk assessment, and (4) security awareness training.

Issue 1: Confidential data exposed because of web application development weaknesses

Confidential information was accessible through a Department website

We identified an instance where statutorily confidential Department data was not properly protected by the Department and was therefore inappropriately available to the public through a Department website. Specifically, in July 2019, a concerned member of the public informed us of a security weakness on a Department website that allowed this individual to access statutorily confidential data as well as copy an authorized user's credentials and use them to log into a Department web application. When the security weakness was discovered and communicated to us, we were also able to access the statutorily confidential data using the same method. This data included names, birthdates, identification numbers, and other information, all of which is confidential per statute and is not authorized to be released publicly. Further, statute states that it is a class 1 misdemeanor for any person, including an employee or official of the Department or another State agency or local government, to breach the confidentiality of this information. Accordingly, we promptly notified the Department of the security weakness, and it immediately ensured that the information was no longer publicly available or accessible through its website. The Department indicated that this weakness may have existed since September 2018.

The Department indicated that as of August 2019, it had conducted an investigation and determined that this was a security incident and had reported the incident to ASET as required. The Department also reported that its investigation into the incident was closed.

Department's web application development processes do not incorporate security requirements

Although the Department has some policies and procedures for developing and modifying web applications (see textbox), its policies and procedures do not include requirements for incorporating security into the web application development and modification process. According to credible industry standards, such as those developed by the Open Web Application Security Project (OWASP), incorporating security into the web application development process is more cost-effective and secure than applying security fixes afterward.[21]

A **web application** is a software program or IT system that is accessed by an end user to perform a transaction with a web browser over a network such as the internet. An external web application is accessible from any user device connected to the internet and could be more susceptible to attack.

Source: Auditor General staff analysis of IT definitions from various sources.

However, we found that the Department's web application development policies and procedures are not aligned with ASET and credible industry standards, which may have prevented confidential data from being exposed.[22] Specifically, the Department's policies and procedures do not require:

- **Gathering security requirements—**Security requirements should include classifying data in the application according to its level of confidentiality and defining how the web application will comply with all relevant regulations and standards related to this data.
- **Using up-to-date secure coding standards—**These are steps that should be followed to develop a web application based on ASET requirements and credible industry standards.
- **Performing threat modeling during development—**Threat modeling involves defining how the application works, exploring potential vulnerabilities and threats by thinking of possible ways a malicious actor would attack the application, and then developing mitigating controls for each of the realistic threats identified.
- **Reviewing source code—**Source code review is the process of manually checking the source code of a web application for security issues that may not be detected with any other form of analysis or testing.
- **Performing security testing before releasing a web application to the live environment—**Conducting security testing, such as scanning or penetration testing, before release helps ensure that web applications function as intended and do not contain vulnerabilities when released.

The Department also does not require staff who are responsible for developing and modifying web applications to receive role-based training on how to build secure web applications (see Issue 4, pages 24 through 25, for more information on role-based training).

[21] OWASP is an open community dedicated to enabling organizations to develop, operate, and maintain applications that can be trusted.

[22] Open Web Application Security Project. (2014). *OWASP testing guide, version 4.0*. Bel Air, MD: OWASP Foundation; Open Web Application Security Project (OWASP). (2017a). *OWASP top 10-2017: The ten most critical web application security risks*. Bel Air, MD: OWASP Foundation; Open Web Application Security Project (OWASP). (2017b). *Code review guide 2.0*. Bel Air, MD: OWASP Foundation; Open Web Application Security Project (OWASP). (2018). *OWASP Proactive controls for developers 3.0*. Bel Air, MD: OWASP Foundation. National Institute of Standards and Technology (NIST). (2013). *NIST Special Publication 800-53, Revision 4: Security and privacy controls for federal systems and organizations*. Gaithersburg, MD.

Recommendations

The Department should:

4. Develop and implement web application development policies and procedures that incorporate security into the development and modification process, including requirements for gathering security requirements, using up-to-date secure coding standards, performing threat modeling during development, reviewing source code, and performing security testing before releasing a web application to the live environment.

5. Require staff who are responsible for developing web applications to regularly receive role-based training on how to develop and maintain secure web applications.

   Department response: As outlined in its **response**, the Department disagrees with the finding, will implement recommendation 4, but will not implement recommendation 5.

Issue 2: Department has not inventoried its data and documented the classifications of that data

We identified some gaps in the Department's data classification procedures. A data classification process identifies whether data is sensitive and stipulates how it should be protected. In protecting data, an entity should consider whether the data is public or confidential, such as health information or personally identifiable information. Data classification helps to ensure sensitive data is protected from loss, misuse, or inappropriate disclosure.

We reviewed the Department's data classification policy and procedures and found that although the Department's data classification policy is consistent with ASET requirements, the Department's procedures do not provide detailed guidance on how to classify data, develop and regularly update a data classification inventory, protect the data based on risk, and handle confidential data, such as processing sensitive data using only approved devices. Additionally, even though the Department reported that it treats all of its data as confidential, it has not inventoried its data and documented the classification of that data. By not formally classifying the data within its systems, the Department runs the risk that it or its employees may provide external entities with access to data or other information they do not need and/or should not have.

Recommendation

6. The Department should develop and implement revised data classification policies and procedures that provide guidance on how to classify its data; require developing a data classification inventory that is updated regularly; specify requirements for protecting data based on its level of risk; and establish processes for handling confidential data, such as ensuring that only approved devices process confidential data.

   Department response: As outlined in its **response**, the Department disagrees with the finding, and will not implement the recommendation.

Issue 3: Department has not conducted a formal Department-wide IT risk assessment since 2015

We identified some gaps in the Department's risk assessment policy, procedures, and process. A risk assessment is a structured process recommended by credible industry standards, such as those developed by the National Institute of Standards and Technology (NIST), and required by ASET policy that at least annually identifies IT risks within an organization, such as weak security practices, outdated systems, or the lack of a plan for restoring IT systems following a disaster.[23] A risk assessment also determines the controls needed to lessen risks and prioritizes risks to an organization's operations that result from the use of IT systems.

[23] NIST, 2013.

We reviewed the Department's risk assessment policy and procedures and found that they include most requirements, such as how to conduct a risk assessment, documenting and disseminating risk assessment results, and implementing a plan of action and milestones to address identified risks. However, they do not provide detailed guidance on categorizing the Department's information based on the potential impact to the State or citizens resulting from disclosure, modification, destruction, or nonavailability of data as required by ASET policy. Classifying information based on the potential impact resulting from disclosure helps an organization determine how to prioritize any risks identified during the risk assessment process

Additionally, the Department reported it is no longer following the requirements outlined in its risk assessment policy and procedures and is instead focusing on implementing the information security controls identified by the State. In addition, as of July 2019, the Department reported that while it has performed some activities, such as completing an IT questionnaire where it self-reports how formalized certain IT security activities are within the Department, including risk assessment, it had not conducted a formal Department-wide risk assessment since 2015. The Department also indicated it has performed informal IT risk assessments using vulnerability scanning results, which are used to identify vulnerabilities, or IT security weaknesses within IT systems. Although vulnerability scanning is important, it is only one practice that should be considered and integrated when creating and implementing an IT risk assessment process. In addition to vulnerability scanning, IT risk assessments should also consider, review, and address other IT security threats, such as weak security practices, lack of plans to address security incidents, and data or hardware loss due to fire or flood.

Recommendations

The Department should:

7. Conduct a formal Department-wide risk assessment at least annually, as required in its risk assessment policy and procedures, to evaluate, document, and prioritize the areas in the Department's IT environment with the highest security risks.

8. Develop and implement a revision to its risk assessment policy and procedures to include categorizing the Department's information based on the likelihood of risk and magnitude of harm as required by ASET policy.

Department response: As outlined in its **response**, the Department disagrees with the finding, but will implement the recommendations.

Issue 4: Department has not enforced requirement that its employees complete security awareness trainings during onboarding and annually thereafter

We identified some gaps in the Department's security awareness policy, procedures, and processes. Security awareness education and training helps to ensure that an organization's employees understand the meaning of information security, risks associated with information security, the importance of complying with information security policies, and their information security responsibilities.

We reviewed the Department's security awareness training policy, which specifies that all employees and contractors must complete basic security awareness training when initially hired and annually thereafter, as required by ASET policy. The Department indicated that this training consists of 2 classes—a basic security awareness class and a Health Insurance Portability and Accountability Act (HIPAA) privacy and information security class. However, the Department is not enforcing this requirement because it has not tracked and ensured that its employees and contractors are completing these trainings as required. Specifically, only 20 percent of the Department's 1,128 employees completed both trainings in calendar year 2018.[24] The Department reported

[24] We were not able to determine a training compliance rate for the Department's contractors because the Department's training rosters do not include contractors' hire dates.

that the training-completion percentages for calendar year 2018 were abnormal and that ASET reported to the Department that their training-completion rate as of June 2019 for the basic security awareness class was 86 percent, which meets ASET's 80 percent compliance requirement for employees. The Department did not provide any information on the training-completion rate for its calendar year 2019 HIPAA security class.

Further, the Department's security awareness training policy requires that all of its employees and contractors complete acceptable use attestations during security awareness training. Acceptable use attestations are agreements employees and contractors sign to indicate that they understand and agree with acceptable-use rules when accessing the Department's IT systems. However, based on our review of a random sample of 28 employees, 14 did not complete the acceptable use attestation during annual security awareness training in calendar year 2018.[25]

We also assessed the Department's security awareness training policy for compliance with other ASET requirements, including those related to role-based training. Although the Department's security awareness training policy mentions role-based security training, the Department has not developed and implemented procedures that provide guidance on the type of role-based training it should provide. ASET policy requires that State agencies develop and implement security awareness training that is specifically geared toward employees' roles and responsibilities. Additionally, the Department indicated that it has not yet developed and implemented role-based training but plans on doing so in 2020. Finally, the Department lacks procedures that detail how it will implement its security awareness program, such as requiring employees and contractors to complete the 2 security awareness classes annually; descriptions of the topic areas that its security awareness training classes should cover; and how it will communicate security awareness training throughout the year.

Recommendations

The Department should:

9. Develop and implement revised security awareness training policies and procedures that include a process for ensuring employees and contractors comply with annual basic security awareness and HIPAA training requirements and acceptable use attestations; specify the role-based training that is required based on employees' and contractors' responsibilities; explain how it will implement its security awareness program; describe the topic areas that its security awareness training classes should cover; and specify how it will communicate security awareness training throughout the year.

10. Continue with its plans to develop and implement role-based training.

    Department response: As outlined in its **response**, the Department disagrees with the finding, but will implement the recommendations.

[25] After selecting our random sample of 30 employees, we removed 2 employees because their start dates were in calendar year 2019.

In accordance with A.R.S. §41-2954, the Legislature should consider the following factors in determining whether the Department should be continued or terminated.

In addition to the recommendations in this report, the Department should address the recommendations directed to it in the other 3 performance audit reports we issued as a part of this sunset review (see Auditor General Reports 19-107, 19-109, and 19-111).

Sunset factor 1: The objective and purpose in establishing the Department and the extent to which the objective and purpose are met by private enterprises in other states.

The Department was established to provide and coordinate public health services and programs for the State. Some of the Department's key responsibilities include regulating some health-related occupations, such as emergency medical care technicians; regulating childcare and healthcare facilities; responding to public health emergencies; and helping control public health epidemics. The Department is also responsible for ensuring all retail food and drink in the State is safe for consumption. In addition, it administers the WIC program, which offers nutrition education and breastfeeding support services along with access to supplemental nutritious foods and operates the State Hospital, which provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

The Legislature has changed some of the services the Department is responsible for providing. Specifically, Laws 2015, Ch. 19, transferred the administration of behavioral health services from the Department to AHCCCS effective June 30, 2016. In addition, Laws 2017, Ch. 313, and Laws 2018, Ch. 234, eliminated ARRA, the Arizona Radiation Regulatory Hearing Board, and the Arizona Medical Radiologic Technology Board of Examiners and transferred their authority, powers, duties, and responsibilities to the Department.

We did not identify any states that met the Department's objective and purpose through private enterprises.

Sunset factor 2: The extent to which the Department has met its statutory objective and purpose and the efficiency with which it has operated.

Some of our performance audits or other work we conducted as a part of the Department's sunset review found that the Department has met its statutory objective and purpose or is improving the efficiency with which it has operated. Specifically:

- **Department appropriately approved and denied applications for the medical marijuana cardholders we reviewed—**We reviewed 50 cardholder applications issued in fiscal year 2018 and found that the Department issued these in a timely manner and in accordance with statute and rule. In addition, we reviewed 10 additional cardholder applications that were denied in fiscal year 2018 and found that they were denied for appropriate reasons. Similarly, our review of a sample of 10 cards that were revoked in fiscal year 2018 found that the Department had revoked these 10 cards for appropriate reasons. See Auditor General Report 19-107.

- **Department appropriately monitored grants we reviewed—**We reviewed the Department's grant monitoring processes and grant files for 3 of the 115 grants the Department paid monies to in fiscal year 2017: SNAP-Ed, Teenage Pregnancy Prevention/Title V Abstinence Education, and Domestic Violence Prevention and Services. We did not identify any concerns with the Department's grant monitoring processes or file documentation for these 3 grants when compared to grant monitoring criteria, such as the Arizona Department

of Administration's *Arizona Grants Manual*. Specifically, for these 3 grants, the Department regularly received programmatic reports, reviewed invoices and supporting documentation, conducted site visits, and reflected its grant monitoring process requirements in written policies and procedures.

- **Department working to reduce nonionizing and x-ray facility inspection backlog—**As indicated in Sunset Factor 1 (see page 27), the regulatory responsibilities of ARRA were transferred to the Department in 2017. In our February 2019 follow-up report on our performance audit and sunset review of ARRA, we reported that the Department was addressing a nonionizing and x-ray facility inspection backlog—which existed when it received the ARRA responsibilities—by increasing the number of inspector positions while reducing the number of administrative staff (see Auditor General Report No. 15-115, 36-month follow-up report). Based on our review of Department inspection backlog data for February 2019 and May 2019, the Department had reduced the nonionizing facility inspection backlog from 399 to 209 facilities and the x-ray facility inspection backlog from 698 to 537 facilities between February 2019 and May 2019.

- **State Hospital is accredited and has established processes for admitting patients, ensuring patients receive prescribed treatment, and reporting incidents—**Our review of the State Hospital, which is responsible for caring for patients with mental illnesses, found that since 1970, the State Hospital has maintained its accreditation through The Joint Commission, a nonprofit organization that accredits and certifies hospitals nationally. In addition, we reviewed the State Hospital's processes for admitting individuals into the State Hospital and for helping to ensure its patients receive their prescribed treatment. We found that the State Hospital has adhered to its established processes for the admission applications and patient treatment files we reviewed. Further, we found that the State Hospital had implemented 5 of 6 recommendations from a 2015 independent investigation to improve the State Hospital's incident-reporting processes. For example, we found that the State Hospital had established a method to follow incidents from beginning to conclusion, improved staff training for preparing incident reports, and taken steps to ensure all required events are reported in an incident report. See Auditor General Report 19-111.

We also identified some areas where the Department should improve its effectiveness. Specifically:

- **Department did not timely, consistently, or adequately perform several medical marijuana regulatory activities and misallocated some Medical Marijuana Fund (Fund) monies—**We found that the Department did not always timely revoke some registry identification cards, did not timely and consistently inspect facilities or consistently address facility noncompliance, inadequately investigated some complaints, did not inspect infusion kitchens according to Arizona food safety standards, has not formally reviewed its Medical Marijuana Program fees, and misallocated some Fund monies. We recommended that the Department take more timely actions to revoke cards, and develop or update and implement policies and procedures or processes for several areas including inspections, complaint handling, and allowable use of Fund monies (see Auditor General Report 19-107).

- **Department did not follow some procurement requirements and paid for some services without ensuring they were provided and contract requirements were met—**We found that the Department did not follow some State procurement requirements for 22 of 25 contracts we reviewed, paid for some services without ensuring they were provided, and did not consistently provide adequate oversight to ensure the appropriate use of public monies. For example, we found that the Department incorrectly procured a professional services contract and paid the contractor more than allowed by statute; did not follow other key purchasing requirements, such as having conflict-of-interest disclosure statements for all Department program staff who participated in the procurement for 11 of the 25 contracts we reviewed; did not ensure 17 of the 37 contract requirements we reviewed were met; and paid for unauthorized services or services without ensuring they were received. We recommended that the Department develop and implement policies and procedures in various areas and implement a centralized process for overseeing its contract monitoring efforts (see Auditor General Report 19-109).

- **State Hospital should evaluate effectiveness of strategies to reduce assaultive patient behavior—**We recommended that the State Hospital evaluate the effectiveness of its strategies to reduce assaultive patient behavior (see Auditor General Report 19-111).

- **Department should improve IT security policies, procedures, or practices in 4 areas—**Some gaps in Department IT security processes resulted in the Department exposing statutorily confidential data, including names, birthdates, and identification numbers. We recommended the Department make improvements in 4 areas: web application development, data classification, risk assessment, and security awareness training (see Finding 3, pages 21 through 25).

- **Department's grant award evaluation documentation did not meet statutory requirements—**Based on our review of the 3 grants previously discussed (see pages 27 through 28), we found that the Department did not appropriately document its award decisions for the 3 grants we reviewed. Statute requires that the Department evaluate grant applications based on evaluation factors specified in the grant solicitation, maintain a written record of the award decision, and include in its award documentation comments regarding the applicant's compliance with evaluation factors.[26]

  The Department uses a color-coded scoring sheet to evaluate whether grant applicants meet application requirements and should be awarded grant monies, which it includes in its grant files to document award decisions. However, for 2 of the 3 grants we reviewed, the Department's scoring sheets were black and white, so it was not clear what score the applicant received, and the scoring sheets also did not contain comments or other indications showing whether applicants complied with evaluation factors. In addition, for 1 of the 3 grants we reviewed, the Department evaluated the application against additional criteria not set forth in the solicitation. Although the grantee submitted documentation with the application that addressed the additional criteria, statute requires all evaluation factors to be included in the grant solicitation.

  During the audit, the Department began taking steps that would address the documentation issue. Specifically, in July 2019, the Department began requiring its staff to use the Arizona Office of Grants and Federal Resources' electronic grants management system to evaluate grant applicants using a numerical score.[27] The Department reported that it plans to use this system to also maintain the award evaluations and decisions.

Recommendation

11. The Department should continue using the electronic grants management system, and ensure that for all future grant evaluations conducted using this system its grant evaluations clearly indicate whether grant applicants complied with all evaluation criteria and that all evaluation factors are included in the grant solicitation.

    Department response: As outlined in its **response**, the Department agrees with the finding, and will implement the recommendation.

Sunset factor 3: The extent to which the Department serves the entire State rather than specific interests.

The Department serves the entire State by providing services designed to promote, protect, and improve the health of Arizona's citizens and communities. Although some of these services and programs are directed toward specific populations, they can be accessed by eligible Arizonans across the State. For example, the Department administers:

- Arizona's WIC program, which serves eligible women, infants, and children across the State through 21 local agencies. The program provides participants with breastfeeding support, information about other community resources, nutrition education, and electronic benefits cards that can be used to purchase food.

- The Smoke-Free Arizona program, which was implemented to protect Arizonans from the harmful effects of secondhand smoke exposure in most enclosed public places and places of employment. Smoke-Free Arizona requires that no smoking occur inside or within 20 feet of a place of business, with 7 exemptions,

[26] A.R.S. §41-2702(G).

[27] ECivis is a State-wide grant management system that centralizes grant activities among State agencies, departments, boards, and commissions. For example, State agencies such as the Department must use the system to solicit grants, evaluate grant applications, and track reports the grantee is required to submit after the grant has been awarded, such as financial reports.

including 1 for outdoor patios that meet specific requirements. The Department provides "No Smoking" signs free of charge to businesses.

In addition, many of the Department's services and information can be accessed online. This includes access to the Department's inspection records for childcare and healthcare facilities through a searchable database, available on the Department's AZ Care Check website; ordering official birth and death certificates; and information about chronic diseases such as heart disease, stroke, lung disease, diabetes, asthma, and cancer.

However, we found that deficiencies in the Department's conflict-of-interest process increased the risk of nondisclosure and recommended that the Department continue its efforts to develop and implement a new conflict-of-interest disclosure process that will help it comply with the State's conflict-of-interest requirements and best practices, such as having public officials and employees annually disclose whether or not they have any substantial financial and/or decision-making conflicts and training employees on how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities (see Finding 2, pages 17 through 19).

Sunset factor 4: The extent to which rules adopted by the Department are consistent with the legislative mandate.

We were unable to determine if the Department had fully adopted rules required by statute because the Department does not maintain a list of all statutes requiring rules and the associated rules that have been adopted. However, according to the Department, it monitors legislation to identify rules or rule changes that may be needed because of changes in legislation. In addition, the Department regularly reviews and updates its rules. For example, in 2018, the Department submitted 21 rule review reports, which are reports of existing rules that statute requires agencies to submit every 5 years to the Governor's Regulatory Review Council for review to determine whether any rule should be amended or repealed.[28] In addition, according to the Department's website, as of May 9, 2019, the Department had 13 rulemakings in process. The Department also addressed rule deficiencies identified in our 2009 sunset review of the Department (see Report No. 09-11), including making changes to childcare facilities and group homes licensing rules between 2009 and 2018, hearing aid dispensers licensing and regulation rules in 2014, and tuberculosis control rules in 2018 and 2019.

Sunset factor 5: The extent to which the Department has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

The Department has provided opportunities for public input before adopting its rules. Specifically, we reviewed 3 rulemakings finalized prior to January 25, 2019, and in all 3 cases, the Department had informed the public of its rulemaking activities, encouraged the public to provide input on the proposed rules, and informed the public of the expected impact the proposed rules would have.

The Department is responsible for more than 30 boards, commissions, committees, councils, subcommittees, teams, and user or work groups that are subject to open meeting law requirements. However, we found that the Department did not consistently comply with open meeting law requirements for 3 meetings we reviewed: the April 2019 and May 2019 meetings of the Public Health Prevention Services Block Grant Advisory Committee and the May 2019 meeting of the Emergency Medical Services Council. Specifically:

- The Public Health Prevention Services Block Grant Advisory Committee did not publicly notice its April 2019 meeting. Further, although both the Public Health Prevention Services Block Grant Advisory Committee and the Emergency Medical Services Council properly posted online notices for their May 2019 meetings, the Department has not conspicuously posted a statement on its website stating where all notices of public meetings would be posted, including the physical and electronic locations, as required by A.R.S. §38-431.02 (A)(1).

[28] A.R.S. §41-1056(A).

- The Public Health Prevention Services Block Grant Advisory Committee did not provide its April 2019 meeting minutes or an audio recording of the meeting to us until 9 business days after the meeting occurred, as opposed to within 3 business days as required by A.R.S. §38-431.01(D). Meeting minutes and audio recordings were provided within 3 business days after the meeting for the May 2019 meetings of the Public Health Prevention Services Block Grant Advisory Committee and the Emergency Medical Services Council.

The Department lacks comprehensive policies and procedures and formalized training for open meeting law compliance for its boards and commissions and staff members. It also does not have an oversight process to help ensure that the boards and commissions it supports comply with open meeting law requirements. Further, the Department's website does not have a conspicuously posted statement indicating the location for electronic and physical postings of public notices of meeting and is missing some information about the boards, councils, and committees it supports, such as information about their purpose, meeting minutes, and agendas. In addition, some of the entities listed on the Department's website as being subject to open meeting law are no longer active, such as the Racial & Ethnic Approaches to Community Health Advisory Council.

Recommendations

The Department should:

12. Develop and implement policies, procedures, and training to help guide the boards, commissions, and councils it supports; and its staff members' compliance with open meeting law requirements.

13. Develop and implement an oversight process to ensure that the boards, commissions, and councils it supports comply with open meeting law requirements.

14. Update its website to include a conspicuously posted statement indicating the location for all electronic and physical postings of public meeting notices and a complete and accurate listing of all the entities that are subject to open meeting law along with information about their purposes and where to locate information about these entities' public meetings, such as agendas and minutes.

    Department response: As outlined in its **response**, the Department agrees with the finding, and will implement the recommendations.

Sunset factor 6: The extent to which the Department has been able to investigate and resolve complaints that are within its jurisdiction.

The Department receives complaints pertaining to the functions it performs. Complaints can be submitted to the Department in many ways, including electronically. For example, the Department's Public Health Licensing Division has an online complaint system for people to submit complaints about the areas it regulates, such as childcare, long-term care, medical, and residential facilities. In addition, the Department has another online system, AZ Care Check, that provides the public with Statements of Deficiencies, which include the citations of noncompliance with laws or rules for substantiated complaints, and the Plan of Correction developed and implemented by the facility to address the cited deficiencies. According to Department-provided data, the Department received 14,707 complaints during calendar years 2017 and 2018, for the functions its Public Health Licensing, Preparedness, and Prevention Divisions perform, including complaints regarding the various facilities and some medical-related professions it licenses and regulates.

We reviewed the Department's complaint-handling policies and procedures for the Bureau of Emergency Medical Services and Trauma System, which is part of the Department's Preparedness Division. This Bureau is responsible for establishing, coordinating, and administering a State-wide system of emergency medical services, trauma care, and trauma registry. It handles complaints against emergency medical care technicians and emergency medical services providers, such as ground ambulance services and advanced life support base hospitals. We found that the Bureau's procedures were detailed and provided step-by-step processes for handling complaints from start to finish. We also conducted a review of the Department's complaint-handling processes for 2 additional areas—medical marijuana facilities and long-term care facilities—and identified the following:

- **Some medical marijuana facility complaints inadequately investigated and monitored—**We found that some complaints were inappropriately determined to not be within the Department's jurisdiction and, therefore, were not investigated; some complaints were inaccurately categorized after investigation; and complaint investigations were not adequately documented. We recommended that the Department update and implement policies and procedures and staff training for its medical marijuana complaint-handling process (see Auditor General Report 19-107).

- **Some long-term care facility complaints and self-reports not investigated or not investigated timely—**We found that the Department did not investigate or untimely prioritized, investigated, or resolved some long-term care facility complaints and self-reports. We recommended that the Department investigate all complaints and self-reports; and ensure that all complaints and self-reports are prioritized, investigated, and resolved in a timely manner by continuing its efforts to allocate new or reallocate some existing staff to complaint and self-report prioritization, investigation, and resolution, establishing a time frame for completing investigations and closing long-term care facility complaints and self-reports, and developing and implementing additional bimonthly management reports for monitoring whether and how quickly complaints and self-reports are being prioritized, investigated, and resolved (see Finding 1, pages 7 through 15).

Sunset factor 7: The extent to which the Attorney General or any other applicable agency of State government has the authority to prosecute actions under the enabling legislation.

A.R.S. 41-192(A)(1) requires the Attorney General to act as the Department's legal advisor and to provide all legal services the Department requires.

Sunset factor 8: The extent to which the Department has addressed deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate

According to the Department, there are no deficiencies in its enabling statutes that prevent it from fulfilling its statutory mandate.

Sunset factor 9: The extent to which changes are necessary in the laws of the Department to adequately comply with the factors listed in this sunset law.

We recommended that the Legislature consider establishing in statute requirements for the Department to investigate all long-term care facility complaints and self-reports and time frames for completing investigations of and closing out long-term care facility complaints and self-reports (see Finding 1, pages 7 through 15).

Sunset factor 10: The extent to which the termination of the Department would significantly affect the public health, safety, or welfare.

Terminating the Department would affect the public health, safety, and welfare if its responsibilities were not transferred to another entity. The Department's mission is to promote, protect, and improve the health and wellness of individuals and communities in Arizona. According to the Department, it manages over 300 programs designed to address State-wide public health issues. Some examples of the Department's programs that promote, protect, and/or improve public health, safety, and welfare include:

- Its regulatory programs that license, inspect, and handle complaints for childcare and healthcare facilities, including 147 long-term care facilities.

- Its State Laboratory Services, which include identifying and investigating infectious and communicable diseases.

- Its WIC program, which, according to its website, assists over 145,000 women, infants, and children monthly with breastfeeding support, information about community resources, nutrition education, and nutrition assistance.

- Its programs at the State Hospital, which provide inpatient psychiatric care services to court-ordered persons with mental illnesses.

Sunset factor 11: The extent to which the level of regulation exercised by the Department compares to other states and is appropriate and whether less or more stringent levels of regulation would be appropriate.

We found that the level of regulation the Department exercises appears appropriate and is generally similar to the level of regulation in the 3 other states that we selected for review: Colorado, Nevada, and New Mexico.[29] Specifically, we found that Arizona and all 3 of the other states regulate similar areas, including facilities where care for vulnerable populations is provided, such as childcare and assisted living facilities, and nursing care institutions. In addition, Arizona and these other states also regulate medical facilities, such as hospitals, hospice and home health agencies, medical marijuana, and emergency medical services, such as ground ambulance services. Finally, Arizona and these other states also regulate some health-related occupations, such as emergency medical care technicians, certain medical radiologic technologists, and speech-language pathologists.

We more closely reviewed the regulation of nursing care, assisted living, and childcare facilities and ground ambulance services in these 3 states and found:

- **Nursing care facilities and assisted living facilities—**Arizona and all 3 states require these facilities to be licensed. Licensure requirements generally include the requirement to have a governing body that is responsible for the organization, operation, and administration of the facility; a licensed/certified administrator/manager; administrative and operational policies and procedures; and compliance inspections.

- **Childcare facilities—**Arizona and all 3 states require childcare facilities to be licensed. In Arizona, a childcare facility is any facility in which childcare is regularly provided for compensation for 5 or more children not related to the proprietor. Licensure requirements generally require licensed facilities to undergo inspections and ensure that their staff complete continuing education and fingerprinting. Also, childcare facilities must establish health and safety standards, such as those related to immunization requirements and child-to-staff ratios.

- **Ground ambulance services—**Arizona and all 3 states regulate ground ambulance services. In Arizona, ground ambulance services are regulated through a Certificate of Necessity (CON) system. Under this system, an applicant must apply for and receive a CON through the Department and adhere to the restrictions in the CON. The CON regulates service areas, response times, and rates and charges to ensure providers are charging appropriately. Although the 3 other states do not regulate ground ambulance services through a CON, we found that each state or another governmental entity within each state regulate the same types of areas included within Arizona's CON. For example, Arizona and all 3 states have regulations related to response times, service areas, and certificates of insurance. In addition, Arizona and New Mexico require that the ambulance service provider be deemed fit and proper. In Arizona, this is defined as having expertise, integrity, fiscal competence, and resources to provide ambulance service in the service area.

Sunset factor 12: The extent to which the Department has used private contractors in the performance of its duties as compared to other states and how more effective use of private contractors could be accomplished.

The Department uses contracts and agreements to help accomplish major functions. Specifically, in fiscal year 2018, the Department spent more than $193 million for more than 1,100 contracts and agreements, which represented 43 percent of the Department's fiscal year 2018 expenditures. We compared the Department's use of contracted services to those used by 3 states: Colorado, Nevada, and New Mexico. We compared 17 contracted services that the Department deemed key to its mission-critical functions and found that the other states generally used similar contracted services. For example, Arizona and all 3 states use private contracts for EMS and Trauma System data registry and storage, HIV patient pharmaceuticals, marketing, and temporary staffing. There were a few areas where Arizona was contracting for services that none of the 3 other states were contracting for or only one other state was doing so. For example, Arizona is the only state that contracts for housekeeping services for state-run, in-patient behavioral health facilities. In addition, only one of the 3 other

[29] These states were judgmentally selected (see Appendix A, page a-3).

states, Colorado, contracts for medical marijuana card printing, software, and supplies, and New Mexico was the only other state that, like Arizona, contracted for teen pregnancy prevention education services.

We did not identify any additional areas where the Department should consider using private contractors. However, our performance audit of the Department's procurement and contract monitoring practices found that the Department did not follow some State procurement requirements for 22 of 25 contracts we reviewed, paid for some services without ensuring they were provided, and did not consistently provide adequate oversight to ensure the appropriate use of public monies (see Auditor General Report 19-109).

Auditor General makes 13 recommendations to the Department and 1 recommendation to the Legislature

The Department should:

1. Ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner by taking the following actions:

    a. Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

    b. Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

    c. Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

    d. Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

    e. Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level (see Finding 1, pages 7 through 15, for more information).

2. Continue its efforts to develop and implement a new conflict-of-interest disclosure process and form that will help it comply with the State's conflict-of-interest requirements and best practices, such as having public officials and employees annually disclose whether or not they have any substantial financial and/or decision-making conflicts, and train employees on how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities (see Finding 2, pages 17 through 19, for more information).

3. Develop and implement web application development policies and procedures that incorporate security into the development and modification process, including requirements for gathering security requirements, using up-to-date secure coding standards, performing threat modeling during development, reviewing source code, and performing security testing before releasing a web application to the live environment (see Finding 3, pages 21 through 25, for more information).

4. Require staff who are responsible for developing web applications to regularly receive role-based training on how to develop and maintain secure web applications (see Finding 3, pages 21 through 25, for more information).

5. Develop and implement revised data classification policies and procedures that provide guidance on how to classify its data; require developing a data classification inventory that is updated regularly; specify requirements for protecting data based on its level of risk; and establish processes for handling confidential data, such as ensuring that only approved devices process confidential data (see Finding 3, pages 21 through 25, for more information).

6. Conduct a formal Department-wide risk assessment at least annually, as required in its risk assessment policy and procedures, to evaluate, document, and prioritize the areas in the Department's IT environment with the highest security risks (see Finding 3, pages 21 through 25, for more information).

7. Develop and implement a revision to its risk assessment policy and procedures to include categorizing the Department's information based on the likelihood of risk and magnitude of harm as required by ASET policy (see Finding 3, pages 21 through 25, for more information).

8. Develop and implement revised security awareness training policies and procedures that include a process for ensuring employees and contractors comply with annual basic security awareness and HIPAA training requirements and acceptable use attestations; specify the role-based training that is required based on employees' and contractors' responsibilities; explain how it will implement its security awareness program; and describe the topic areas that its security awareness training classes should cover; and specify how it will communicate security awareness training throughout the year (see Finding 3, pages 21 through 25, for more information).

9. Continue with its plans to develop and implement role-based training (see Finding 3, pages 21 through 25, for more information).

10. Continue using the electronic grants management system, and ensure that for all future grant evaluations conducted using this system its grant evaluations clearly indicate whether grant applicants complied with all evaluation criteria and that all evaluation factors are included in the grant solicitation (see Sunset Factor 2, pages 27 through 29 for more information).

11. Develop and implement policies, procedures, and training to help guide the boards, commissions, and councils it supports; and its staff members' compliance with open meeting law requirements (see Sunset Factor 5, pages 30 through 31, for more information).

12. Develop and implement an oversight process to ensure that the boards, commissions, and councils it supports comply with open meeting law requirements (see Sunset Factor 5, pages 30 through 31, for more information).

13. Update its website to include a conspicuously posted statement indicating the location for all electronic and physical postings of public meeting notices and a complete and accurate listing of all the entities that are subject to open meeting law along with information about their purposes and where to locate information about these entities' public meetings, such as agendas and minutes (see Sunset Factor 5, pages 30 through 31, for more information).

The Legislature should:

1. Consider forming a task force to study and propose policy options for addressing the Department's timely investigation and processing of long-term care facility complaints and self-reports to help ensure resident health and safety. Options to consider include establishing requirements for investigating all complaints and self-reports, appropriate time frames for conducting investigations of and closing out long-term care facility complaints and self-reports, and reporting performance metrics to the Legislature. Task force members should include appropriate stakeholders, such as legislators, Department representatives, Arizona Department of Economic Security representatives, industry members (i.e., long-term care facility owners or licensed administrators), patient advocates, and if appropriate, a federal CMS representative. Legislation forming the task force should identify task force membership, its overall purpose and expected outcomes, and deadlines for reporting recommendations to the Legislature. (see Finding 1, pages 7 through 15, for more information).

APPENDIX A

Objectives, scope, and methodology

The Office of the Auditor General has conducted a performance audit and sunset review of the Department pursuant to a September 14, 2016, resolution of the Joint Legislative Audit Committee. This performance audit and sunset review was conducted as part of the sunset review process prescribed in A.R.S. §41-2951 et seq. This report addresses the statutory sunset factors and includes a review of various Department processes for disclosing conflicts of interest, adopting rules, holding public meetings, handling complaints, protecting IT systems and data, and regulating healthcare and childcare facilities.

We used various methods to review the issues in this performance audit and sunset review. These methods included interviewing Department staff and reviewing Department statutes and rules and Department-provided information, including policies, procedures, its responses to the sunset factors, and website information. We used the following specific methods to meet the audit's objectives:

- To assess the Department's compliance with State and federal long-term care facility complaint- and self-report-handling requirements, we reviewed the Department's policies and procedures, CMS State Operations Manual chapters 5 and 7, code of federal regulations, and complaint-handling time frame requirements for 11 western states, and conducted interviews with Department staff and CMS officials.[30] In addition, we reviewed complaints and facility-reported incidents (self-reports) for a judgmental sample of 5 of the 147 CMS certified/state licensed long-term care facilities. We judgmentally selected 2 of the 5 facilities in our sample using information from a searchable database available through the Department's AZ Care Check website and CMS' websites because of discrepancies in each facility's ratings on the 2 websites. Specifically, the Department's AZ Care Check website indicated that both facilities had been given an A rating, yet the CMS website indicated that the 2 facilities were rated overall as below average and much below average. We selected 3 facilities from a list of 39 facilities that had undergone and completed surveys (inspections) between December 2018 and May 2019 to ensure we captured facilities from across the State within our sample. Specifically, of the 5 total facilities selected, 2 were Phoenix-area facilities, 1 was a Tucson facility, and 2 were facilities located in rural areas. We reviewed 33 of the 34 complaints pertaining to these facilities that the Department received in calendar years 2017 and 2018 and judgmentally selected 37 of 172 self-reports submitted by these 5 facilities in calendar years 2017 and 2018 for review.[31] We judgmentally selected these 37 self-reports to ensure our sample included self-reports from each of the 5 facilities, self-reports that were received throughout both calendar years, and self-reports at different stages of completion (such as closed, pending investigation, or not yet prioritized).

  We also reviewed Department-provided data concerning all long-term care complaints and self-reports the Department received during calendar years 2017 and 2018. We conducted work to assess the validity and reliability of this data and determined it to be reasonably complete and accurate for the purposes of this audit, including reporting the overall number and statuses of complaints and self-reports received by the Department in calendar years 2017 and 2018. In addition, to determine if Department staff had sufficient

[30] We reviewed 11 western states: California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

[31] We removed 1 complaint from the sample due to inconsistencies in the reported data. For example, the date the complaint was received occurred after the documented date of investigation. In addition, 4 of the self-reports in our sample were submitted to the Department in 2016. We retained these self-reports in our sample because the Department's system classified them as received in 2017 since their intake was not completed until 2017.

complaint processing guidance, we reviewed complaint-handling policies and procedures for the Bureau of Emergency Medical Services and Trauma System.

- To assess the Department's compliance with the State's conflict-of-interest law requirements and alignment with best practices, we reviewed statutes, best practices, the Arizona Department of Administration's State Personnel Employee Handbook, chapter 8 of the *Arizona Agency Handbook*, and the conflict-of-interest form the Department was using.[32]

- To evaluate the Department's compliance with the State's IT security requirements for 4 areas—web application development, data classification, risk assessment, and security awareness training—we compared the Department's policies, procedures and practices to ASET requirements, and credible industry standards. In addition, we assessed whether its employees had received required IT security awareness training and HIPAA training in 2018 and selected a random sample of 30 of 1,128 employees as of March 25, 2019, to determine if they had completed the Department's required acceptable use attestations in calendar year 2018.[33]

- To determine whether the Department was continuing to address the nonionizing and x-ray facility inspection backlog identified in a prior performance audit and associated follow-up reports (see Report No. 15-111, 36-month follow-up report), we analyzed Department-provided inspection backlog data for nonionizing and x-ray facilities as of February 2019 and May 2019. We conducted work to assess the validity and reliability of this data and determined it to be reasonably complete and accurate for the purposes of this audit, including reporting the overall number of nonionizing and x-ray facilities and the status of the inspection backlog as of May 2019.

- To determine whether the Department appropriately awarded and monitored grants, we judgmentally selected 3 of the Department's 115 grants that it made payments for in fiscal 2017: SNAP-Ed, Teenage Pregnancy Prevention/Title V Abstinence Education, and Rural Safe Home/Domestic Violence Prevention. These 3 grants were selected based on the amount of grant monies awarded and the importance of the grant programs to the Department's mission. We reviewed the Department's grant award files and practices for these grants and compared them to statutory requirements for awarding grants outlined in A.R.S. §41-2701 et seq and grant monitoring criteria.[34]

- To assess the Department's compliance with the State's open meeting law requirements, we selected 2 entities from the list of over 30 entities the Department reported supporting that are subject to open meeting law. We selected these 2 entities based on their mission-critical function, statutory obligations, and availability of information provided by the Department's website. We reviewed the notice, agenda, and meeting minutes and attended 2 public meetings—the May 2019 Public Health Prevention Services Block Grant Advisory Committee meeting and the May 2019 Emergency Medical Services Council meeting. In addition, we assessed the Public Health Prevention Services Block Grant Advisory Committee's compliance with open meeting law requirements for its April 2019 meeting. We also conducted interviews with staff from the meetings we attended, reviewed Department open meeting law policies and procedures, and reviewed the Bureau of Emergency Medical Services and Trauma System's bylaws.

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[32] Organization for Economic Cooperation and Development (OECD). (2003). *Guidelines for managing conflicts of interest in the public service*. Paris, France. Retrieved 3/27/2019 from http://www.oecd.org/gov/ethics/2957360.pdf; Ethics & Compliance Initiative. (2016). *Conflicts of interest: An ECI benchmarking group resource*. Arlington, VA. Retrieved 3/27/2019 from https://www.ethics.org/knowledge-center/conflicts-of-interest-report/; and Office of the Auditor-General New Zealand. (2007). *Managing conflicts of interest: Guidance for public entities*. Wellington, New Zealand. Retrieved 8/6/2019 from https://www.oag.govt.nz/2007/conflicts-public-entities/docs/oag-conflicts-public-entities.pdf.

[33] After selecting our random sample of 30 employees, we removed 2 employees because their start dates were in calendar year 2019.

[34] *State of Arizona Accounting Manual*; Arizona Office of Grants and Federal Resources. (2018). *Arizona grants manual: Grantor*. Phoenix, AZ: Arizona Department of Administration. Retrieved 8/6/2019 from https://grants.az.gov/grant-manual; National State Auditors Association (NSAA). (2003). *Contracting for services: A National State Auditors Association best practices document*. Lexington, KY; and Financial Fraud Enforcement Task Force (FFETF). (2012). *Reducing grant fraud risk: A framework for grant training*. Washington, DC: U.S. Department of the Treasury. Retrieved 6/8/2019 from https://oig.justice.gov/reports/2012/Grant-Fraud-Training-Framework.pdf.

- To compare the Department's regulatory activities and use of private contractors with other states, we selected 3 states—Colorado, Nevada, and New Mexico—for review.[35] We reviewed these states' statutes, rules, and websites to gather information about their regulatory responsibilities and compare them to Arizona. We also contacted staff in these 3 states to learn more about their use of contracted services and compared this to the Department's use of contracts.[36]

- To obtain information for the report's Introduction, we reviewed the Department's website and Department-provided information on staffing and budget. We reviewed statutes, rules, and session laws related to licensure of intermediate care facilities for individuals with intellectual disabilities. Additionally, we compiled and analyzed information from the Arizona Financial Information System *Accounting Event Transaction File* for fiscal years 2017 through 2019 and Department-provided information.

- Our work on internal controls focused on the Department's processes for handling long-term care facility complaints; disclosing conflicts of interest; complying with State IT security or credible industry standards for web application security, data classification, risk assessment, and security awareness training; awarding and monitoring grants; and complying with open meeting law requirements. Conclusions on this work are included in Findings 1, 2, and 3 (see pages 7 through 25), and in our responses to Sunset Factors 2 and 5 (see pages 27 through 31). Computerized system information was not significant to our objectives; therefore, we did not conduct test work on information systems controls.[37]

We conducted this sunset review 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We express appreciation to the Department's Director and staff for their cooperation and assistance throughout the review.

[35] These states were judgmentally selected based on regulatory functions and geographic location.

[36] We selected Department contracts based on Department input and auditor judgment regarding those contracts that help the Department to complete its mission-critical functions.

[37] Although computerized systems controls were not significant to our objectives, we conducted validation and reliability work on Department-provided data for the total number of long-term care facility complaints and self-reports received in 2017 and 2018 and determined the data to be reasonably complete and accurate for the purposes of this audit.

Auditor General's comments on Department response

The Joint Legislative Audit Committee requires all agencies to respond to whether they agree with our findings and plan to implement the recommendations. However, the Department has included certain statements in its response to the audit findings and recommendations that mischaracterize our work, attempt to minimize our work, or misdirect the reader from the message that the Department needs to improve its performance in various areas. To provide clarity and perspective, we are commenting on the Department's response to our audit.

1. The Department makes the following statements related to Finding 1 (see Department's response pages 2 and 3):

   "For example, in Finding 1, the report makes sweeping statements about public health and safety risks in the context of the auditors' review of 33 complaints and a judgmental sample of 37 self-reports for 5 long-term care facilities that are regulated and funded through an agreement with the federal Centers for Medicare and Medicaid Services (CMS). However, the audit fails to provide context for this analysis and findings. In total, long-term care facilities represent less than 0.5 percent of the total licensees under Department regulation and the sample of 5 facilities represents 0.014% of total licensees under the Department's jurisdiction. The complaints reviewed represent roughly 0.4% of all complaints received by the Department during the two-year period under evaluation. Rather than articulating how the Department performs across this wide range of activities to protect public health and safety and investigating and resolving complaints within its jurisdiction, the audit findings focus on this very narrow non-representative sample. In addition to only representing a small subset of the Department's overall regulatory activity, this sample is even small within the overall long-term care facility regulation framework, which received a total of 4,959 complaints over the two-year period in question."

   We disagree with the Department's characterizations. These statements are misleading, misrepresent the finding, and attempt to deflect attention from the Department's failure to investigate, or timely investigate or resolve, some long-term care facility complaints and self-reports. Specifically:

   a. Finding 1 does not include a sweeping statement regarding public health and safety, but instead clearly indicates that long-term care facility residents may be at risk because of the Department's failure to investigate, or timely investigate, some long-term care facility complaints and self-reports. In fact, the finding provides examples of complaints and self-reports from the sample we reviewed that include allegations of abuse and neglect and unsanitary living conditions that, if substantiated, either did or could put facility residents at risk. The failure to investigate these complaints or investigate them in a timely manner exacerbates this risk (see Finding 1, pages 7 through 15).

   b. Section headings and numerous sentences within the finding clearly discuss how our samples were selected and the specific results of those samples. For example, of the 147 long-term care facilities that are State licensed/CMS certified, we judgmentally selected 2 of the 5 facilities in our sample using information from a searchable database available through the Department's AZ Care Check website and CMS' website because of rating discrepancies in each facility's ratings on the 2 websites. Specifically, the Department's AZ Care Check website indicated that both facilities had been given an A rating, yet the CMS website indicated that the 2 facilities were rated overall as below average and much below average. We selected 3 facilities from a list of 39 facilities that had undergone and completed surveys (inspections) between December 2018 and May 2019 to ensure we captured

facilities from across the State within our sample. Specifically, of the 5 total facilities selected, 2 were Phoenix-area facilities, 1 was a Tucson facility, and 2 were facilities located in rural areas of the State (see Finding 1, footnote 10, page 8).

Although our test work was not designed nor intended to be generalized to the population of long-term care facilities, the methods we used to select and review complaints and self-reports provide reasonable assurance that the problems we identified are likely not limited to the facilities we reviewed. Furthermore, Department-provided data indicates that as of June 2019, 2,767 of the 4,958 long-term care facility complaints and self-reports the Department received in calendar years 2017 and 2018, or approximately 56 percent, remained open and uninvestigated (see Finding 1, page 9), consistent with our conclusion. The sample of complaints and self-reports we reviewed was sufficient, in the context of other evidence we provided in the report, to conclude that the Department did not timely prioritize and initiate some investigations on the complaints and self-reports it received against long-term care facilities (see Finding 1, pages 10 through 11).

2. The Department makes the following additional statements related to Finding 1 (see Department's response page 3):

"We would also note that under this federal program overseeing long-term care facilities, the Department performs functions for CMS, who sets the expectations, requirements and funding for the program. The Department is currently in compliance with those requirements as determined by CMS. The audit establishes expectations for the Department beyond those that exist in its agreement with CMS or as currently established by the Legislature, including establishing investigation time frames by examining policies in other states without a comprehensive analysis of those other states' requirements and available resources. If the State wants to expand the regulation of this industry beyond the federal requirements, including an evaluation of Arizona's long-term care marketplace and resources needed to meet any additional expectations that are set, the Department would be pleased to participate in those discussions. In summary, we will not detail every individual concern with how the audit articulates its findings. But as a result of these concerns, we cannot agree with Finding 1."

Similar to the Department's response noted in number 1 above, the Department includes statements in this portion of its response that misrepresent its compliance with CMS requirements and expectations regarding its performance related to investigating long-term care facility complaints and self-reports. Specifically:

a. Although the Department indicates that CMS has determined it is in compliance with CMS requirements for overseeing long-term care facilities, as indicated in our report, the Department is not meeting all CMS requirements. The Department is federally required to investigate all complaints and self-reports and prioritize and initiate investigations of those complaints and self-reports in a timely manner. As presented in Finding 1, as of June 2019, 38 of the 70 complaints and self-reports in our sample, or 54 percent, remained uninvestigated between 173 and 904 days after receipt. We also identified deficiencies with timely prioritizing and initiating investigations in accordance with CMS requirements for the complaints and self-reports in our sample, similar to CMS findings. Specifically, as indicated in our report, according to the Department's 4 annual CMS State Performance Evaluations for federal fiscal years 2015 through 2018, the Department did not always meet the federal time frame for initiating its complaint and self-report investigations (see Finding 1, pages 9 through 11, and 13).

b. Performance audits provide findings and recommendations to help management improve program performance and operations. These recommendations should not be limited to what is required only by State or federal laws and regulations, but include recommendations to help improve performance and protection of the public health and safety—and in this case, residents of long-term care facilities. As a result, our report provides meaningful, common-sense recommendations, such as establishing a time frame for completing investigations or developing and implementing additional management reports for Department management review and analysis that will help ensure that all complaints and

self-reports are prioritized, investigated, and resolved in a timely manner (see Finding 1, page 14). In addition, we include information on other states when appropriate to provide helpful benchmarking information for the audited agency, policymakers, and other users of our performance audit reports. As indicated in Appendix A of our report (see page a-1), we researched whether 11 western states had complaint-handling time frames and identified 1 state, California, that statutorily requires complaint investigations to be completed within 60 days of receipt (see Finding 1, page 10).

3. The Department makes the following statements related to Finding 3 (see Department response pages 3 through 4):

"The Department also cannot agree with Finding 3. We take seriously our obligation to protect critical, sensitive and confidential data. ADOA-ASET is the Arizona office responsible for setting the technology, security, privacy, and communication strategies, policies, and procedures for the state of Arizona. ASET's guiding principles include *Driving best-in-class, enterprise-wide security standards through the office of the state Chief Information Security Officer (CISO) in an effort to ensure that all cyber security initiatives are secure and compliant*. To this end, ASET provides leadership, standards and governance across all of state government, leveraging its experts to set expectations and monitor enterprise security controls and state agency activities. The report misrepresents our IT security processes, including using inaccurate terminology to describe activities in the report (e.g., use of the term "breach", which did not occur, but was implied to have occurred in the report). The incident referenced in the audit involved a multistep, complicated process in which an individual would have needed specific knowledge to access the information. Contrary to what is reported in the audit, ADHS's web application development policies and procedures are aligned with ASET and credible industry standards."

"In addition, the audit reports that the Department has not conducted a formal Department-wide IT risk assessment since 2015. This misleading statement fails to explain that ASET conducted a state-wide risk assessment several years ago and determined that Arizona could greatly reduce IT risks by implementing enterprise controls. The Department and other states agencies have focused on implementing these controls over the past few years, including the establishment of RiskSense, a tool used for IT vulnerability management and risk scoring. The RiskSense platform includes the assignment of a safety score which is used to evaluate and monitor each agency's risk exposure. Governor Ducey and ASET set a goal for each state agency to maintain a score of 725 or above; the Department currently exceeds this goal. In addition, the score is updated at least twice a month and Department leadership reviews its performance weekly and allocates resources as needed to address identified issues. Now that these controls have been implemented, the Department plans to return to performing annual risk assessment. The Department believes ASET provides sufficient and appropriate leadership on IT security issues and will continue to work collaboratively with ASET to maintain its agency's information security. It will also implement recommendations that will continue to enhance its procedures."

We disagree with some of the Department's statements included in the above portion of its response. They are inaccurate or are an attempt to minimize the importance of our findings and recommendations that are provided to help improve the Department's processes for safeguarding critical, sensitive, and confidential data and reduce the risk of unauthorized access to this data. Specifically:

a. The Department states that by using the term "breach" in Finding 3, our report implies that a breach occurred. This statement misrepresents our finding in this area. We use the term "breach" to explain a statutory requirement relating to the unauthorized access of confidential data, not to describe the incident. Specifically, statute states that it is a class 1 misdemeanor for any person, including an employee or official of the Department or another State agency or local government, to breach the confidentiality of this information. However, in discussing the unauthorized access that occurred, we refer to it as a security weakness and a security incident, not a breach. Similarly, based on its own investigation of what we found and reported to the Department, the Department used similar language in reporting that a security incident had occurred (see Finding 3, pages 21 through 22).

b. The Department indicates that the security incident we report involved a multistep, complicated process. We disagree. Obtaining access to the information involved only a few steps, including a common step that an attacker would initiate. Specifically, as stated in the report, a concerned member of the public informed us of the security weakness on a Department website that allowed them unauthorized access to statutorily confidential data. Based on the information provided, we were able to obtain unauthorized access, and it was not complicated to do so. Additionally, the Department's response downplays the significance of the security weakness found during the audit.

c. The Department indicates that its web application development policies and procedures are aligned with ASET and credible industry standards. We disagree. Based on the documents the Department provided for our review and as indicated in our report, its policies and procedures are not aligned with ASET and credible industry standards because they do not require gathering security requirements, using up-to-date secure coding standards, performing threat modeling during web application development, and performing security testing (see Finding 3, page 22).

d. The Department indicates that our statement regarding when it last conducted a formal Department-wide risk assessment is misleading. However, based on the documents and information the Department provided, we accurately report that the Department has not performed a Department-wide risk assessment since 2015. In addition, despite other activities the Department is performing as mentioned in its response, ASET policy requires the Department to conduct a Department-wide risk assessment at least annually (see Finding 3, pages 23 through 24).

4. Finally, as indicated in its response, the Department also does not plan to implement recommendations 5 and 6 from our report (see Department response page 7).

We disagree with the Department's determination to not implement recommendations 5 and 6. By not taking steps to implement these recommendations, the Department will not be doing everything it can and/or is required by ASET policy to safeguard its IT systems and data, thus increasing the risk of inappropriate or unauthorized access to these systems and data. Specifically, Recommendation 5 focuses on requiring its web application development staff to receive regular role-based training. Although its staff have received training, by not requiring its staff to regularly receive role-based training, the Department risks its staff not being up to date on secure coding practices or IT security threats. Recommendation 6 focuses on updating its data classification policies and procedures to provide guidance on how to classify its data and creating and updating a data classification inventory, as required by ASET and recommended by credible industry standards. As indicated in our report, data classification helps to ensure sensitive data is protected from loss, misuse, or inappropriate disclosure (see Finding 3, page 23).

DEPARTMENT RESPONSE

ARIZONA DEPARTMENT
OF HEALTH SERVICES

September 23, 2019

Ms. Lindsey Perry, Auditor General
Arizona office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

RE: Statutory Sunset Factors Audit

Thank you for the opportunity to respond to your audit on our statutory sunset factors. We appreciate the role that the Auditor General plays in supporting the legislative Sunset Review process in providing information used to evaluate whether departments are meeting their statutory obligations and continue to be needed in state government.

The Arizona Department of Health Service (ADHS or the Department) serves a critical role in promoting, protecting and improving the health and wellness of all Arizonans as we provide public health services throughout their entire lifecycle. The Department, through approximately 300 programs it administers, serves all 7.1 million Arizonans. Many people may not recognize the impact that public health has on every facet of our daily lives. There are many ways we help improve the lives of all Arizonans, including:

- Protecting the health and lives of all Arizonans by controlling epidemics
- Educating people on healthy habits, such as nutritious eating and getting physical activity
- Assisting people with tobacco cessation and disease self-management
- Ensuring safe food and water
- Testing virtually all newborns for metabolic diseases and serving as the State's only reference laboratory
- Improving access to physical and behavioral health
- Monitoring hospitals, nursing homes, assisted living centers, ambulances, childcare centers and other licensed facilities and professionals
- Documenting every vital event in Arizona including all births, deaths and adoptions

We also operate the Arizona State Hospital (ASH), which provides high acuity, inpatient psychiatric services to our state's most vulnerable residents.

ADHS is proud to be a part of Arizona's strong public health system, providing safe parks, clean air, clean water, safe meals and a healthy environment to raise our families. The work we do adds value to our state and brings health and wellness to all Arizonans. ADHS has been recognized nationally as a leader in public health initiatives and is accredited by the National Public Health Accreditation Board (PHAB).

More information about the Department's objectives and anticipated accomplishments are detailed in the ADHS Fiscal Year 2020 Strategic Plan and the Department's FY18 Annual Report, which is posted online.

We appreciate your report highlighting the important work we do as part of our mission of supporting *Health and Wellness for all Arizonans* and that the Department has met its statutory objective and purpose, and is improving the efficiency with which it has operated. As we have noted in prior communications, we are committed to continuous improvement and will undertake activities that will enhance our processes. However, we are concerned that how your findings are conveyed does not provide adequate context for readers and legislators and could result in misinterpretation of the findings and our overall performance. Because the purpose of the Sunset Review process is to provide overall perspective on the Department's performance to allow legislators to "review the purpose and functions of state agencies to determine whether continuation, revision, consolidation or termination is warranted,"[1] overall context is particularly important in audits that support Sunset Reviews. Therefore, while we will employ strategies that will address the findings, you will see in our response that there are certain findings with which we cannot agree.

For example, in Finding 1, the report makes sweeping statements about public health and safety risks in the context of the auditors' review of 33 complaints and a judgmental sample of 37 self-reports for 5 long-term care facilities that are regulated and funded through an agreement with the federal Centers for Medicare and Medicaid Services (CMS). However, the audit fails to provide context for this analysis and findings. In total, long-term care facilities represent less than 0.5 percent of the total licensees under Department regulation and the sample of 5 facilities represents 0.014% of total licensees under the Department's jurisdiction. The complaints reviewed represent roughly 0.4% of all complaints received by the Department during the two-year period under evaluation. Rather than articulating how the Department performs across this wide range of activities to protect public health and safety and investigating and resolving complaints within its jurisdiction, the audit findings focus on this very narrow non-representative sample. In addition to only

[1] *Handbook on Arizona's Sunset & Sunrise Review*, Fifty-Fourth Legislature, 2019-2020.

representing a small subset of the Department's overall regulatory activity, this sample is even small within the overall long-term care facility regulation framework, which received a total of 4,959 complaints over the two-year period in question.

We would also note that under this federal program overseeing long-term care facilities, the Department performs functions for CMS, who sets the expectations, requirements and funding for the program. The Department is currently in compliance with those requirements as determined CMS. The audit establishes expectations for the Department beyond those that exist in its agreement with CMS or as currently established by the Legislature, including establishing investigation time frames by examining policies in other states without a comprehensive analysis of those other states' requirements and available resources. If the State wants to expand the regulation of this industry beyond the federal requirements, including an evaluation of Arizona's long-term care marketplace and resources needed to meet any additional expectations that are set, the Department would be pleased to participate in those discussions. In summary, we will not detail every individual concern with how the audit articulates its findings. But as a result of these concerns, we cannot agree with Finding 1.

The Department also cannot agree with Finding 3. We take seriously our obligation to protect critical, sensitive and confidential data. ADOA-ASET is the Arizona office responsible for setting the technology, security, privacy, and communication strategies, policies, and procedures for the state of Arizona. ASET's guiding principles include *Driving best-in-class, enterprise-wide security standards through the office of the state Chief Information Security Officer (CISO) in an effort to ensure that all cyber security initiatives are secure and compliant.* To this end, ASET provides leadership, standards and governance across all of state government, leveraging its experts to set expectations and monitor enterprise security controls and state agency activities. The report misrepresents our IT security processes, including using inaccurate terminology to describe activities in the report (e.g., use of the term "breach", which did not occur, but was implied to have occurred in the report). The incident referenced in the audit involved a multistep, complicated process in which an individual would have needed specific knowledge to access the information. Contrary to what is reported in the audit, ADHS's web application development policies and procedures are aligned with ASET and credible industry standards.

In addition, the audit reports that the Department has not conducted a formal Department-wide IT risk assessment since 2015. This misleading statement fails to explain that ASET conducted a state-wide risk assessment several years ago and determined that Arizona

could greatly reduce IT risks by implementing enterprise controls. The Department and other states agencies have focused on implementing these controls over the past few years, including the establishment of RiskSense, a tool used for IT vulnerability management and risk scoring. The RiskSense platform includes the assignment of a safety score which is used to evaluate and monitor each agency's risk exposure. Governor Ducey and ASET set a goal for each state agency to maintain a score of 725 or above; the Department currently exceeds this goal. In addition, the score is updated at least twice a month and Department leadership reviews its performance weekly and allocates resources as needed to address identified issues. Now that these controls have been implemented, the Department plans to return to performing annual risk assessment. The Department believes ASET provides sufficient and appropriate leadership on IT security issues and will continue to work collaboratively with ASET to maintain its agency's information security. It will also implement recommendations that will continue to enhance its procedures.

As discussed above, the wording and issue framing of the audit causes us concern in several instances; we have noted others in our detailed response. Again, we appreciate your recommendations and will implement them, where there is agreement, but we do not believe the audit findings provide a full picture of our overall performance.

We appreciate your partnership and look forward to continuing to advance *Health and Wellness for all Arizonans.*

Sincerely,

Cara M. Christ, MD
Director

Attachment

Finding 1: Department's failure to investigate, or timely investigate or resolve, some long-term care facility complaints and self-reports may put residents at risk

Recommendation 1: To help ensure all long-term care facility complaints and self-reports are prioritized, investigated, and resolved in a timely manner, the Department should:

Recommendation 1a: Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department is currently assigning two additional staff to handle complaints. The ADHS will focus these staff to respond to high priority complaints. However, retention and training remain an issue to keep highly qualified staff at the Department. The Department recognizes however, that it would require significantly more staff to timely investigate all long-term care complaints. Based on estimates and similar work, The Department believes an additional 44 staff and an additional $3.3M of appropriation and GF allocation will be needed to timely adjudicate the nearly 2,500 complaints received annually. Additionally, the Department leadership is utilizing the Arizona Management System and has assigned this project as a breakthrough for the agency to increase the number of high priority complaints investigated on time.

Recommendation 1b: Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department is currently revising its policies and procedures to account for this recommendation. The Department anticipates completion of this effort by April 2020.

Recommendation 1c: Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department is currently revising its policies and procedures to account for this recommendation. The Department anticipates completion of this effort by April 2020.

Recommendation 1d: Develop and implement additional bi-monthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department has developed the necessary management reports and is currently refining and implementing the new monitoring tools.

Recommendation 1e: Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department is currently assigning two additional staff to handle complaints. The Department will focus these staff to respond to high priority complaints. The Department recognizes however, that it would require significantly more staff to timely investigate all long-term care complaints. Based on estimates, the Department believes an additional 44 staff will be needed and an additional $3.3M of appropriation and GF allocation to timely adjudicate the nearly 2,500 complaints received annually.

Recommendation 2: The Legislature should consider forming a task force to study and propose policy options for addressing the Department's timely investigation and processing of long-term care facility complaints and self-reports to help ensure resident health and safety. Options to consider include establishing requirements for investigating all complaints and self-reports, appropriate time frames for conducting investigations of and closing out long-term care facility complaints and self-reports, and reporting performance metrics to the Legislature. Task force members should include appropriate stakeholders, such as legislators, Department representatives, Arizona Department of Economic Security representatives, industry members (i.e., long-term care facility owners or licensed administrators), patient advocates, and if appropriate, a federal CMS representative. Legislation forming the task force should identify task force membership, its overall purpose and expected outcomes, and deadlines for reporting recommendations to the Legislature.

Department Response: The finding of the Auditor General is Choose an item.

Response explanation:

Finding 2: Department did not comply with some conflict-of-interest requirements

Recommendation 3: The Department should continue its efforts to develop and implement a new conflict-of-interest disclosure process and form that will help it comply with the State's conflict-of-interest requirements and best practices, such as having public officials and employees annually disclose whether or not they have any substantial financial and/or decision-making conflicts, and train employees on how the State's conflict-of-interest requirements relate to their unique program, function, or responsibilities.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will complete development, and implement the conflict of interest disclosure process, by April 1, 2020.

Finding 3: Some gaps in Department IT security processes resulted in a security incident and additional IT security weaknesses

Recommendation 4: The Department should develop and implement web application development policies and procedures that incorporate security into the development and modification process, including requirements for gathering security requirements, using up-to-date secure coding standards, performing threat modeling during development, reviewing source code, and performing security testing before releasing a web application to the live environment.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: ADHS' web application development practices align with ASET's policies and credible industry standards; however, our procedures could be enhanced. ADHS will review and update its web application development procedures to ensure that security is fully incorporated and implement any additional areas mentioned that aren't currently being performed (such as threat modeling).

Recommendation 5: The Department should require staff who are responsible for developing web applications to regularly receive role-based training on how to develop and maintain secure web applications.

Department Response: The finding of the Auditor General is not agreed to and the recommendation will not be implemented.

Response explanation: Staff responsible for developing web applications receive ASET Secure Coding training. Developers that are not FTE's are required to have this knowledge and interviews include this type of questioning.

Recommendation 6: The Department should develop and implement revised data classification policies and procedures that provide guidance on how to classify its data; require developing a data classification inventory that is updated regularly; specify requirements for protecting data based on its level of risk; and establish processes for handling confidential data, such as ensuring that only approved devices process confidential data.

Department Response: The finding of the Auditor General is not agreed to and the recommendation will not be implemented.

Response explanation: ADHS has a Data Classification policy that is consistent with State of Arizona policy. Data is classified at the system level. ASET is in the process of working with an agency to pilot a third party tool that will categorize and classify data so we will review the results of this pilot to see if this is something feasible to implement in the future. We are working on implementing the State Data Governance Organization policy to formalize data roles and provide associated training for data owners, data stewards, and data custodians.

Recommendation 7: The Department should conduct a formal Department-wide risk assessment at least annually, as required in its risk assessment policy and procedures, to evaluate, document, and prioritize the areas in the Department's IT environment with the highest security risks.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The last risk assessment the Department had performed was when Behavioral Health Services (BHS) was part of the Department and BHS funded a third party to perform this. Several years ago the state did a risk assessment and determined that the State could greatly reduce IT risks by implementing enterprise controls. The Department has focused on these implementations the last couple of years. One of the controls that was implemented was RiskSense for vulnerability management and risk scoring on a state-wide basis.

Recommendation 8: The Department should develop and implement a revision to its risk assessment policy and procedures to include categorizing the Department's information based on the likelihood of risk and magnitude of harm as required by ASET policy.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department Information Security Program policy is consistent with the State policy. The Department will work to enhance our procedures and standards regarding the categorization of information.

Recommendation 9: The Department should develop and implement revised security awareness training policies and procedures that include a process for ensuring employees and contractors comply with annual basic security awareness and HIPAA training requirements and acceptable use attestations; specify the role-based training that is required based on employees' and contractors' responsibilities; explain how it will implement its security awareness program; describe the topic areas that its security awareness training classes should cover; and specify how it will communicate security awareness training throughout the year

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department has a mature security awareness and HIPAA training program which require initial and ongoing (annual) Security Awareness and HIPAA training per policy. However, the Department hasn't always obtained 100% compliance. The Department will work to improve its compliance on these trainings. We utilize the State Security Awareness computer based training which contains the required content. Security Awareness training and acceptable use attestations were recently completed in June of 2019. HIPAA training for 2019 has been taken historically in the month of December each year, and is scheduled for December of 2019.

Recommendation 10: The Department should continue with its plans to develop and implement role-based training.

Department Response: The finding of the Auditor General is not agreed to, but the recommendation will be implemented.

Response explanation: The Department intends to develop and implement a more formal role-based training program. The state of Arizona has conducted role-based training for IT leaders, Information Security personnel, System Administrators, and Developers over the years and the Department has participated in these trainings. These types of training are not logged into the State's current Learning Management System because that system lacks the capabilities of logging third party training.

Sunset Factor 2: The extent to which the Department has met its statutory objective and purpose and the efficiency with which it has operated.

Recommendation 11: The Department should continue using the electronic grants management system, and ensure that for all future grant evaluations conducted using this system, its grant evaluations clearly indicate whether grant applicants complied with all evaluation criteria and that all evaluation factors are included in the grant solicitation.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will implement the recommendation by April1, 2020.

Sunset Factor 5: The extent to which the Department has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.

Recommendation 12: The Department should develop and implement policies, procedures, and training to help guide the boards, commissions, and councils it supports; and its staff members' compliance with open meeting law requirements.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department has begun to implement this recommendation (training is now being done through the State Ombudsman's Office as suggested on the Attorney General's web site) and will have the recommendation fully implemented by April1, 2020.

Recommendation 13: The Department should develop and implement an oversight process to ensure that the boards, commissions, and councils it supports comply with open meeting law requirements.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department will implement this recommendation by April1, 2020.

Recommendation 14: The Department should update its website to include a conspicuously posted statement indicating the location for all electronic and physical postings of public meeting notices and a complete and accurate listing of all the entities that are subject to open meeting law along with information about their purposes and where to locate information about these entities' public meetings, such as agendas and minutes.

Department Response: The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

Response explanation: The Department has begun to implement this recommendation (statement now posted on ADHS' Administrative Rules' web site) and will have the recommendation fully implemented by April1, 2020.


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