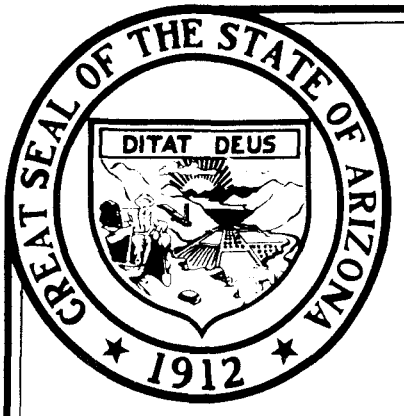

PERFORMANCE AUDIT

DEPARTMENT OF HEALTH SERVICES

SUNSET FACTORS

Report to the Arizona Legislature
By the Auditor General
November 1989
89-11

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November 8, 1989

Members of the Arizona Legislature
The Honorable Rose Mofford, Governor
Mr. Ted Williams, Director
Department of Health Services

Transmitted herewith is a report of the Auditor General, A Performance Audit of Department of Health Services, Sunset Factors. This report is in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. The performance audit was conducted as a part of the Sunset Review set forth in Arizona Revised Statutes §§41-2351 through 41-2379.

The report addresses the twelve statutory Sunset Factors for the Department of Health Services. In addition, it contains a finding on the need for stronger central oversight of DHS' contracting process.

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

Sincerely,

Douglas R. Norton
Auditor General

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SUMMARY

The Office of the Auditor General has prepared agencywide Sunset Factors for the Arizona Department of Health Services (DHS), in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. These factors were prepared as part of the Sunset Review set forth in Arizona Revised Statutes §§41-2351 through 41-2379.

The Arizona Department of Health Services was established in 1974 through the consolidation of the State Department of Health, Arizona Health Planning Authority, Crippled Children Services, Arizona State Hospital, and the Anatomy Board into a single department with a variety of responsibilities.

DHS has 5 divisions and 13 support services offices. The department is programmatically organized by general category to meet public health needs. DHS' five divisions include the Divisions of Behavioral Health Services, Family Health Services, Emergency Medical Services/ Health Care Facilities, Disease Prevention Services, and the State Laboratory. Some of the department's 13 support services offices were previously grouped under a Division of Administration, but this division was dissolved in order to meet recent mandated budget reductions.

During this audit we prepared the twelve statutory Sunset Factors for the department. We also reviewed several administrative functions, and developed a finding on the contracting process.

DHS Contracting Procedures Need Stronger Central Oversight **(see pages 17 through 26)**

DHS needs to strengthen controls over its contracting process. Although contract practices under the direct control of DHS' Contracts Administration Section (CAS) appear strong, contracting procedures outside of CAS' control are weak. The department appears to comply with those provisions of the procurement code for which CAS has authority and responsibility, such as advertising, approval signatures, and inclusion

of certain required information in solicitation documents. However, CAS typically has no involvement in evaluating proposals, selecting contractors, or negotiating contract terms. As a result, the section cannot verify whether program staff comply with procurement code requirements for those stages. In addition, CAS' role stops as soon as the contract is signed, leaving program staff solely responsible for all subsequent phases of contract management.

Our audit work also revealed weaknesses in the awarding and monitoring of contracts. Although we did not document widespread problems throughout the department, the analysis does indicate problems with individual offices and divisions and the policies they practice. For example, the Office of Emergency Services (OEMS) (under the Division of Emergency Medical Services/Health Care Facilities) had to reissue fiscal year 1988 request for proposals (RFP) because the contracts were awarded based on factors not listed in the RFP. We found other examples where programs failed to create or retain contract award documentation as required by law. Also, audit work indicates there is poor contract monitoring in several divisions or programs. This lack of monitoring could make it difficult to terminate a contract for poor performance.

Stronger participation by CAS could address some of the control and monitoring problems we identified. First, since CAS has expertise in contracting and familiarity with the procurement law, the section should directly participate in all phases of the procurement process and overall contract management. Second, CAS should also participate in the awarding and evaluating of the contracts. Presently, those evaluating contract proposals consist largely of program staff who have prior or current involvement with contract providers. Including CAS in the process could reduce the opportunities for bias and abuse. However, in the past several years CAS' staff has been reduced from six to three positions and CAS may not currently have enough staff to adequately participate in this process.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has prepared agencywide Sunset Factors for the Department of Health Services (DHS) in response to a June 2, 1987, resolution of the Joint Legislative Oversight Committee. These Sunset factors were prepared as a part of the Sunset Review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

DHS was created in 1974 pursuant to A.R.S. §36-102 et seq. by consolidating several agencies into a single department with a variety of responsibilities. These agencies included the State Department of Health, Arizona Health Planning Authority, Crippled Children Services, Arizona State Hospital, and the Anatomy Board.

Organization

DHS has 5 divisions and 13 support services offices. The department is programmatically organized by general category to meet public health needs. DHS' five divisions include the Divisions of Behavioral Health Services, Family Health Services, Disease Prevention Services, and Emergency Medical Services/Health Care Facilities, and the State Laboratory. Below is a brief description of each division.

- **Division of Behavioral Health Services** - The division is responsible for operating the Arizona State Hospital and Southern Arizona Mental Health Center. It also provides services through the Office of Community Behavioral Health. The Arizona State Hospital is located in Phoenix and provides in-patient psychiatric care and treatment for residents suffering from severe mental and emotional illnesses and disorders. The Southern Arizona Mental Health Center in Tucson is a State operated treatment center providing specialized mental health services to residents of Pima County and Southern Arizona. The Office of Community Behavioral Health Services contracts with regional nonprofit entities to provide a program of prevention, intervention, and treatment services in the areas of substance abuse, mental illness, and domestic violence.

- **Division of Family Health Services** - The four program offices of Family Health provide a variety of services for women, children, and elderly people. The division offers supplemental food programs through the Office of Nutrition Services. The Office of Children's Rehabilitative Services provides a wide range of health care to Arizona children with special needs such as chronic illness or

handicapping condition. The Office of Dental Health organizes a variety of dental health programs focusing on preventive services.

The Office of Maternal and Child Health offers a variety of programs to promote optimal health of newborns and children 0-18 years of age including a midwife licensing program, perinatal care, and family planning programs.

- **Division of Disease Prevention Services** - The division engages in a variety of public health activities including a birth defects and cancer registry, inspecting wholesale food establishments, AIDS education and counseling, monitoring sexually transmitted diseases, tuberculosis control and environmental, chronic, infectious disease, epidemiological and educational initiatives.

- **Division of Emergency Medical Services/Health Care Facilities** - The division establishes standards and reviews services provided by hospitals, health maintenance organizations, surgicenters, specialized health care centers, nursing homes, supervisory care facilities, and child day-care centers. The division also regulates ambulance service and certifies emergency medical technicians.

- **State Laboratory** - The State lab provides laboratory services to State and local government agencies, hospitals, and independent laboratories. The lab also conducts annual inspections of other laboratories. In addition, the division conducts technical training for laboratorians to maintain or improve their diagnostic and analytical capabilities.

The department has 13 offices which provide support services.[1] Previously, some of these support services were grouped under a Division of Administration, but this division office has been dissolved due to mandated budget cuts. Thirty-one FTEs were cut from DHS' Division of Administration activities in fiscal year 1987-88. According to DHS management, department cutbacks mandated by the Executive Budget Office and the Legislature in recent years were absorbed by personnel cuts in the Division of Administration. Attrition in this office and continued efforts to reduce costs without cuts in service led to the department's decision to eliminate the division. The administrative oversight duties are now assumed by the Director's Office.

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(1) The 13 offices are Administrative Counsel, Affirmative Action, Auditing Office, Management Information Systems, Financial Services, Business Office, Local and Border Health, Personnel Management, Planning and Health Status Monitoring, Public Information Office, Special Investigations, Staff Development & Training, and Vital Records.

Staffing and Budget

DHS has a total of 1,501.5 State funded and 147.32 federally funded positions within the 5 divisions and 13 support services offices for fiscal year 1989-90.

The Department of Health Services receives operating money from the federal government and a general fund appropriation. State funding was approximately $145 million in fiscal year 1987-88. The agency receives money from the federal government in the form of grants. In 1989-90, the department will receive an estimated $42 million in federal grant monies. The bulk of this money will go to the Division of Family Health Services to fund such programs as Supplemental Food Program - Women, Infants, and Children (WIC), Dental Health Education for the Aging and Elderly, and Child/Adolescent Injury Prevention Initiative.

The department's and divisions' general fund expenditures for fiscal years 1986-87 through 1988-89 are shown in Table 1 (page 4).

Scope of Audit

We addressed the 12 statutory Sunset Factors. Analysis of DHS' performance regarding these factors is presented on pages 7 through 16. In addition, we reviewed DHS' contracting process, the expansion of DHS' management information systems, and other administrative activities. Based on this review we developed a Finding on the contracting process (see pages 17 through 26), and Other Pertinent Information on the management information systems (see pages 27 through 31).

TABLE 1

DEPARTMENT OF HEALTH SERVICES
STATEMENT OF ACTUAL EXPENDITURES - ALL FUNDS
FISCAL YEARS 1986-87 THROUGH 1988-89
(unaudited)

	Actual 1986-87	Actual 1987-88	Actual 1988-89
Division:			
Office of the Director	$ 37,421,272	$ 3,132,389	$ 7,508 (a)
Administration	9,562,374	8,525,941	11,966,815 (a)
Southern Arizona Mental Health Center	3,123,679	-0-	-0- (b)
Behavioral Health Services	33,838,668	76,115,921	95,963,399 (a)
Environmental Health Services	20,484,553	10,878	-0- (c)
Disease Control	6,782,282	7,460,047	9,122,402
Family Health	34,874,441	41,087,839	43,184,819
Emergency Medical Services/ Health Care Facilities	3,150,048	5,809,123	6,657,490
Laboratory Services	4,812,848	2,582,684	2,848,394
Total Divisions	$154,050,165	$144,724,822	$169,750,827
Expenditures:			
Personal services	$ 40,317,007	$ 34,913,446	$ 38,371,043
Employee-related	9,628,144	8,079,214	9,513,603
Professional and outside services	15,264,343	4,827,668	6,408,968
Travel, in-state	598,917	429,882	443,824
out-of-state	111,912	92,424	149,050
Food	1,897,298	1,881,414	1,942,810
Aid to organizations	61,882,149	66,825,188	82,722,469
Aid to individuals	10,046,704	14,427,022	15,025,027
Other operating	11,067,839	10,681,556	12,129,695
Capital outlay	3,234,852	2,567,008	3,044,338
Total Expenditures	$154,050,165	$144,724,822	$169,750,827

(a) Internal restructuring during this period transferred behavioral health expenditures from the Office of the Director to a separate division, and combined Administration and the Office of the Director into a single division.

(b) Southern Arizona Mental Health Center was incorporated into the Division of Behavioral Health Services.

(c) Environmental Health Services was removed from DHS to become the Department of Environmental Quality.

Source: Arizona Financial Information System

This audit was conducted in accordance with generally accepted governmental auditing standards.

The Auditor General and staff express appreciation to the Director and staff of the Department of Health Services for their cooperation and assistance during the audit.

SUNSET FACTORS

In accordance with A.R.S. §41-2354, the Legislature should consider the following 12 factors in determining whether the Department of Health Services (DHS) should be continued or terminated.

1. **Objective and purpose in establishing the agency**

DHS was established in 1974 (A.R.S. §36-102 et seq.) by consolidating several agencies into a single department with a variety of responsibilities. These agencies included the State Department of Health, Arizona Health Planning Authority, Crippled Children Services, Arizona State Hospital, and the Anatomy Board. According to the department's enabling act, DHS is responsible for providing or promoting the following seven activities:

> "...1) quality health care in coordination with the private sector providers, to the citizens of this state; 2) cost control mechanisms that will insure that the costs of health care to the citizens of this state are justified and equitable; 3) control of quantity and quality of health care facilities within the state; 4) necessary health services for medically dependent citizens of this state; 5) essential health care services, including but not limited to, emergency medicine, preventive medicine, mental, maternal, and medical rehabilitation; 6) comprehensive and continuing planning, including assessment, identification and publication of health needs in this state; 7) compliance with standards in licensing of health facilities."

2. **The effectiveness with which the agency has met its objective and purpose and the efficiency with which it has operated**

DHS has been effective in meeting its overall objective and purpose. However, our previous reports identified numerous ways the Department of Health Services could improve its efficiency and effectiveness. In this report, we recommend that DHS improve its overall contracting process by increasing its Contract Administration Section's involvement in the process. The section's expanded role would include participation in all phases of contractor selection and development and implementation of monitoring procedures.

In addition, our other audit work in the department showed that efficiency and effectiveness could be improved within each of the divisions or offices we reviewed. In some of these areas the department was at the time of the audit, evaluating a course of action or action was in process to implement changes recommended in the audit. In other areas, the department has since made or is in the process of making recommended changes.

- The Health Care Facilities Function (HCFF) could increase its effectiveness through the use of a stronger enforcement policy for nursing and supervisory care homes. In several cases DHS failed to use available enforcement options, allowing some day-care centers and nursing homes to repeatedly violate state rules and regulations (see performance audit report 88-5). The department has recently strengthened its enforcement policies in each area by developing procedures manuals, assigning enforcement responsibilities to specific employees and making greater use of intermediate sanctions.

- The Office of Emergency Medical Services (OEMS) could increase its ability to measure emergency medical technician (EMT) competence by adopting an examination that validly measures critical skills. We found OEMS gave the identical examination year after year and recommended that the office use the national registry examination for EMTs (see performance audit report 88-12). Since our audit, the office has obtained a bank of valid questions that can be used to generate new examinations.

- Efficiency of the Women, Infants, and Children Program (WIC) in the Division of Family Health Services (FHS) could be enhanced by implementing an infant formula rebate program similar to programs used in other states. Auditor General analysis found that Arizona could save as much as $310,000 per month by instituting the new program. This would allow the State to serve an additional 6,900 people. The department was evaluating an infant formula rebate program at the time of the audit and has since implemented a rebate program. Another FHS program,

Children's Rehabilitative Services (CRS), may not be addressing the most significant medical problems of its clients. Serious illnesses such as hemophilia and bronchopulmonary displasia are not funded, while other illnesses which are easily treated are funded (see performance audit report 89-1). CRS is currently reviewing its medical eligibility criteria to determine whether specific conditions should be added or deleted.

- The Division of Disease Prevention Services could improve reporting of sexually transmitted diseases. For example, we found that the division could better utilize laboratory reports, increase its contacts with health care providers, work with medical licensing boards, distribute mass mailings, and make periodic contacts with randomly selected health providers throughout the State in an effort to ensure consistency in reporting (see performance audit report 89-2). The division has since initiated efforts in many of these areas to improve reporting.

- The Arizona State Hospital (ASH) has difficulty providing adequate staff on its treatment units due to its extreme staffing problems. Because of the type of seriously ill patients the hospital is dealing with, it is important to have adequate staff. However, shortages of staff are a common occurrence on the treatment units. These shortages stem from the hospital's high turnover and extended vacancies. Some of ASH's efforts to cover the shortages caused by the vacancies actually increase the problem. ASH should address problems contributing to turnover, and should also consider a comprehensive study to determine its long-term staffing needs (see performance audit report 89-9).

- The Office of Vital Records (OVR) can increase efficiency and customer service in several ways. OVR can better utilize its in-house computer system. Most birth certificates issued are photocopies of the original records rather than the faster-to-produce, computer-generated copies. In addition, OVR needs to improve its record storage room. The present facility

lacks adequate physical security and has poor climate controls. (The department has requested funds to address these problems in the last three budget requests.) Further, weak and limited internal controls provide opportunity for OVR employees to make unauthorized use of records (see performance audit report 89-5).

- The Division of Behavioral Health Services has been lax in monitoring the performance of administrative entities. Important deficiencies and problems have gone undiscovered or uncorrected because the department is not conducting adequate site visits, verifying services, or following up when problems are discovered. Monitoring has not been a management priority, and staff responsible for monitoring entities have not received clear direction (see performance audit report 89-10).

3. **The extent to which the agency has operated within the public interest**

The Department of Health Services has generally operated in the public interest by developing, coordinating, monitoring, and providing health care and health care related activities. For example, the Division of Disease Prevention Services coordinates immunization programs with the counties to protect citizens from whooping cough and measles; the Office of Emergency Medical Services provides monies to rural emergency service providers in attempts to ensure that all citizens receive adequate emergency medical care; the Division of Family Health Services administers the U.S. Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children to improve the nutrition of low income pregnant and postpartum women, and children under the age of five; the Division of Emergency Medical Services/Health Care Facilities Long-Term Care Office provides technical assistance, related support services, and information to individuals, families, and long-term health care providers.

In our audits of the department, we identified ways DHS can better protect the public's interest. These activities include improvement of testing procedures for emergency medical technicians

(see performance audit report 88-12), better inspection of and follow-up on nursing home violations (see performance audit report 88-5), and improved public notification of meetings held by the Governor's Task Force on AIDS (see performance audit report 89-2). Follow up contacts with the department indicate that it is acting in each of these areas.

4. **The extent to which rules and regulations promulgated by the agency are consistent with the legislative mandate**

The department's rules and regulations appear to be consistent with its legislative mandate. The Attorney General's Office, the Governor's Regulatory Review Council, and DHS' Administrative Counsel are all responsible for reviewing agency rules and regulations to determine if they are consistent with statute. The department has attempted to involve its own administrative counsel early in the process to ensure necessity and legality of the proposed rules. In addition, rules proposals are reviewed by the Governor's Review Council for comments. Public hearings are then held. Finally, the Attorney General's Office reviews department rules through the formal certification process as required by law.

5. **The extent to which the agency has encouraged input from the public before promulgating its rules and regulations and the extent to which it has informed the public as to its actions and their expected impact on the public**

Typically, rule promulgation in the Department of Health Services is initiated by division program staff. This usually happens in response to new legislation or a need to update existing rules. Draft rules are reviewed by the assistant directors, then forwarded to the Office of Administrative Counsel for confirmation. Drafts may then be mailed to interested parties for comments, or a seminar may be conducted to explain the extent of the rules and gather input. Any revisions to the proposal are also reviewed and approved before submitting the rules to the director for official action.

Rule proposals are sent to each of the local health officers for posting. When a rule proposal is likely to be controversial, a press release is also issued. Anyone may obtain a copy of the proposed rule from the department at any time. After the rule is approved by the Governor's Regulatory Review Council, an informative summary of the rule is printed and distributed by the Office of the Secretary of State. Public hearings, when scheduled, are usually held in three to five locations statewide. Public comments whether written or oral are accepted up to at least one week after the final public hearing.

6. **The extent to which the agency has been able to investigate and resolve complaints within its jurisdiction**

The department has not aggressively pursued or resolved complaints in several cases. Our review of the Office of Emergency Medical Services, the Health Care Facilities Function, and the Division of Family Health Services found various problems with complaint resolution. First, the Office of Emergency Medical Services has lost or mishandled complaints. The office was unable to tell how many complaints it had received and what action was taken. The majority of the complaints received that we documented were never investigated (see performance audit report 88-12). Second, a review of complaints concerning nursing homes and day-care centers found many that contained serious allegations that had not been adequately addressed by the Health Care Facilities Function, Health Care Licensing Office. Many of these allegations were later substantiated by the division's own inspectors. However, little or no action was taken by DHS (see performance audit report 88-5). Finally, our audit work in the Division of Family Health Services, Midwife and Hearing Aid Dispensers (HAD) licensing programs, found a history of poor complaint handling and resolution. The HAD program did not track or log its complaints. The midwife licensing program lacked any formal complaint tracking and investigation system (see performance audit report 89-1).

To improve complaint handling in these three areas, the department has taken various steps. The Office of Emergency Medical Services has established an automated complaint tracking process. This should help the office respond and investigate complaints in a more timely manner. In addition, DHS has recommended laws to strengthen enforcement options in the health care functions area. DHS officials feel that several statutory changes will give the Health Care Facilities Function more enforcement power. According to department officials, this should help to more quickly resolve complaints against repeat offenders. In addition, these statutory changes should help DHS improve efforts to validate complaints against licensees. Finally, the Division of Family Health Services has added a complaint tracking system to govern midwife and HAD complaints. Also, FHS is revising complaint investigations procedures. Both actions should allow the division to respond to complaints in a more timely manner.

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

The Attorney General, the County Attorneys, and the local county health boards all have authority under department statutes to prosecute unlawful actions under DHS enabling legislation. According to the department, depending on the division and the type of unlawful act that has occurred, the responsible prosecuting entity is contacted. The matter is then pursued by that entity. For example, any legal actions needed in the Health Care Facilities Function relating to nursing homes would be handled by the Health Care Licensure Office within that division with the assistance of the Attorney General's Office and the County Attorney of the county in which the home operates.

8. **The extent to which the agency has addressed deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandates**

During the 1989 legislative session DHS requested or supported, and

the Legislature approved, numerous bills to address specific statutory deficiencies. Some key pieces of legislation introduced and approved are as follows.

- **HB 2013 - Mental Health; Treatment**

  The legislation clarifies confidentiality statutes for family involvement and requires a case manager/community agency to which a patient of ASH is being transferred to be involved in the patient's plan of care. The legislation also defines the duty of mental health providers to warn identifiable victims of imminent and explicit threat.

- **HB 2419 - Day Care; Intermediate Sanctions**

  The law strengthens the department's ability to take action against day-care centers and day-care group homes. The law provides for intermediate sanctions such as bans on admissions, mandatory capacity reductions, and termination of specific services. It deletes the provision requiring the department to make on-site visits to document each day of a violation.

  HB 2419 was based on recommendations from our office that DHS strengthen statutes to take intermediate sanctions against licensed health care facilities.

- **SB 1312 - Children Camps**

  This law allows DHS to delegate responsibility for licensing and inspecting children's camps to county health departments.

- **SB 1355 - Health Care Licensure**

  The law allows the department to establish and collect license and building permit fees for health care institutions. It also allows the department to establish rules for background checks of applicants who seek health care licenses and gives the department the authority to establish rules for denying those same applicants.

- SB 1414 - Fingerprinting

  The law allows DHS to fingerprint children's behavioral health services contract provider personnel. In addition, manslaughter and aggravated assault were added to the list of criminal offenses that can be identified through the fingerprint registration program.

In addition, 20 other bills which impact the department and its operations were passed.

9. **The extent to which changes are necessary in the laws of the agency to adequately comply with the factors listed in the Sunset Law**

Based on our audits of the Department of Health Services, we have recommended in previous reports that the Legislature consider the following changes to DHS statutes.

- Provide DHS with statutory authority to impose fees adequate to recover costs for examining and certifying emergency medical technician applicants (see performance audit report 88-12).

- Amend A.R.S. §§36-1901 through 36-1938 to give DHS the authority to order hearing aid dispenser licensees to make restitution to complainants. In addition, amend A.R.S. §§36-751 through 36-757 to give midwife licensing program personnel the authority to access patient records from the admitting hospital (see performance audit report 89-1).

10. **The extent to which the termination of the agency would significantly harm the public health, safety, or welfare**

Regulation of health care and health care related activities is necessary for the protection of the public health, safety, and welfare. The need for the control, guidance, education, intervention, and monitoring of health care and its activities is well established. All 50 states and the federal government regulate health care activities, although regulatory structures vary dramatically. Terminating DHS would probably require that

other State agencies or local governments assume the department's current responsibilities.

11. **The extent to which the level of regulation exercised by the agency is appropriate and whether less or more stringent levels of regulation would be appropriate**

Our audit work suggests that the Department of Health Services regulation is appropriate in most areas. However, audit work conducted in the Office of Emergency Medical Services and Health Care Facilities Function indicate stronger regulatory action may be needed to ensure compliance with all applicable State laws. In addition, our work suggests that stronger enforcement actions may be needed (see performance audit reports 88-5 and 88-12).

12. **The extent to which the agency has used private contractors in the performance of its duties and how effective use of the private contractors could be accomplished**

DHS uses contracting extensively. The department contracted for over $106 million in professional and outside services in fiscal year 1988.

FINDING I

DHS CONTRACTING PROCEDURES NEED STRONGER CENTRAL OVERSIGHT

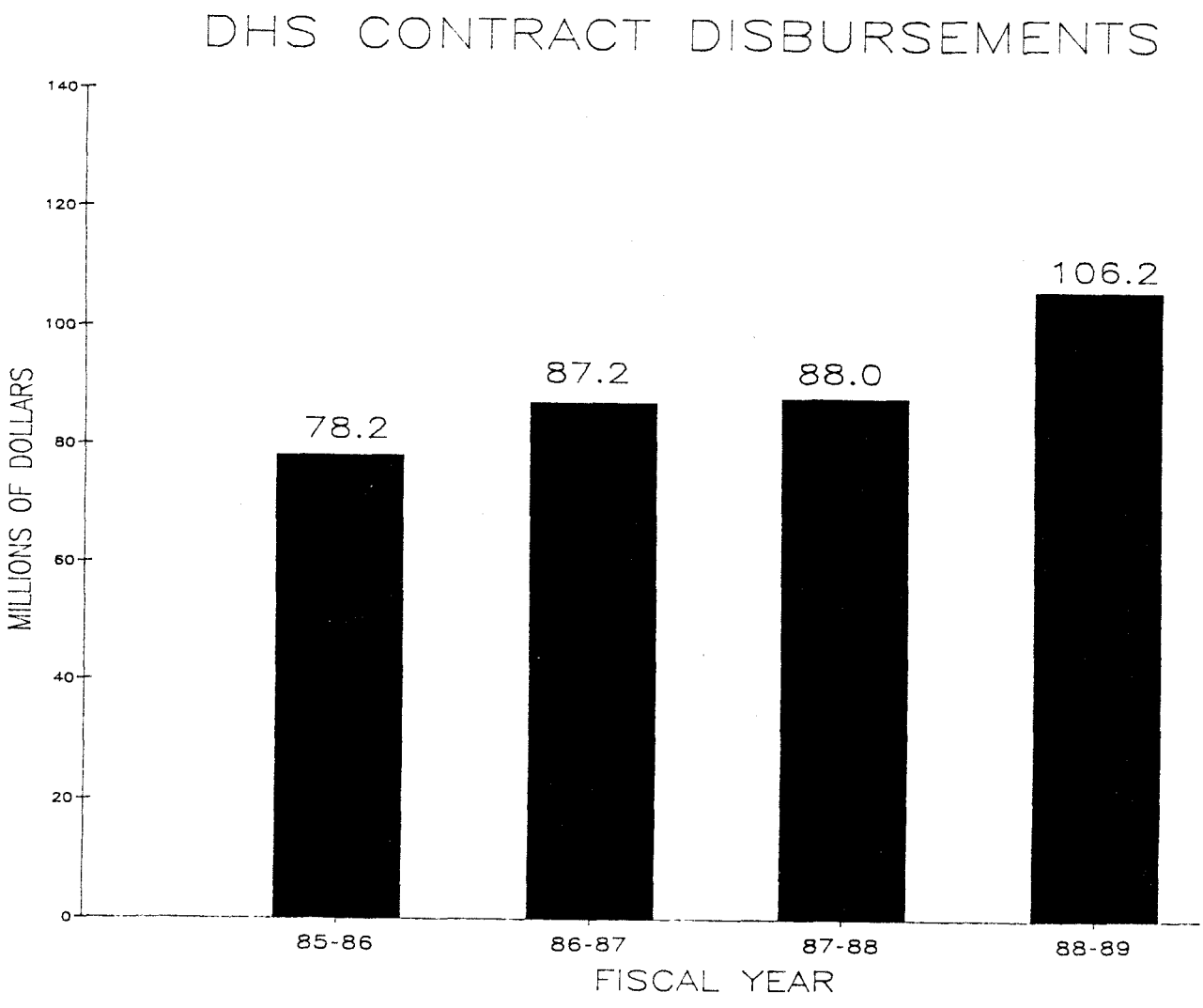
The Department of Health Services needs to strengthen control over its contracting process. DHS spent more than $106 million for contract services in fiscal year 1989, with authority for the contracts scattered throughout the department. However, DHS has little systematic control over many aspects of its contracting process. DHS policy gives program managers extensive responsibilities involving contracts. However, due to staff reductions in the Contracts Administration Section (CAS), limited support and oversight is available to the program managers from persons knowledgable in contracting procedures. Moreover, DHS' policy of decentralization provides little opportunity for division or program staff to share solutions to common problems. Stronger participation by the Contracts Administration Section could improve contracting practices and facilitate communication.

Contracting Responsibilities and Activities within DHS Are Very Decentralized

DHS spends millions of dollars each year for contract services. During fiscal year 1988-89 the department spent $106 million (see Figure 1, page 18) on 1,046 contracts and amendments. All five divisions and the director's office use contracts to obtain goods and services. Two divisions, Behavioral Health Services and Family Health Services, accounted for 91 percent of the department's contract expenditures for fiscal year 1988-89. DHS contract costs are growing: expenditures for fiscal year 1988-89 were 36 percent above contract costs in fiscal year 1985-86.

DHS uses contracts to address some of its most significant responsibilities. Most of DHS' behavioral health services budget, for example, is allocated to organizations under contract to DHS. The department also contracts with county health departments to provide a wide array of public health services.

Figure 1



Source: Fiscal Year 1986, 1987, and 1989 supplied by DHS. Fiscal year 1988 from Auditor General analysis of AFIS data.

Because contract services are a significant aspect of DHS operations, Auditor General staff conducted an extensive sample review of contracts for fiscal year 1987-88.[1] Overall, the sample showed no widespread, serious problems with DHS contracts. However, our review identified the potential for problems, especially in view of the limited controls in place for most contracting decisions.

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(1) The sample consisted of 184 contracts selected from the department's fiscal year 1987-88 contracts. Base data was collected for all 184 contracts. However, data and time limitations led audit staff to focus on a sample subset of 42 contracts.

CAS Has Very Limited Control Over Contracting Process

Although some contracting activities are administered by the Contracts Administration Section (CAS), the section has limited responsibility. The Contracts Administration Section is responsible for ensuring that contracts comply with State law and for maintaining contract documentation. However, CAS has no responsibility for many critical aspects of the process. Program staff are responsible for much of the significant activity.

CAS has procedural role - DHS' Contracts Administration Section is responsible for ensuring that contracts comply with the Arizona Procurement Code or other relevant statutes. CAS checks solicitations prepared by program staff for use of the correct procurement method and inclusion of all information required by the code. The section obtains any required approvals from the Department of Administration, other State agencies, and other offices within DHS. It advertises solicitations and distributes them to interested parties. CAS maintains contract logs, and functions as the department's custodian of final contract and solicitation documents. Most importantly, CAS' contract management specialists review contracts and intergovernmental agreements for completeness and compliance with relevant statutes, rules, and regulations.

Our review of DHS' 1987-88 contracts revealed strong control practices in areas under the direct control of DHS' CAS. The department appears to have good compliance with some provisions of the procurement code. These provisions are ones for which DHS' Contracts Administration Section has authority as well as responsibility, such as advertising, approval signatures, and the inclusion of certain required information in solicitation documents.

No responsibility for critical aspects of process - Although the Contracts Administration Section is responsible for ensuring that contracts comply with statutes and regulations, its authority is limited in most contract decisions. For example, CAS typically is not involved in evaluating proposals, selecting contractors, or negotiating contract

terms. As a result, CAS cannot verify whether program staff comply with procurement code requirements for those stages. In addition, CAS' role stops as soon as the contract is signed, leaving program staff solely responsible for all subsequent phases of contract management.

Responsibility for Overall Contract Management Occurs at Program Level

Most responsibility for contract management is at the program level. DHS' program staff are responsible for developing and monitoring contracts. Because program staff are not trained as purchasing or contracting experts, the manner in which they meet these responsibilities varies from program to program. Systematic procedures are not available throughout the department to ensure fair and open competition. Monitoring procedures are inconsistent, and do not adequately verify whether contracted services are being rendered or whether costs are appropriate.

Program staff responsible for majority of contracting activities - DHS program staff have primary responsibility for developing and monitoring contracts. Because these individuals have knowledge, experience, and professional contacts within their specialties, DHS management believes they are best able to make all program decisions, including those related to contracts. DHS relies on program staff to identify needs for services and write solicitation documents and contracts. In addition, program staff supply names of potential bidders, evaluate proposals, and select successful bidders. Program staff negotiate contract prices and work statements. After contracts are in place, program staff work with contractors to assure the success of the program. They provide assistance and supervision during the life of the contract. Finally, program staff are responsible for monitoring contract performance and authorizing payments to contractors.

These current procedures can place a burden on program staff. The Newborn Intensive Care program, for example, has 66 contracts but only one professional and four support staff to administer the program. In addition to their responsibility for making intensive care available to

all infants who need it, they are also responsible for developing and implementing the procedures for monitoring the 66 contracts to ensure that the State's money is used efficiently.

Award process has significant weaknesses - DHS lacks systematic procedures to assure that contracts are awarded fairly. Although we did not document widespread problems throughout the department, the information we did obtain indicates problems and weaknesses with individual offices and divisions and the policies they practice. Some DHS programs have allowed questionable contracting practices and violated provisions of the procurement code. This places the department at potential risk when dissatisfied bidders protest contract awards. The following four examples illustrate some of the DHS' questionable contract practices.

- Because the procurement code does not require advertising for quotations under $10,000, program staff may solicit as few as three bids for some professional services contracts. One office relies on word of mouth to identify these potential bidders. Documentation indicates this practice was apparent in two contracts that appeared in our sample from the Office of Dental Health. Such practices could raise questions of favoritism. Although advertising is not required by law in these cases, good business practice supports and departmental policy requires obtaining multiple bids for any procurement. This promotes competition and helps protect against collusion.

- Some contract award decisions have been based on factors not listed in the Request for Proposals (RFP). This has been a serious problem in the Office of Emergency Medical Services (OEMS). In fiscal year 1988, OEMS was forced to reissue the RFP for 75 provider grants because in CAS' assessment, it would be unable to defend its decisions against protests.

- Although the State procurement code requires them to do so, at least two programs do not always create or retain documentation of the basis for contract awards. Because DHS relies on program staff to keep these records, central management cannot easily determine whether awards are made in compliance with the law. This problem was identified with the 75 OEMS grants, Newborn Intensive Care professional services contracts. In addition, OEMS has a new 11-page evaluation form but still does not document the basis for an award. Documentation is the department's protection against protests by rejected bidders.

- Additional contract reviews indicated that in areas of automation and health care professional services, DHS has written some solicitations with specifications so restrictive that only one bidder could respond. This impairs the competition that the State procurement

code relies on to keep prices fair. One contract for computers and computer software was protested by other bidders on these grounds. In a case involving lab equipment, DHS rectified the problem by amending the "Invitation For Bid" (IFB). In a similar case, the protester's price was so much higher than the successful bidder's that changing the IFB would not have mattered. Therefore, DHS denied the protest. The protester appealed the decision to the Department of Administration, but later withdrew the appeal.

Finally, one program has not followed DHS' policy that all contracts be reviewed and approved by CAS. As a result, DHS could be held to unacceptable or outdated contract provisions in some of its fiscal year 1989-90 contracts. CAS review allows division staff and CAS to determine if the contract contains appropriate language. Even though standard DHS policy requires that all contracts be reviewed and approved by CAS, CAS has no authority to require programs to meet specific deadlines to ensure adequate time for review and correction. One division submitted 41 final 1989-90 contracts with amendments at the end of the day before the contracts were to begin, thus, making it impossible for CAS to review them before DHS signed the contracts. However, the contracts included errors. For example, DHS changed its general provisions in 1988, but 21 of these late contracts had the 1986 version instead. The general provisions are an important part of all contracts and cover such matters as disputes, warranty, and recovery of contract payments.

DHS contract monitoring is uneven - DHS lacks a formal contract monitoring system and central oversight of the monitoring function. Some DHS program managers do little to ensure compliance with contract terms.

Contract monitoring is important to ensure service provider accountability and compliance with stated terms and conditions of the contract. Although government agencies can delegate a governmental function through a contract, they are still responsible for that function. Effective monitoring verifies that the function is performed. We identified several areas where monitoring appears weak.

- One program which contracts for in-patient newborn intensive care services relies on accreditation by an outside agency and the contractors' internal quality assurance systems as adequate proof of contract compliance by hospitals. Accreditation is based on a hospital's ability to provide services. Quality assurance systems monitor medical performance in terms of quality of service. Neither,

however, reviews whether a hospital has actually provided services required by DHS contracts. Although the program budgeted $3.5 million for contractors in fiscal year 1989, it does not do any formal contract monitoring to assure compliance with contract provisions.

- One program chief reports tracking at least two contractors through regular meetings and planning sessions. However, he keeps no written records of these meetings. This could make it difficult to terminate a contract for poor performance. In addition, because complete written records are not available, the department may be unable to document contractor compliance in the event of the program chief's termination or departure.

- In one division, contracts are not aggressively monitored for compliance. In the Division of Behavioral Health Services, we found that contract performance is not monitored through visiting sites, verifying services, or following up when problems are discovered. The contracts in question have complex requirements and involve many millions of dollars. Therefore, effective monitoring is essential.

In contrast, auditors identified one area where the department is making progress towards strong monitoring. In the Division of Family Health Services, staff are implementing a quality assurance plan which includes contract monitoring. When fully operational, this may provide an effective means of evaluating contract compliance.

Stronger Participation by CAS Could Address Many of DHS' Contracting Control Problems

Stronger participation by CAS could address many of the control problems noted in preceding sections. DHS may need more staff, however, to adopt this change and establish effective control over its many contracts. In addition to improving control, central and/or stronger oversight could enhance communication of ideas among programs staff.

CAS participation would strengthen control - Contracting standards require that the Contracts Administration Section be involved in contract development and selection as a check on program areas. According to the State purchasing director and professional procurement literature, CAS staff should directly participate in most of the procurement process. The State purchasing director recommends CAS staff involvement for several reasons. First, CAS staff have the expertise in contracting and familiarity with procurement law that program area staff may not have. Contracts Administration Section involvement can ensure that DHS complies with the State procurement code. Second, direct participation by CAS

personnel in awarding and evaluating contract proposals could reduce the potential for bias. Currently, bias may occur, or it may appear that the process is biased, because those evaluating the proposals (program area personnel) consist largely of program staff who have prior or continuing involvement with current providers. Thus, outside review or participation in these duties and responsibilities would lessen or reduce the opportunity for bias.

Staff may need to be increased - The Contracts Administration Section may not have enough staff to adequately participate in and oversee the contracting process. CAS has only two contract administrator positions, one of which is currently vacant, to oversee 581 contracts and 465 amendments valued at $106 million. As shown in Figure 1 (page 18), the dollar amount expended on contracted services has increased 36 percent in the past four years. At the same time, the number of staff has actually decreased, from four grade 20 health planning consultants and two grade 15 administrative assistants to two grade 19 contract management specialists and one grade 13 administrative assistant. According to the DHS director, the department made a conscious decision to reduce administrative personnel to meet mandated budget cuts instead of eliminating programs or services to the general public. Consequently, adequate staff or positions are not available for CAS to perform additional day-to-day contract monitoring activities. The limited staff available for these activities reduces the department's ability to effectively control contracts.

Central and/or stronger participation could improve communication - Some DHS program managers have developed solutions to contract-related problems that exist throughout DHS, but these solutions are not being shared. The following examples found within DHS illustrate answers to some of DHS' contracting problems.

- The Division of Disease Prevention Services has a simple and effective system for writing contracts. It builds draft contracts from a set of standard paragraphs maintained on its computer system. This enables the division to avoid the typographical errors and unacceptable contract language that create delays for other divisions.

Behavioral Health Services (BHS) on the other hand, was working on manually searching for and correcting typographical errors until a week before the planned effective date of their 1989-90 contracts. As mentioned earlier, BHS ultimately submitted its contracts for the director's signature on the day before the contracts' effective date.

- Child Rehabilitative Services (CRS) writes only one main contract for physicians' services, and any physician may apply to join the "medical staff" in order to be authorized for payment under that contract. This frees CRS staff from handling contracts for each individual physician.

  Newborn Intensive Care Program (NIC) contracts separately with at least 25 physicians and physician groups. This appears to place an unnecessary burden on NIC's two-person staff.

- NIC's funds are inadequate to pay hospitals for all the care they provide for NIC infants, so NIC has devised a funding formula based on the number of infants treated and the amount written off by the hospitals in prior years. Hospitals appear to be satisfied with this arrangement.

  The Office of Emergency Medical Services (OEMS), with a similar funding situation, allocates money by a method which changes every year. OEMS service providers filed three protests against the allocations which resulted from the use of this method for the 1987-88 contracts.

- Finally, as was indicated earlier, Family Health Services has developed a quality assurance plan to ensure that programs are as effective as possible and consistent with the division's overall goals. Such a process could be beneficial to all divisions and programs.

Many of these innovative procedures streamline contract administration and strengthen overall control. They appear particularly valuable because they represent DHS' solutions to its own problems. However, without an organized approach to disseminating these ideas, divisions may not become aware of potentially useful procedures. Greater participation in the contracting process by CAS may provide an effective means for disseminating these ideas.

RECOMMENDATIONS

1. The department should strengthen contracting procedures by increasing CAS' participation in the contracting process. Specifically, DHS should:

- Establish and follow a systematic method of selecting and awarding contracts. It should mandate that CAS actively participate in the selection process.

- Develop formal contract monitoring procedures to ensure adequate and consistent monitoring efforts throughout the department. It should designate CAS to help develop and oversee these procedures.

2. CAS should use its oversight position to identify common problems and should collect and disseminate ideas throughout DHS for improving contracting procedures.

3. Because CAS should more actively participate in the contracting process, the department should consider increasing staffing in this area.

OTHER PERTINENT INFORMATION

During the course of our audit we developed information on DHS' and Management Information Systems contract service evaluation.

DHS Experiencing Rapid Growth In Management Information System

DHS is experiencing rapid growth in the Management Information Systems area. According to a Department of Administration Data Center official, the DHS Office of Management Information Systems (MIS) is among the fastest growing data processing installations in State government. In fiscal year 1987-88, DHS spent approximately $2.5 million on routine system operation, development, and maintenance. This estimate does not include microcomputer costs or the Family Health and Behavioral Health major system development initiatives.[1]

The role of information systems at DHS has been expanding as new information needs have been identified. For instance, the Division of Family Health Services (FHS) is developing a system to identify those clients receiving benefits from its various programs such as the Women, Infants, and Children voucher program and the Maternal and Child Health programs. FHS administrators feel that tracking patients across programs will enhance the effectiveness of referrals and provide important patient information at direct service sites. The direct link that the FHS system will provide between personal computers at service sites and the DHS computer will give a service provider access to current information even if the client has never been seen at that site.

In addition, the Behavioral Health system, which began operating on July 1, 1989, is another example of DHS' information needs being identified and acted upon.[2] This system is designed to provide information in

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(1) The Behavioral Health system is funded through special appropriation HB 2511 for the Chronically Mentally Ill and will cost in excess of $2 million. The Family Health system development contract, with an outside consultant, is being funded in large part with federal money at a cost of $1.5 million.

(2) The development of the Behavioral Health system was in response to the legislative mandate from HB 2511.

the following areas: case management, client tracking, contract compliance, program monitoring, client assessment, treatment outcome evaluation, program efficiency assessment, quality assurance, and needs and resource assessment. This system, like the Family Health system, will give service providers access to current information on clients previously seen elsewhere in the system. DHS officials also expect improvements in management control over services performed by contracted direct service providers.

DHS has undertaken at least three new major system development projects in each of the last three years. Five new systems are planned for fiscal year 1989-90, and an additional eight are projected for fiscal year 1990-91. Currently, 46 systems are maintained by the department. Although some of these are to be replaced by new systems, the total number of systems is still expected to rise to 55 in fiscal year 1990-91.[1]

Increased demands for new systems and already limited staff resources will force DHS to contract out for programming services and to hire additional staff. DHS officials indicate that contract programmers will be needed to handle work other than the routine maintenance conducted by DHS programming staff. According to MIS manager, without contract programmers, DHS will not meet the deadlines imposed by DOA.[2]

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(1) The impetus for many of the replacement systems is directly tied to closing down the Data Center Honeywell mainframe which currently supports 19 DHS systems. These systems must be off the DOA computer by July 1991. Some of these systems conversions have been tied to system enhancements as in the case of Family Health Services. The MIS manager expects a substantial amount of reprogramming will be needed to move the systems from one machine to the other. A DHS official estimates that conversion of systems not covered by federal funds will cost the State approximately $800,000 in the next two fiscal years.

(2) DOA will pass on the cost of keeping the Honeywell mainframe on-line to the few remaining users. Therefore, DHS expenses could be much higher than current levels depending on how many other users transfer systems off the computer by the deadline.

The department's increasing reliance on automated systems may create the need for a more comprehensive systems planning process.[1] Since DHS will continue to use both consultants and in-house staff to work on major systems projects underway simultaneously, it is unclear how well integrated these systems will be and whether department-wide information needs will be considered. Currently, sharing of system information between divisions relies heavily on the project leaders of divisional programming teams. Programmers within a team identify opportunities in their assigned division's automation plans to provide useful information for other divisions. To date, department officials feel this process has worked well. For example, when the Office of Vital Records programming team worked on the on-line birth certificate system, FHS and other users of birth certificate information were approached in an effort to include their informational needs in the development of the system. However, the growing number of DHS systems and their increasing complexity may require greater management direction and interaction to ensure that departmental needs are met in a cost-effective manner.

A recent consultant study addressed this scenario at the Arizona Department of Transportation (ADOT). The consultant advised ADOT to consider a departure from the divisional assignment of programming teams and to use a department-wide management level steering committee to facilitate an integrated planning process. The consultant further recommended the preparation and periodic update of a detailed, department-wide, long-range data processing plan which would include needs prioritized by the steering committee.

Service Measures for Contract Programs

The Department of Health Services' required collection of average cost per client data for evaluating contract services is not being utilized at

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(1) At present, MIS reports directly to the director of the department. Strategic planning is an outgrowth of the budget process. A division which can fund a systems development project with available State or federal monies from within its own budget can proceed with the project after consultation with MIS and approval from the director.

present. DHS, along with other agencies, has been required to report this information on contract services since 1985. Although DHS continues to collect the data, specific details of reporting requirements have never been clearly defined. As a result, the value of information collected and reported by DHS is questionable.

Since fiscal year 1986, Arizona appropriation acts have contained a footnote requiring certain agencies to report information on contract services. The footnote mandates that:

> "No funds for services shall be disbursed by the Department after December 31, 1985, without a standardized evaluation system that...has been approved by the Joint Legislative Budget Committee. The evaluation system for each program shall include but shall not be limited to a statement of the objectives of the program; the number of recipients of the service,...the cost per client served by the program; and methodology for measuring the performance of the program with respect to the statement of the objectives for the program."

According to Joint Legislative Budget Committee (JLBC) staff, the purpose of these requirements is to provide information that can be used to compare the costs of obtaining services throughout Arizona. The agencies are to submit this information to JLBC. The footnote applies to most DHS programs, as well as to the Department of Economic Security and to some Department of Corrections programs.

However, report and evaluation requirement details have never been defined. Shortly after the footnote was passed, JLBC staff met with agency representatives to determine the data to include and the format for reporting. No consensus was reached on evaluative measures for the departments. JLBC allowed each department considerable discretion in selecting what measures to track. After discussion with the agencies, JLBC staff also recognized that in many cases, comparative cost data was not a valid indicator of quality since costs can vary among locations. As a result, JLBC and DHS staff have questioned the value of the data. JLBC officials also indicate that legislative intent regarding this information is unclear.

Despite questions about its value, a DHS official indicates that all DHS divisions attempt to collect and report cost per client data. According to a DHS official, the department has not been advised of any change in reporting requirements. JLBC staff affirm that collecting this data is difficult in some areas because DHS provides few direct services; rather, many services are delivered by county health service departments using State and federal funds. Even where data is collected, little is done to ensure its reliability or consistency. For example, we found that the Division of Disease Prevention Services receives program reports from county health services departments that contain wide variances in per capita costs for similar services. However, the division staff do not attempt to identify reasons for the variances. They simply record the information for JLBC.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of the Director

ROSE MOFFORD, GOVERNOR
TED WILLIAMS, DIRECTOR

November 6, 1989

Mr. Douglas Norton
Auditor General
2700 North Central, Suite 700
Phoenix, AZ 85004

Dear Mr. Norton:

I recently received your revised preliminary draft report on ADHS agencywide Sunset Factors dated October 26, 1989. I appreciate the consideration you gave my comments dated October 19, 1989 on the preliminary draft report together with our discussions in the October 23, 1989 meeting and the changes resulting therefrom. Upon review of the revised preliminary report, the following comments are submitted:

* 1. It is recommended that Sunset Factor Number 2, page 8, last sentence, be modified to read "In some of these areas the department was at the time of the audit, evaluating a course of action or action was in process to implement changes recommended in the audit. In other areas, the department has since made or is in the process of making recommended changes." This change is recommended to present the most accurate identification of existing circumstances.

* 2. It is recommended that Sunset Factor Number 2, page 8, third "bullet point," fourth sentence, be modified to read "The department was evaluating an infant formula rebate program at the time the audit was conducted and has since implemented a rebate program." This change is recommended to present the most accurate identification of existing circumstances.

3. It is recommended that Sunset Factor Number 2, page 8, the third "bullet point," the fifth sentence through the end of the paragraph on page 9, be modified to read "Another FHS program, Children's Rehabilitative Services (CRS), should expand its services to address those significant medical problems such as hemophilia and bronchopulmonary displasia, that are not now provided. The ongoing review of CRS medical eligibility criteria to determine whether specific conditions should be added or deleted, should be concluded expeditiously. The department has requested additional funding in its last three annual budget requests to expand CRS services, in particular hemophilia and bronchopulmonary displasia." Although the addressed area has been modified in response to our previous discussions, the inference remains that if "illnesses which are easily treated" were not funded, the more significant illness could be, which is not factual. Further, the Department does not concur that hemophilia and bronchopulmonary displasia are the "most significant medical problems of its clients."

4. It is recommended that Sunset Factor Number 2, page 9, fifth "bullet point," last sentence, be modified to read "ASH should address problems contributing to turnover." The Department had identified the need to conduct a staffing study and had implemented the contracting process to obtain the study prior to the audit.

*5. It is recommended that a final sentence be added to Sunset Factor Number 2, page 10, sixth "bullet point," as follows "The department has requested funds to improve the OVR facilities in its last three annual budget submissions." The deficiencies identified in the audit report have been addressed in the cited budget submissions.

6. The audit report continues to fail to identify that the Department has not had, and does not have, an internal audit capability or to address the importance of such an activity to the overall effectiveness of Department operations. As previously stated, regardless of the strength of the Department's policies and procedures, ongoing internal audits insure that appropriate procedures exist and are being complied with. The Department has requested additional auditing resources in the last two annual budget processes and will continue to request these positions until they are authorized. However, that process is impaired by the audit report's failure to address the issue.

Sincerely,

Ted Williams

Ted Williams
Director

TW:JM:mw

* Auditor's Note: Text has been changed as suggested.