CALIFORNIA STATE AUDITOR

Department of Public Health:

It Faces Significant Fiscal Challenges and Lacks Transparency in Its Administration of the Every Woman Counts Program

July 2010 Report 2010-103R

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July 21, 2010 2010-103R

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the Department of Public Health's (Public Health) administration of the Every Woman Counts (EWC) program.

This report concludes that Public Health could do more to maximize the funding available to pay for breast and cervical cancer screening services, which is—in our opinion—the primary focus of the program. Although total tobacco tax revenues supporting the EWC program are declining and costs to administer the program are rising, state law requires that Public Health provide services at the level of funding appropriated by the Legislature. When it requested $13.8 million in additional funding from the Legislature in June 2009, Public Health claimed that redirecting funds from other areas of the EWC program—such as efforts aimed at providing health education to women and technical assistance to medical providers—to pay for additional screening services would not be possible given federal requirements and would jeopardize federal funding. However, our review of federal requirements and discussions with the Centers for Disease Control and Prevention indicate that Public Health has the flexibility to redirect funding to screening activities without risking the loss of federal funds. Unfortunately, Public Health's ability to identify and redirect funds toward paying for clinical aspects of the EWC program is hampered by the fact that it does not know how much its contractors are spending on specific activities. As a result, in an environment of scarce fiscal resources, Public Health lacks a basis to know whether paying for certain contract activities are a better use of funds than paying for additional mammograms or other screening procedures.

Finally, our audit found that Public Health should do more to improve the public transparency and accountability with which it administers the EWC program. For example, state law requires Public Health to develop regulations to implement the EWC program in a manner that considers the public's input. However, nearly 16 years after the program began, such regulations still have not been developed. Public Health cited staff and funding limitations as the cause for the delay. State law also requires Public Health to report on the activities and effectiveness of the EWC program and submit an annual report to the Legislature. Although Public Health has provided information on an ad hoc basis, including during the State's budgetary process, it has provided only one formal report to the Legislature—in August 1996. This lack of information on the effectiveness of the EWC program limits Public Health's ability to effectively advocate for appropriate funding and hampers the Legislature's and the public's ability to exercise effective oversight.

Sincerely,

ELAINE M. HOWLE, CPA
State Auditor

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Contents

Summary 1

Introduction 5

Audit Results
The Every Woman Counts Program Faces Fiscal Challenges While Experiencing Increasing Demand for Services 15

Opportunities Exist for Public Health to Identify and Potentially Redirect EWC Program Funds to Screening Services 20

Public Health Needs to Provide the Legislature With Better Information Regarding Caseload and Cost 26

Public Health Needs to Provide More Transparency Regarding How It Administers the EWC Program to Promote Public Input and Enhance Legislative Oversight 28

Recommendations 31

Appendix A
The Department of Public Health's Expenditures for the Every Woman Counts Program 33

Appendix B
Diagnostic Outcomes of Women Screened for Breast and Cervical Cancer Through the Every Woman Counts Program 37

Response to the Audit
Department of Public Health 41

California State Auditor's Comments on the Response From the Department of Public Health 45

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Summary

Results in Brief

The Every Woman Counts (EWC) program is administered by the Department of Public Health (Public Health). Spending nearly $52.1 million in fiscal year 2008–09, the EWC program provides funding for breast and cervical cancer screening services for low-income women. During fiscal year 2008–09, Public Health provided EWC services to nearly 350,000 women.

Under the EWC program, medical providers submit claims to the State for the screening services they provide to women enrolled in the program. Although the EWC program provides health-related services to low-income women, the establishing laws did not structure it as an entitlement program. The number of breast and cervical cancer screenings provided—and by extension the number of women served by the EWC program—is inherently limited each year by the level of spending authorized by the Legislature.

The EWC program is funded both by state funds—tobacco tax revenue—and by a federal grant provided by the Centers for Disease Control and Prevention (CDC). However, declines in proceeds from tobacco taxes, along with the fiscal pressures placed on the State's budget resulting from the economic recession, will likely make funding the EWC program more difficult for the Legislature in the future. In June 2009 Public Health informed the Legislature that it would require a $13.8 million budget augmentation to pay for actual and projected claims during fiscal years 2008–09 and 2009–10. Public Health also took steps to reduce the number of women eligible for the EWC program by imposing more stringent eligibility standards and freezing new enrollment for six months beginning in January 2010.

Although Public Health's EWC program has faced declining revenues and increased costs in recent years, state law only requires Public Health to provide breast cancer screening at the level of funding appropriated by the Legislature. According to an official at Public Health, given the high profile of the EWC program, its political sensitivity, and the potential for public outcry, there has been a reluctance to limit services to women in the past. However, such an approach can cause Public Health to spend through its available funding before the fiscal year concludes if more women than expected access screening services. This can result in the need for Public Health to seek additional funding, as it did in June 2009.

Our audit found that Public Health could do more to maximize the funding available to pay for screening services. When requesting additional funding from the Legislature in June 2009, Public Health

Audit Highlights . . .

Our review of the Department of Public Health's (Public Health) administration of the Every Woman Counts (EWC) program, revealed the following:

- » *Funding the EWC program will likely be more difficult in the future due to:*
  - *Declines in tobacco tax revenue.*
  - *Fiscal pressures placed on the State's budget resulting from the economic recession.*
- » *As a result of the budget problems, Public Health:*
  - *Asked for a budget augmentation of $13.8 million in June 2009.*
  - *Imposed more stringent eligibility requirements and froze new enrollment for six months beginning in January 2010.*
- » *Contrary to its previous claims, Public Health has a great deal of flexibility to use existing EWC program funds to provide screening services to women.*
- » *Public Health's ability to redirect funds is hampered because it cannot easily identify funds it uses for activities that do not directly support women.*
- » *Public Health does not provide the Legislature with estimates of the number of women it expects to serve in a fiscal year, even though it provides this information to the federal government to secure federal funds.*

continued on next page . . .

» *Public Health has not fully complied with certain aspects of state law. Specifically, it has not:*

- *Developed regulations that implement the EWC program—nearly 16 years after the program began.*
- *Evaluated the effectiveness of the EWC program in annual reports to the Legislature—since 1994, only one report was submitted.*

claimed that redirecting funds within the EWC program from other areas—such as efforts aimed at providing outreach to women and training for medical providers—to pay for additional screening services would not be possible given federal requirements and would jeopardize federal funding. Our analysis found, however, that Public Health's claim was incorrect. During fiscal year 2008–09, federal requirements mandated that Public Health spend $1.9 million in state funds as a match to federal funding, and it did. In addition, Public Health was required to spend another $12.4 million in state funds on any aspect of the EWC program, including screening women for breast and cervical cancer. The CDC leaves the decisions regarding how to allocate these additional funds to Public Health. As a result, it appears that Public Health has a great deal of flexibility to use existing EWC program funds for what we consider the core mission of the program—providing screening services to women. We estimate that had Public Health redirected one-half of the amount it spent on various contracts for nonclinical activities in fiscal year 2008–09, it could have dedicated about $3.4 million to pay for screening activities. This funding would have allowed more than 27,500 additional women to obtain services from EWC.

However, Public Health's ability to identify and redirect funds toward activities that directly support women is hampered by the fact that Public Health cannot determine how much its contractors spend on other activities. For example, Public Health spent more than $6.7 million on various contracts with local governments and nonprofit organizations during fiscal year 2008–09; however, it does not know how much these contractors spent on each contracted activity. Instead, Public Health knows only the total amount payable under each contract and how much has been billed for general categories such as personnel costs and overhead to date. Without knowing how much contractors are spending on specific services that support the EWC program, Public Health lacks a basis to know whether the funds paid for these activities would have been better spent on additional mammograms or other screening procedures. Public Health indicated that its staff use their collective training and experiences as health care professionals to guide how they allocate funding within the EWC program. Although Public Health may feel that it can rely on its staff's professional expertise to determine how much of its funding to invest in the nonclinical aspects of the EWC program, it would be in a better position to defend these funding decisions to the Legislature and other program stakeholders if it knew how much it spends on these nonclinical costs and could demonstrate why spending in these areas is a better choice than paying for additional screenings for eligible women.

Our audit also found that Public Health develops its budget for the EWC program based on past expenditure trends and applies an assumed growth rate for these expenditures, but does not explicitly

establish estimates of how many women it expects to serve in a given fiscal year. Public Health could help establish clear expectations for program outcomes by providing the Legislature with information on its expected caseload and cost, as it does with its federal grant with the CDC. The EWC program chief indicated that Public Health would like to use caseload data to be more precise in forecasting its costs, but has not done so because it lacks confidence in the reliability of the caseload data it collects. In order to provide the federally required caseload data to the CDC, Public Health has entered into a contract with the University of California, San Francisco, to assure the quality of its caseload data. The data that Public Health submits to the CDC are the number of women served based on the federal funds provided. Had Public Health done the same at the state level, it could have helped the Legislature define expectations for the program—in terms of the number of women to be served or other similar measures—during the budget process for fiscal year 2008–09. In doing so, it would have been in a stronger position to explain to the Legislature why it needed an additional $6.3 million to pay for clinical claims for that year. Specifically, Public Health would have been able to explain to the Legislature whether it had already served the agreed-upon number of women based on the funding provided.

Finally, our audit found that Public Health could do more to improve the public transparency and accountability with which it administers the EWC program. State law requires Public Health to develop regulations that implement the EWC program. Nearly 16 years after the program began, such regulations still have not been developed. Public Health cited staff and funding limitations as the cause for the delay. Nevertheless, had Public Health developed the required regulations, it would have provided the public with an opportunity to comment and to provide input on important aspects of the EWC program, such as eligibility requirements and service priorities should funding be exhausted. State law also requires Public Health to evaluate the effectiveness of the EWC program annually and submit a report on its findings to the Legislature. Specifically, the report is required to contain information such as the number of women served and their race, ethnicity, and geographic area, as well as information on the number of women in whom cancer was detected through the screening services provided and the stage at which it was detected. Since this reporting requirement was placed in state law in 1994, the Legislature has received only one report—in August 1996—in response to this requirement. This lack of information on the effectiveness of the EWC program limits Public Health's ability to advocate for appropriate funding and hampers the Legislature's and the public's ability to exercise oversight.

Recommendations

To ensure that Public Health maximizes its use of available funding for breast cancer screening services, it should evaluate each of the EWC program's existing contracts to determine whether the funds spent on nonclinical activities are a better use of taxpayer money than paying for women's breast or cervical cancer screenings. To the extent that Public Health continues to fund its various contracts, it should establish clearer expectations with its contractors concerning how much money is to be spent directly on the different aspects of the EWC program and should monitor spending to confirm that these expectations are being met.

To ensure that Public Health can maintain fiscal control over the EWC program, we recommend that it take the following steps:

- Develop budgets for the EWC program that clearly communicate to the Legislature the level of service that it can provide based on available resources. One way Public Health could do this would be to estimate the number of women that can be screened at given levels of funding.

- Seek legislation or other guidance from the Legislature to define what actions the program may take to ensure that spending stays within amounts appropriated for a fiscal year.

To ensure better public transparency and accountability for how the EWC program is administered, Public Health should do the following:

- Comply with state law to develop regulations, based on input from the public and interested parties, that will direct how Public Health administers the EWC program. At a minimum, such regulations should define the eligibility criteria for women seeking access to screening services.

- Provide the Legislature and the public with a time frame indicating when Public Health will issue its annual report on the effectiveness of the EWC program. Further, Public Health should inform the Legislature and the public of the steps it is taking to continue to comply with the annual reporting requirement in the future.

Agency Comments

Public Health generally agreed with our recommendations. However, it disagrees with our conclusion that the EWC program would be able to serve more women and still meet the federal grant requirements if it redirected some of the funds it spends on various contracts for nonclinical activities.

Introduction

Background

According to the U.S. Preventive Services Task Force (task force), breast cancer is the second leading cause of cancer deaths among women in the United States. Although research suggests that mortality from breast cancer has decreased since 1990 as a result of screening and other factors, the State has reported that many women with low incomes, and those who are minorities or are underinsured or uninsured (underserved women) are unaware of the lifesaving value of breast cancer screening, have little or poor access to medical care, or use providers who do not routinely perform screening. The Every Woman Counts (EWC) program,[1] administered by the Department of Public Health's (Public Health) Cancer Detection Section, aims to save lives by using federal and state resources to screen women for breast and cervical cancer and to reduce the devastating effects of these illnesses, especially for underserved women. In addition to providing early detection and diagnostic services to eligible women, EWC works to reduce breast and cervical cancer screening disparities through public education and outreach, professional education and training, and improvements in mechanisms intended to reduce missed or delayed cancer diagnoses.

Current Screening Recommendations

According to a 1996 report prepared by Public Health's predecessor—the Department of Health Services (Health Services)—75 percent of all breast cancers occur in women with no known risk factors, other than being female and older. Since the cause of breast cancer is unknown, there are presently no ways to prevent it. Breast cancer, like some other cancers, is less likely to have spread to other areas of the body and is easier to treat if detected at an early stage. Therefore, regular screenings increase the possibility of detecting most cancers early, increasing the likelihood of successful treatment and reducing mortality. Methods for early detection of breast cancer, such as self-exams, clinical breast exams, and mammography,[2] can improve the chances of early diagnosis and treatment.

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[1] In this audit report, EWC is the name given to the combined state and federally funded program that Public Health operates to screen women for both breast and cervical cancer. State law established the Breast Cancer Control Program in 1994 to provide breast cancer screening services in coordination with a grant from the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program, which was established by the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354).

[2] A mammogram is an X-ray of the breast. A screening mammogram is used to check for breast cancer in women who have no signs or symptoms of the disease. A diagnostic mammogram is used to check the breast for cancer after a lump or other symptom of the disease has been found.

In its 1996 report to the Legislature, Health Services indicated that, despite the availability of such lifesaving early detection methods, research had shown that many women did not know the benefits of early screening or lacked the means to obtain screening. For example, women with low incomes and minority women were disproportionately diagnosed with cancer in later stages and used screening services at lower rates. Health Services concluded that these women were least likely to seek cancer screening services, for a variety of reasons. In particular, Health Services stated that these women rely to a greater extent than women in general upon overburdened publicly funded clinics or hospitals. In addition, these women are more likely to seek medical help for urgent situations, not preventive care, and may avoid screening because they are unable to afford treatment if cancer is found.

Although expert organizations believe that early detection is beneficial, these organizations and published research studies do not agree on when it is most advantageous and cost‑effective to begin regular breast cancer screenings performed by trained professionals. The Susan G. Komen for the Cure Foundation, the American Cancer Society, and the National Cancer Institute recommend regular mammograms for women beginning at age 40. The task force, sponsored by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, recommends that women begin routine mammography screening at age 50.

According to the Susan G. Komen for the Cure Foundation, there are a few reasons why mammography may be less beneficial in younger woman. First, breast cancers affecting younger women are often more aggressive and are not easily detected in their more dense breast tissue. This means that regular mammograms every one to two years in younger women are less likely to detect cancer early, when it is most treatable. Second, compared to older women, women ages 40 to 49 have a lower risk of breast cancer. Third, mammograms in women aged 40 to 49 have a high rate of false positive test results. As a result, these women may undergo a variety of follow‑up tests, such as additional mammograms, ultrasounds, or biopsies to investigate abnormalities and ultimately discover that they do not have breast cancer.

Despite these issues, all of the groups mentioned—except for the task force—recommend routine breast cancer screening for women beginning at age 40. According to the Susan G. Komen for the Cure Foundation, these organizations believe that the modest survival benefits of mammography in this age group outweigh the risks of false positive results. Moreover, a 2008 study by researchers at the University of California, San Francisco (UCSF), argued that regular screening and access to treatment would allow earlier diagnosis of breast cancer, improving the prognosis of the women involved and

reducing the economic burden of breast cancer in California. The task force, on the other hand, as well as the American College of Physicians, encourages women aged 40 to 49 to make individualized, informed decisions about when to begin mammography screening, and has stated that these decisions should be guided by a woman's breast cancer risk profile as well as her own preferences based on knowledge of the potential harm, such as a false positive diagnosis, and benefits of mammography screening.

Participation in the EWC Program

Women are eligible for the EWC program if (1) their household income is at or below 200 percent of the federal poverty line and (2) they are at least age 25 for cervical cancer screening services or at least age 50 for breast cancer screening services. Prior to January 1, 2010, women between the ages of 40 and 49 were also eligible for breast cancer screening services. Women may learn about and become enrolled in the EWC program in a variety of ways. Although many women enroll in the EWC program while seeing a doctor familiar with the program, others hear about it through the program's hotline. This toll-free hotline provides women with general and eligibility information about the EWC program and gives each woman referrals to three providers in her geographic area. Hotline operators also follow up with the women periodically to increase the likelihood that they will be screened.

Women enroll in the EWC program through a primary care provider offering breast and cervical cancer screening services. A woman's enrollment in the program lasts for one year. Providers are also enrolled in the program. To be an EWC provider, one must first be participating in and be in good standing with Medi-Cal, the State's Medicaid health care program. After completing the EWC screening services—such as a mammogram or biopsy—providers submit bills to the Medi-Cal fiscal intermediary, HP Enterprise Services. Payments may also be requested for case management services, which are paid to providers to ensure that follow-up services are recommended and diagnostic outcomes are reported. We refer to bills for the providers' services as clinical claims.

The EWC program also provides outreach and health education to women, as well as works to enhance the knowledge, attitudes, skills, and behavior of health care professionals who provide these services in the detection of breast and cervical cancer. To help facilitate these goals, EWC relies on contractors in different regions to, for example:

- Recruit and maintain a network of providers.
- Perform targeted health education to high-risk populations.
- Deliver professional education to providers.

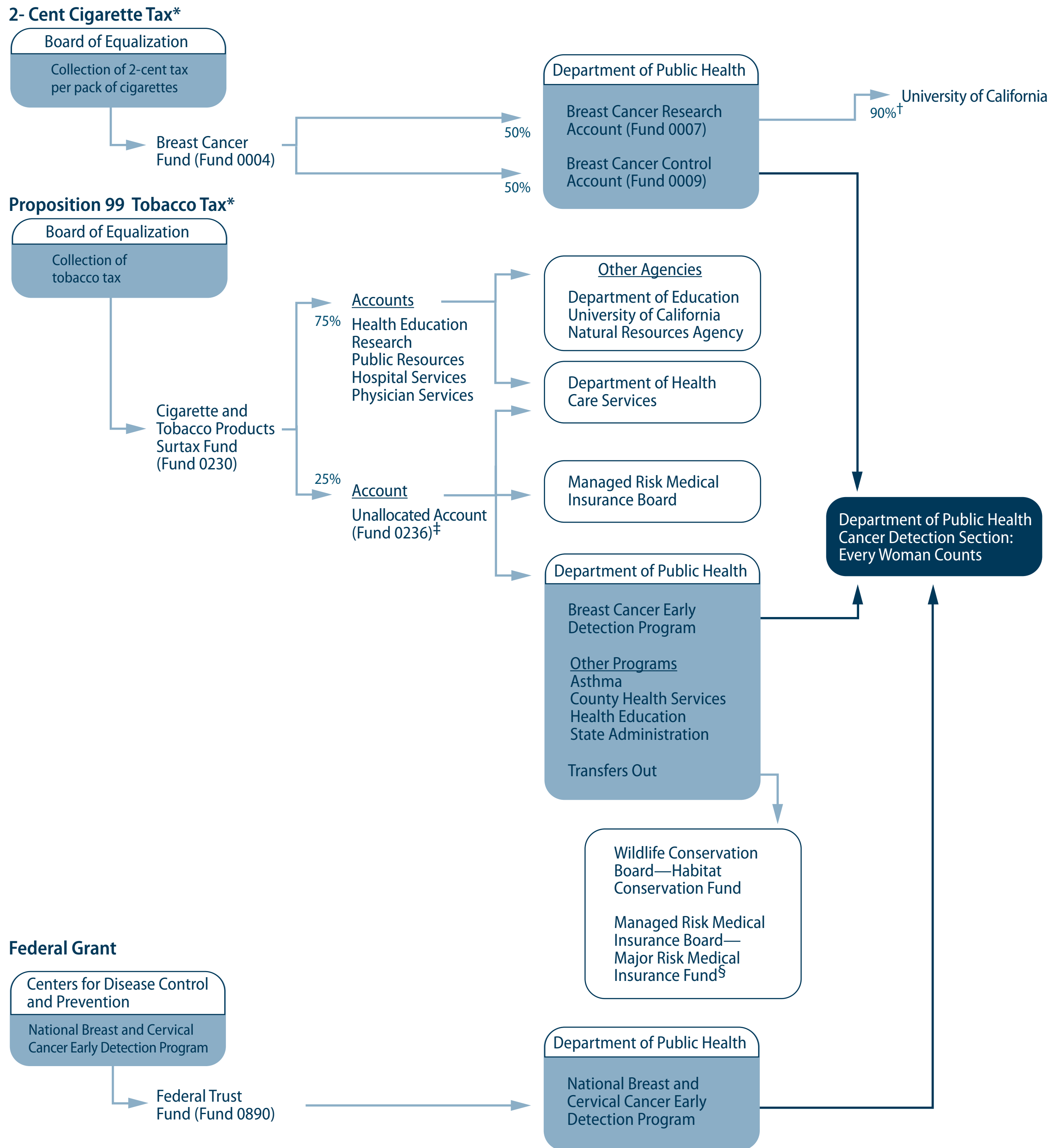
- Perform monitoring of, and provide technical assistance to, providers for submitting quality assurance reports.

Federal and state law established EWC as a program of last resort in that it pays for services not covered by other government programs or insurance. In California there are limited options for breast and cervical cancer screening funded by the State. Aside from the EWC program, there are two other state‑funded programs that provide these services: Family Planning, Access, Care, and Treatment (Family PACT) and Medi‑Cal. Family PACT does not offer the same range of breast cancer screening services that EWC does. Specifically, it provides breast cancer screening services only to determine whether a woman may safely use certain forms of contraception. According to EWC management, women who receive an abnormal screening result through Family PACT are referred to the EWC program, and Family PACT does not conduct any further diagnostic tests or follow‑up. Medi‑Cal recipients receive the same screening services as those provided by EWC; however, women who receive Medi‑Cal are generally not eligible for EWC unless they are required to pay for screening but cannot afford their share of the costs. According to Public Health, if a woman seeking to enroll in the EWC program is not eligible for screening, one of its regional contractors will provide her with referrals for free or reduced‑cost screening services from other local entities in her area, such as nonprofit organizations.

Funding Sources for the EWC Program

The EWC program receives funding from two state funds and one federal grant. The Figure depicts these funding streams. Operationally, the EWC program is the combined administration of a federal program and a state program. The federal Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101‑354, authorized the Centers for Disease Control and Prevention (CDC) to make grants to the states for the prevention and control of breast and cervical cancer. California Health and Safety Code, Section 104150, requires Public Health to provide screening services at the level of funding budgeted from the grant and other resources. In 1991 California first received federal funding for breast and cervical cancer screening services. As a condition of receiving federal funds, the State must fulfill certain requirements, such as matching every three federal dollars with the equivalent of one nonfederal dollar and providing periodic reports. Between July 1, 2006, and, December 31, 2009, funds from the CDC to Public Health for the National Breast and Cervical Cancer Early Detection Program paid for 13.4 percent of total expenditures for the EWC program.

Figure
Funding for the Every Woman Counts Program



Source: Bureau of State Audits based on relevant laws and documentation from the Department of Finance.

* Funding from these taxes is supplemented by amounts collected under Proposition 10, a subsequent tobacco tax increase implemented in 1998. Proposition 10 required payments to certain programs supported by existing tobacco taxes as reimbursement for tobacco tax revenue losses resulting from the increased tax imposed by Proposition 10.

† Under Revenue and Taxation Code, Section 30461.6 (b)(1)(A), the Department of Public Health's Cancer Surveillance Section receives 10 percent from Breast Cancer Research Account (Fund 0007) to collect breast cancer-related data and conduct epidemiological research.

‡ Revenue allocation from the Unallocated Account (Fund 0236) is not defined in statute. Allocations to various programs are determined through annual appropriations.

§ The Managed Risk Medical Insurance Board receives an amount transferred from the Unallocated Account annually to support the Major Risk Medical Insurance Fund. It also receives additional funds appropriated from the Unallocated Account to support other programs.

Effective January 1, 1994, state law established the Breast Cancer Fund to receive money from a 2-cent tax on each pack of cigarettes. Under current law, half of the revenue goes to the Breast Cancer Control Account for use by the EWC program, and the other half is deposited in the Breast Cancer Research Account, which supports breast cancer research and is not a part of the EWC program. Between July 1, 2006, and December 31, 2009, funds from the Breast Cancer Control Account paid for 24.6 percent of total expenditures for the EWC program.

In 1999 the Legislature provided the EWC program with a third funding stream when it appropriated funding from the Proposition 99 tobacco tax initiative. Proposition 99 imposed an additional 25-cent tax on each pack of cigarettes, as well as an additional tax on other tobacco products, as determined by the State Board of Equalization. Money from the taxes is deposited in various accounts. One of these accounts, the Unallocated Account, receives 25 percent of the total tobacco tax collected under Proposition 99; these funds are used to support the EWC program and other programs at several state agencies, though the proportions provided by the Unallocated Account to these programs are not specified in law. Between July 1, 2006, and December 31, 2009, funds from the Unallocated Account paid for 62.1 percent of total expenditures for the EWC program.

Declines in State Tobacco Tax Revenue

Tobacco tax revenue that supports the EWC program and other state programs has declined slightly, from $95.2 million in fiscal year 2006–07 to $90.4 million in fiscal year 2008–09. As described in the previous section, the majority of EWC's funding is provided by two state tobacco taxes that are deposited into the Breast Cancer Control Account and the Unallocated Account. The majority of the decline in revenue is attributable to the Unallocated Account.

According to the governor's budget for fiscal year 2009–10, overall consumption of tobacco products in California is on a long downward trend as a result of tax increases, increasingly restrictive environments for smokers, and antismoking campaigns. The governor's budget overestimated tobacco tax revenue for the Breast Cancer Control Account by 5.6 percent on average for fiscal years 2006–07 through 2008–09. Specifically, its estimates for the Breast Cancer Control Account were higher than the actual tax revenues as reported in the State Controller's Office *Budgetary/ Legal Basis Annual Report* by $1.2 million in fiscal year 2006–07, by $433,000 in fiscal year 2007–08, and by $779,000 in fiscal year 2008–09. Further, the governor's budgets underestimated the

funds available from the Unallocated Account by $806,000 in fiscal year 2006–07, and overestimated the funds available by $3 million in fiscal year 2007–08 and by $5.2 million in fiscal year 2008–09 compared to the actual tax revenues collected for those years.

The overall drop in tobacco revenue is reflected in the declining appropriations to Public Health from the Breast Cancer Control Account and the Unallocated Account. Between fiscal years 2007–08 and 2008–09, Public Health's annual appropriations from the two tobacco tax revenue accounts declined from $55 million to $51 million[3]—a decrease of approximately $4 million. Although appropriations for the EWC program from the Breast Cancer Control Account increased from $17 million in fiscal year 2007–08 to $19 million in fiscal year 2008–09, the governor's budget for fiscal year 2010–11 proposes to reduce this amount to $14.1 million. Further, allocations from the Unallocated Account are declining. Because of the overall declines in tobacco tax revenues and the fact that the Unallocated Account also supports other state programs, the Legislature's appropriation for the EWC program from the Unallocated Account may decline to $22.1 million in fiscal year 2010–11, per the governor's January 2010 budget proposal, an overall drop of nearly $8 million from the Legislature's fiscal year 2006–07 appropriation of roughly $30 million.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits (bureau) to identify the circumstances leading to the EWC program's budget crisis and determine if Public Health has operated the EWC program efficiently over the past several years. Specifically, the audit committee asked the bureau to identify the difference between program revenue and demand over the past three years by comparing estimated tobacco tax revenue to actual revenue, evaluating the size of the EWC program's caseload and trends in caseload data, and determining the average cost per woman and the reasons for any changes in average costs. The audit committee also asked us to review and assess Public Health's rationale for its recent changes to the eligibility and enrollment policies for the EWC program, including any alternatives it may have considered, and to determine whether the women affected have other state-funded options for cancer screening services. In

[3] In fiscal year 2009–10 the Legislature approved a one-time funding augmentation from the fund balance that had accumulated in the Breast Cancer Control Account. The augmentation is not included in our discussion of EWC funding amounts because it is not part of the typical financial support for the program. We discuss the EWC's budget augmentation further in the Audit Results section of this report.

addition, the audit committee asked the bureau to determine the methods Public Health uses to forecast and monitor the EWC program's fiscal viability.

The audit committee also asked the bureau to evaluate the efficiency of Public Health's operation of the EWC program and whether its implementation is consistent with its intended purposes. Further, the audit committee asked us to examine the aspects of the program that do not involve direct services to women, in order to assess the value of continuing such operations.

To gain an understanding of the sources of revenue that support the EWC program, we examined various laws and guidelines governing the EWC program's activities and verified our understanding with Public Health's staff. Specifically, we reviewed relevant portions of California law, including sections of the Government Code, Revenue and Taxation Code, and Health and Safety Code, and we examined Public Health's policies and procedures related to the EWC program. We also examined federal laws and guidance from the federal government that pertain to the program. Additionally, we interviewed Public Health staff to obtain and understand relevant budgetary and accounting records supporting program funding. Also, to provide more up-to-date information related to Public Health's administration of the EWC program, we expanded our audit period to cover July 1, 2006, through December 31, 2009. Furthermore, because the Unallocated Account—one of the tobacco revenue sources that fund the EWC program—supports multiple programs at Public Health and other state departments, we reviewed the funding amounts for this account in total. Our analysis of EWC tobacco tax revenue is based on proposed amounts shown in the governor's budgets for fiscal years 2006–07 through 2009–10 and actual revenue received according to the State Controller's Office. From this information, we identified trends in state tobacco tax revenue.

We relied upon various electronic data in performing this audit. The U.S. Government Accountability Office, whose standards we follow, requires us to assess the sufficiency and appropriateness of computer-processed data. To determine caseload by calculating the number of recipients for whom at least one clinical service was paid during the audit period and the average cost per participant during the audit period, we used information from the Department of Health Care Services' (Health Care Services) California Medicaid Management Information System, (CAMMIS). We assessed the reliability of CAMMIS by performing data set verification procedures and electronic testing of key data elements. However, we did not conduct accuracy or completeness testing because the source documents required for this testing are stored at medical providers' offices located throughout the State.

Therefore, we concluded that Health Care Services' CAMMIS data was of undetermined reliability for the purposes of determining caseload and the average cost per participant.

Further, to determine caseload by calculating the number of recipients for whom at least one clinical service was paid during the audit period, the number of participants for whom a full diagnostic outcome was reported during the audit period, and the average cost per participant during the audit period, we used information from Public Health's Detecting Early Cancer (DETEC) system. We assessed the reliability of the DETEC system by performing data set verification procedures and electronic testing of key data elements. However, we did not conduct accuracy or completeness testing because the source documents required for this testing are stored at medical providers' offices located throughout the State. Therefore, we concluded that these data were of undetermined reliability for the purposes of determining caseload, the number of participants for whom a full diagnostic outcome was reported during the audit period, and the average costs per participant.

Moreover, to obtain and understand information regarding the demand for the EWC program's services, or caseload, we interviewed the program's data contractor, UCSF. To derive caseload information, identify trends in demand for screening services, and calculate the average cost per woman served, we analyzed an extract of the CAMMIS system. To derive diagnostic outcome data for both breast and cervical screenings, we analyzed an extract of the DETEC system. The extract included data that UCSF had "cleaned"—that is, data that it had analyzed to eliminate duplicate records. As a major component of its contract, UCSF applies the technique of probabilistic matching, which weighs and matches certain demographic information to determine the likelihood that it belongs to the same woman in order to assign unique client identification numbers, thus improving the accuracy of the count of women served by the EWC program. The process uses various combinations of data to identify errors, such as the transposition of numbers or names and misspellings. Because we used the date that a service was adjudicated for payment to count women within a certain period, the caseload figures we cite include some women who received services in a period earlier than the fiscal year in which the payment was made.

To gain an understanding of Public Health's responsibilities with regard to the EWC program and to understand its rationale for changing its eligibility and enrollment policies, we interviewed Public Health and EWC program management and reviewed documentation that supported the policy change decisions. This allowed us to identify and assess the program's consideration of alternatives to the implemented policy changes.

To determine if there are other state-funded alternatives for women affected by Public Health's enrollment changes for the EWC program, we interviewed EWC program management and staff regarding their knowledge of other programs. Further, we reviewed the eligibility requirements for these other state-funded programs and assessed the types of services they provide in relation to EWC program services.

To determine Public Health's methods for forecasting and monitoring the EWC program's fiscal viability, including how it responds to resource limitations, we interviewed staff and reviewed the program's forecasts to understand its budgeting processes for clinical claims.

To evaluate Public Health's administration of the EWC program for efficiency and the extent to which it meets intended purposes, we obtained and reviewed documents to understand how the program measures success in meeting its objectives. In addition, we analyzed federal and state requirements concerning how program funds should be spent and assessed Public Health's flexibility to allocate funds between clinical and nonclinical activities. We also examined Public Health's contracts to ensure that the services performed were allowable activities. We categorized each of EWC's contracts to determine if aspects of the contracts supported either clinical or nonclinical aspects of the EWC program.

To assess the effectiveness of the EWC program's nondirect, or nonclinical, activities, we first obtained and analyzed Public Health's CALSTARS accounting records to categorize and quantify EWC program expenditures. The accounting records provided us with the EWC program's expenditures by fiscal year; the amounts presented in our analysis do not contain encumbrances and obligations.[4] Therefore, the expenditure amounts presented may differ from those documented in the governor's budget or other accrual basis accounting records. Nonetheless, the accounting records provided us with the level of detail necessary to categorize Public Health's expenditures into clinical and nonclinical activities. We also reviewed invoices submitted to Public Health from its contractors, as well as the scope of work for these contracted activities.

[4] For the purpose of our expenditure analysis, encumbrances and obligations represent financial commitments made by the State that have not been paid.

Audit Results

The Every Woman Counts Program Faces Fiscal Challenges While Experiencing Increasing Demand for Services

During fiscal year 2008–09, tobacco tax funding provided $44.2 million of the $52.1 million that the Department of Public Health (Public Health) spent on the Every Woman Counts (EWC) program. During fiscal years 2006–07 through 2008–09, proceeds from tobacco taxes provided roughly 87 percent of EWC program's annual funding. However, it is possible that these funding sources will not be able to provide the same level of financial support to the EWC program that they have in prior years. In an environment of declining tobacco tax revenue overall and increasing demand for screening services, the Legislature will likely find it increasingly difficult to provide the funding necessary to support the EWC program while also balancing competing spending priorities. Table 1 on the following page provides information on the beginning and ending balances for the two tobacco taxes that provide funding to the EWC program.

As was discussed in the Introduction and as shown in Table 1, the EWC program has two sources of tobacco tax revenue. The first source comes from a cigarette tax of 2 cents per pack that has been imposed since 1994. Half of the proceeds collected from this 2-cent tax are deposited in the Breast Cancer Control Account (fund 0009) and are designated solely for the EWC program under state law. The second source of tobacco tax funding comes from the Proposition 99 cigarette and tobacco tax, which was first appropriated to EWC in 1999. The Unallocated Account (fund 0236) receives 25 percent of the Proposition 99 cigarette and tobacco tax and supports a variety of programs in addition to EWC. Table 1 shows that the Breast Cancer Control Account's funding[5]—primarily transfers from the Breast Cancer Fund—has increased slightly over time but is expected to decline. Interest revenue and tax proceeds transferred to this account—shown as total additions—were nearly $13.2 million in fiscal year 2006–07 and nearly $14 million in fiscal year 2008–09, but are predicted to fall to $12.4 million in fiscal year 2010–11 according to the governor's proposed budget.

[5] As noted in the Figure, the Breast Cancer Fund (fund 0004) receives additional tobacco tax revenue, as a result of Proposition 10, to backfill revenue losses incurred as a result of the passage of that proposition. Although actual tobacco tax revenues deposited into the Breast Cancer Fund have been declining, the offset from Proposition 10 tax revenues has allowed the EWC program's funding from the Breast Cancer Control Account to increase overall.

Table 1
Tobacco Tax Funding Available for the Every Woman Counts Program and Uses of Funds
Fiscal Years 2006–07 Through 2010–11
(Dollars in Thousands)

	2006–07		2007–08		2008–09		ESTIMATED ACTUALS 2009–10*		GOVERNOR'S PROPOSED BUDGET 2010–11*	
	FUND 0009†	FUND 0236‡	FUND 0009†	FUND 0236‡	FUND 0009†	FUND 0236‡	FUND 0009†	FUND 0236‡	FUND 0009†§	FUND 0236‡
Beginning Fund Balance	**$7,316**	**$12,198**	**$7,728**	**$5,751**	**$12,767**	**$3,371**	**$13,720**	**$5,598**	**$2,316**	**$6,264**
Additions										
Revenues	718	1,156	821	1,253	523	406	261	138	261	138
Transfers from other funds	12,441	82,767	13,070	80,399	13,458	76,911	14,350	69,400	12,113	68,701
Total Additions	**$13,159**	**$83,923**	**$13,891**	**$81,652**	**$13,981**	**$77,317**	**$14,611**	**$69,538**	**$12,374**	**$68,839**
Deductions										
Total appropriation expenditures‖	13,976	77,030	14,344	73,077	19,596	66,113	26,015	36,259	14,185	45,377
Other deductions#	(1,229)	13,340	(5,492)	10,955	(6,568)	8,977		32,613		27,331
Total Deductions	**$12,747**	**$90,370**	**$8,852**	**$84,032**	**$13,028**	**$75,090**	**$26,015**	**$68,872**	**$14,185**	**$72,708**
Ending Fund Balance	**$7,728**	**$5,751**	**$12,767**	**$3,371**	**$13,720**	**$5,598**	**$2,316**	**$6,264**	**$505**	**$2,395**

Sources: California State Controller's Office *Budgetary/Legal Basis Annual Report* and governor's proposed budget for fiscal year 2010–11.

* The additions and deductions shown for fiscal years 2009–10 and 2010–11 are based on the governor's proposed budget for fiscal year 2010–11.

† The Breast Cancer Control Account (fund 0009) was established under Section 30461.6 of the Revenue and Taxation Code. According to state law, money in this account is allocated for the Every Woman Counts (EWC) program. Further, as noted in the Figure, the Breast Cancer Fund (fund 0004)—which feeds the Breast Cancer Control Account—receives additional tobacco tax revenue, as a result of Proposition 10, to backfill revenue losses incurred as a result of the passage of that proposition. Although actual tobacco tax revenues deposited into the Breast Cancer Fund have been declining, reimbursement from Proposition 10 tax revenues has allowed the EWC program's funding from the Breast Cancer Control Account to increase overall.

‡ The Cigarette and Tobacco Products Surtax Fund—Unallocated Account (fund 0236) provides funding for other programs besides EWC. As a result, the amounts shown reflect activities related to the EWC program and other programs.

§ According to its May 2010 request to reduce its appropriation for fiscal year 2010–11, the Department of Public Health indicated that its balance of available funds in the Breast Cancer Control Account was $1.7 million less than it expected and it projects a reserve of $860,000 at the end of fiscal year 2010–11.

‖ The expenditures presented in this table are prepared on a budgetary legal basis and include encumbrances and obligations. As a result, the expenditure amounts shown will be different from the amounts shown in Table 3 and Appendix A, which do not include obligations and encumbrances. For the purpose of our analysis, encumbrances and obligations represent financial commitments made by the State that have not been paid.

The amounts appearing as "other deductions" generally represent adjustments to prior-year expenditures charged to the Breast Cancer Control Account and transfers out of the Unallocated Account to other state funds.

An important fact about the Breast Cancer Control Account is that its ending balance increased every year between fiscal years 2006–07 and 2008–09. In fiscal year 2006–07, the ending fund balance for this account was $7.7 million, and it exceeded $13.7 million in fiscal year 2008–09. The reason for the increase in fund balance was that Public Health did not spend all of the funds that the Legislature had authorized during those years. For example, the Legislature appropriated $16.8 million during fiscal year 2006–07 to Public Health's predecessor agency—the Department of Health Services (Health Services)—to spend on local assistance and its own support from the funds in the Breast Cancer Control Account. However, Health Services—and its successor, Public Health—had spent only $5.1 million of this amount by June 30, 2009. Similarly, the Legislature provided Public Health with $17.2 million in funding during fiscal year 2007–08 from the

Breast Cancer Control Account; however, as of December 31, 2009, Public Health had spent only $9.1 million and planned to spend only an additional $630,000.

When we asked Public Health for its perspective on why it had been accumulating large fund balances in the Breast Cancer Control Account, the chief of the EWC program's fiscal and legislative unit (fiscal chief) explained that Public Health tries to spend funds from this account last. Public Health's rationale for following this approach is that any unused funds would be available to the EWC program in future years. The fiscal chief also explained that it has tried to ensure that the Breast Cancer Control Account has adequate funds to guard against issues such as greater-than-expected demand for EWC program services. In June 2009 Public Health submitted a request to the Legislature for additional funding for fiscal years 2008–09 and 2009–10 that relied heavily on its accumulated balance in the Breast Cancer Control Account.[6] However, Public Health will not be able to rely on excess balances for future shortfalls. As Table 1 demonstrates, the beginning balance in the Breast Cancer Control Account was $13.7 million in fiscal year 2009–10 but may only be $2.3 million in fiscal year 2010–11.[7]

Public Health's request for additional funding in June 2009 relied heavily on its accumulated balance in the Breast Cancer Control Account. However, this balance may be only $2.3 million in fiscal year 2010–11—far less than the $13.7 million the previous fiscal year.

Another fiscal challenge facing Public Health and the EWC program is the possibility that the Legislature may decide to redirect available funding from the Unallocated Account into programs other than EWC. For example, in fiscal year 2009–10, the Legislature appropriated $19.4 million from the Unallocated Account to the Managed Risk Medical Insurance Board to improve prenatal and postnatal care for women and infants who might not otherwise receive such care. This represented an increase of more than $19 million from the appropriation for fiscal year 2008–09. Further, the Legislature appropriated an additional $5.2 million in fiscal year 2009–10 from the Unallocated Account to the Managed Risk Medical Insurance Board to help provide for state residents who are not otherwise able to obtain adequate health insurance. Overall, these appropriations represented $24.6 million in funds that were transferred from the Unallocated Account in fiscal year 2009–10 that were not available to support the EWC program. The Legislature's decision to change how it uses the Unallocated Account, as in this example, highlights the fact that EWC cannot necessarily rely on consistent funding from this source. The potential for volatility is magnified further by the fact that funding

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[6] Specifically, Public Health requested an augmentation of $13.8 million. Of this amount, $6.3 million was requested to pay for clinical claims in fiscal year 2008–09 while the other $7.5 million was for fiscal year 2009–10. This $13.8 million augmentation request also considered a $4.5 million reduction in funding from the Unallocated Account. As a result, the net augmentation to the EWC program was $9.3 million.

[7] According to Public Health's May 2010 request to reduce its appropriation for fiscal year 2010–11, Public Health indicated that its balance of available funds in the Breast Cancer Control Account was $1.7 million less than it expected and it projects a reserve of $860,000 at the end of fiscal year 2010–11.

from the Unallocated Account supported between 61 percent and 75 percent of all of EWC expenditures between fiscal years 2006–07 and 2008–09. In an environment of uncertain future revenue, EWC has continued to serve increasing numbers of women. Table 2 provides information on the number of women who had at least one service paid for by EWC, such as a mammogram or other diagnostic procedure, between fiscal years 2006–07 and 2008–09. It also includes information for the first six months of fiscal year 2009–10.

Table 2
Number of Women Served by Age Group and the Average Cost per Woman Served—Every Woman Counts Program
July 1, 2006, Through December 31, 2009

	NUMBER OF WOMEN FOR WHOM AT LEAST ONE SERVICE WAS PAID	VALUE OF ALL CLAIMS FOR COUNTED WOMEN*	AVERAGE COST PER WOMAN SERVED†
Fiscal Year 2006–07			
Age 39 and under	13,554	$880,564.00	$64.97
Age 40 to 49	90,233	12,616,315.64	139.82
Age 50+	126,541	17,144,534.82	135.49
Totals	**230,328**	**$30,641,414.46**	**$133.03**
Fiscal Year 2007–08			
Age 39 and under	15,169	$996,261.90	$65.68
Age 40 to 49	100,257	13,336,032.73	133.02
Age 50+	145,066	18,553,787.69	127.90
Totals	**260,492**	**$32,886,082.32**	**$126.25**
Fiscal Year 2008–09			
Age 39 and under	18,542	$1,435,568.87	$77.42
Age 40 to 49	132,709	17,228,901.02	129.82
Age 50+	198,224	24,073,700.04	121.45
Totals	**349,475**	**$42,738,169.93**	**$122.29**
July 1, 2009, Through December 31, 2009			
Age 39 and under	10,897	$738,177.98	$67.74
Age 40 to 49	73,858	8,523,928.17	115.41
Age 50+	118,809	12,978,176.01	109.24
Totals	**203,564**	**$22,240,282.16**	**$109.25**

Source: Bureau of State Audits' analysis of the Department of Heath Care Services' (Health Care Services) California Medicaid Management Information System claims data and the Department of Public Health's (Public Health) Detecting Early Cancer system.

Note: This analysis was performed using data that the University of California, San Francisco—the Every Woman Counts (EWC) program's data contractor—had "cleaned" to eliminate duplicate records.

The dollar amounts shown here differ from the amounts shown for health care payments in Table 3 and Appendix A. The fiscal intermediary and Health Care Services bill Public Health in arrears for claims paid under the EWC program.

* These figures include payments for case management services.

† Average cost per woman served amounts are based on the date that the decision was made to pay for the services. Therefore, amounts may not reflect the year the services were provided due to lag time between service date and the date the service was paid.

Although EWC is not a part of Medi-Cal—the State's version of the federal Medicaid program—it uses the Medi-Cal payment system to pay health providers who render services authorized under the EWC program. As the table shows, the number of women accessing services under the EWC program has increased by nearly 52 percent, from 230,328 in fiscal year 2006–07 to nearly 350,000 in fiscal year 2008–09.

Although the number of women served by EWC has been increasing, as has the total cost of paying for these services, the average cost per woman being served has decreased slightly. In fiscal year 2006–07, the average cost per woman for all age groups was just over $133. In fiscal year 2008–09, the average cost per woman dropped to slightly more than $122. There was also a large increase in the number of women served and the total cost of claims between fiscal years 2007–08 and 2008–09, with nearly 89,000 more women receiving screening services and the costs of claims increasing by nearly $10 million, from $32.9 million to $42.7 million. When we asked Public Health for its perspective on the cause behind the increase in the number of women served, the EWC fiscal chief indicated that EWC outreach efforts and endorsements from other cancer foundations have educated women regarding the benefits of breast cancer screening. Further, Public Health cited the poor economy as a reason for the greater caseload, explaining that women may have lost their health insurance due to job losses and now use the EWC program.

Nearly 89,000 more women received screening services between fiscal years 2007–08 and 2008–09, and the costs of claims increased by almost $10 million.

Public Health provided additional explanations for the increasing overall cost of clinical claims. According to Public Health, although the reimbursement rates to medical providers have not changed, the mix, or number, of services a woman may receive to achieve a diagnosis may be increasing. For example, Public Health indicated that, whereas in the past a woman who may have experienced an abnormal breast cancer screening would have next received a biopsy, advancements identified by the medical community to reduce the number of missed or delayed cancer diagnoses may suggest other intervening services such as a diagnostic mammogram or ultrasound (between the initial screening mammogram and biopsy). The mix of services provided is driven by the physicians who are caring for the women enrolled in the EWC program, not by the EWC program.

Finally, the increase in caseload and the number of services provided also increases processing fees. Because the EWC program utilizes the Department of Health Care Services' (Health Care Services) billing and payment system for Medi-Cal, it is billed by Health Care Services for its fiscal intermediary's processing of clinical claims. According to the EWC program chief, the EWC program paid a 17-cent fee per claim in 2006. However, Public

Health expects to pay 27 cents per claim beginning in fiscal year 2010–11, along with additional one-time fees associated with the switch to the State's new fiscal intermediary. In December 2009 Health Care Services announced that it had awarded its fiscal intermediary contract to a different provider. According to Public Health, this contract includes nearly $300 million in new one-time costs, including $40 million in takeover costs. Federal rules require that such costs be allocated proportionately to the programs that use the billing and payment system. Consequently, Public Health believes that the EWC program will incur a substantial cost increase to pay for its share. The EWC program chief stated that because the EWC program accounts for only 0.64 percent of the claims processing performed by the fiscal intermediary, it does not have a voice in influencing the fees levied on the program.

Opportunities Exist for Public Health to Identify and Potentially Redirect EWC Program Funds to Screening Services

According to Public Health, the number of women eligible for breast cancer screening services exceeds the State's capacity to serve them—in fiscal year 2006–07 only 20 percent of the estimated 1.2 million women eligible to receive screening services were served.

In its June 2009 request to the Legislature for additional funding for the EWC program, Public Health estimated that 1.2 million women aged 40 and older are eligible to receive breast cancer screening services under the EWC program, but only 20 percent of these eligible women were served in fiscal year 2006–07. In an environment in which the number of women eligible for screening services exceeds the State's capacity to serve them, Public Health needs to take steps to ensure that it is maximizing the funding available for screening and other clinical services. In our opinion, screening women is the main focus of the EWC program. This focus is reflected in federal guidance and is further evidenced by the Centers for Disease Control and Prevention's (CDC) emphasis on evaluating Public Health's performance based on the number of clinical services performed, such as the number of mammograms provided, and the related clinical outcomes, such as whether treatment for cancer has begun. However, in its June 2009 funding request, Public Health dismissed the possibility that it could redirect funds from nonclinical aspects of the program—such as outreach and provider training programs—stating that doing so may result in a loss of federal funds, since the CDC requires these services. However, our review of federal requirements and discussions with the CDC indicate that Public Health has the flexibility to redirect funding to screening activities without risking the loss of federal funds.

Although federal law requires Public Health to expend no less than 60 percent of its federal grant award to provide clinical screening and follow-up services, states have significant flexibility in how they spend the remaining 40 percent of their federal funds. Federal law requires only that states not spend more than 40 percent on

nonclinical activities, such as program management and planning, public education, professional development, quality assurance, program monitoring, and administrative costs, and does not specify minimum spending amounts on any single activity. Thus, states could spend 80 percent or more of their federal funds on clinical claims if they chose to do so. For example, in fiscal year 2008–09, Public Health received a $5.7 million federal grant award for the EWC program, of which it was required to spend at least $3.4 million on clinical screening and follow-up services. The remaining $2.3 million could be spent on nonclinical services. Although Public Health must provide some level of nonclinical activities, the CDC's program guidance indicates that despite the inherent value of these activities, Public Health must ensure that federal grant money remains focused on screenings. Further, according to the CDC's guidelines, states have complete flexibility regarding how they spend nonfederal funds on the program.

Additionally, federal law requires that Public Health continue spending the same average amount of state funds on breast and cervical cancer screening services as California spent during the two years before Public Health—then Health Services—received its initial National Breast and Cervical Cancer Early Detection Program screening funding in 1991. To meet this requirement, referred to as a maintenance-of-effort requirement, California must spend nearly $12.4 million in state funds on breast and cervical cancer screening activities each year. In addition to the maintenance-of-effort requirement, federal law requires Public Health to contribute $1 in nonfederal funds to the program for every $3 in federal funds received. Since Public Health received $5.7 million in federal funds in fiscal year 2008–09, its required match was $1.9 million for that year.

To meet the federal "maintenance-of-effort" requirement, California must spend nearly $12.4 million in state funds on breast and cervical cancer screening activities each year.

Although Public Health must maintain its level of effort and match ratio for the federal funds it receives, the CDC does not require Public Health to spend state funds according to the proportions mandated for federal funds. Similarly, state law does not specify minimum amounts that must be spent on any particular aspect of the EWC program, allowing Public Health complete flexibility in determining how to most efficiently expend its resources to maximize screening services to women. Therefore, Public Health could spend all of its maintenance-of-effort and matching funds—$14.3 million for fiscal year 2008–09—on any mix of services, including clinical screening services and nonclinical program components.

To provide some context regarding the amount of flexibility the State has with respect to its spending on screening services, we examined Public Health's spending under the EWC program. Table 3 on the following page provides information on how

much Public Health spent per year, by type of expense, between July 2007 and December 2009. The expenditure amounts shown in the table do not include obligations or encumbrances—amounts Public Health has reserved for future expenditures but has not paid. For example, the relatively low amount of expenditures shown in Table 3 for fiscal year 2007–08 is the result of more than $14.4 million in obligations and encumbrances that are not reflected in the table because they were not paid in that year.

Table 3
Every Woman Counts Program Expenditures by Category
July 1, 2006, Through December 31, 2009

	TRANSACTION YEAR 2006–07		TRANSACTION YEAR 2007–08		TRANSACTION YEAR 2008–09		TRANSACTION YEAR 2009–10*	
EXPENDITURE CATEGORY	CATEGORY TOTAL	PERCENTAGE†	CATEGORY TOTAL	PERCENTAGE	CATEGORY TOTAL	PERCENTAGE†	CATEGORY TOTAL	PERCENTAGE†
Personal Services‡	$1,932,356.36	4.2%	$2,332,808.39	6.8%	$2,405,368.62	4.6%	$1,238,163.14	6.5%
Operating Expenses and Equipment								
Consultant and professional services—Interdepartmental§	2,707,150.76	5.9	1,561,069.07	4.6	2,726,465.32	5.2	1,927,871.50	10.2
Other services‖	2,095,253.33	4.6	533,158.17	1.6	2,430,789.11	4.7	279,257.06	1.5
All other operating expenses and equipment	1,293,167.85	2.8	1,620,484.09	4.8	1,488,248.76	2.9	536,879.99	2.8
Special Items of Expense#	39,999.96	0.1	26,666.64	0.1	–	–	–	–
Local Costs								
Grants and subventions, governmental**	1,682,136.09	3.7	2,851,846.01	8.4	1,581,546.86	3.0	13,743,944.83	72.6
Grants and subventions, nongovernmental—Medical and health care payments ††	35,656,802.21	78.0	25,114,142.34	73.7	40,949,483.20	78.6	1,195,365.45	6.3
Grants and subventions, nongovernmental—Other miscellaneous payments‡‡	295,311.27	0.7	54,367.06	0.2	499,975.80	1.0	–	–
Total Program Costs	$45,702,177.83		$34,094,541.77		$52,081,877.67		$18,921,481.97	

Source: Department of Public Health's (Public Health) and Department of Health Care Services' accounting records.

Note: The expenditures presented in this table do not include encumbrances or obligations. As a result, the expenditure amounts shown are different from the amounts shown in Table 1.

* Data reflect the half-year period from July 1, 2009, through December 31, 2009.

† Percentage total does not equal 100 percent due to rounding.

‡ Personal Services includes salaries, wages, staff benefits, and other personnel-related services.

§ These expenses include the Every Woman Counts (EWC) program's contracts with the University of California, San Francisco, and the San Diego State University Research Foundation. Beginning in fiscal year 2009–10, Public Health began capturing its costs related to processing clinical claims in this category.

‖ Support costs for the EWC program's contracts with 10 regional partners and its hotline administered by the Northern California Cancer Center are included in this category.

\# These expenses were for student financial aid.

** Local assistance costs for the regional contracts and hotline are captured here. Beginning in fiscal year 2009–10, Public Health also started using this category for clinical claims.

†† This category accounts for clinical claims costs—medical services and case management provided to women—during fiscal years 2006–07 through 2008–09.

‡‡ This category included fees related to the fiscal intermediary's processing of EWC program clinical claims through fiscal year 2008–09.

According to Table 3, Public Health spent $52.1 million for the EWC program in fiscal year 2008–09. Roughly $41.0 million of this amount was paid for clinical claims, while $2.7 million was used to pay for various quality assurance and professional education contracts Public Health had entered into with the University of California, San Francisco (UCSF), and the San Diego State University Research Foundation, as described in Table 4 beginning on the following page. In addition, Public Health spent about $4.0 million on its telephone hotline and on additional contracts with various regional contractors that work with health providers on behalf of Public Health. Without considering the $2.4 million Public Health spent on payroll for its own employees, these costs amounted to roughly $6.7 million for fiscal year 2008–09. As shown in Table 4, our review of Public Health's contracts with these entities found that they do not result in clinical services to women eligible under EWC. If Public Health had redirected one-half of this $6.7 million—or about $3.4 million—toward paying for clinical screening activities, it potentially could have paid for screening services for more than 27,500 additional women through EWC, assuming an average cost of $122 per woman as previously shown in Table 2.

Public Health could have potentially paid for screening services for more than 27,500 additional women if it had redirected one-half of costs spent on contracts for nonclinical services in fiscal year 2008–09.

However, Public Health's ability to redirect funds away from the nonclinical aspect of its contracts is hampered by the fact that Public Health cannot determine how much its contractors spend on the specific activities shown in Table 4. As a result, it cannot evaluate whether investing these funds in such services is a better choice than screening more women. Table 4 enumerates the 10 regional contracts and five professional service contracts Public Health uses to administer the EWC program.

Although Public Health's expenditures on these contract activities are allowable under federal and state law, Public Health lacks specific accounting mechanisms, such as more detailed invoices to track expenditures for individual activities. As a result, Public Health does not know what proportion of the contractors' efforts were for the specific activities identified in Table 4. The contract agreements are also silent on this matter, specifying only a budget for the total personnel, operating, travel, and indirect costs. As a result, Public Health cannot measure the true cost of specific contractor activities and evaluate whether its spending on these areas is the best possible use of program funds.

According to its chief, the EWC program lacks staff resources to evaluate its contract activities. She asserted that although this capacity existed previously within the EWC program, evaluation activities were some of the first services cut from the program when dealing with past budget deficits. She further indicated that Public Health's EWC program currently does not have sufficient

staff resources to conduct assessments of the value added by or the cost-effectiveness of all its contracted activities. Rather, the EWC program relies on its lead staff team—program and contract managers responsible for certain monitoring activities associated with the contracts—to provide input on the status of the contracts and their deliverables during team meetings held every other week. According to EWC program management, this approach is sufficient because EWC is a public health program characterized by its provision of more than just screening services, and thus the perspective, education, training, and expertise of its program managers and contract staff inform their overall assessment of the right mix of activities to maximize the number of lives saved while continuing to meet federal and state mandates. Further, the EWC program chief explained that this perspective—how to maximize

Table 4
Contractors Supporting the Every Woman Counts Program

	CONTRACT	TOTAL CONTRACT AMOUNT	CONTRACT TERM	AVERAGE CONTRACT AMOUNT PER YEAR	GENERAL DESCRIPTION OF SERVICES PROVIDED
Regional Contracts					
1	California Health Collaborative Bay Area	$1,354,341	March 1, 2007, through June 30, 2010	$406,709	Nonclinical Activities • Maintain a diverse network of primary care providers. • Provide tailored health education and outreach to women. • Recruit primary care providers to attend professional education courses. • Conduct site reviews of enrolled primary care providers. • Participate in any continuous quality improvement projects as determined by the Department of Public Health (Public Health).
2	California Health Collaborative Central	1,415,061	March 1, 2007, through June 30, 2010	424,943	
3	California Health Collaborative Gold Country	1,104,942	March 1, 2007, through June 30, 2010	331,814	
4	California Health Collaborative Northern	1,104,942	March 1, 2007, through June 30, 2010	331,814	
5	Community Health Partnership	1,104,942	March 1, 2007, through June 30, 2010	331,814	
6	County of Orange Health Care Agency	1,104,942	March 1, 2007, through June 30, 2010	331,814	
7	Inland Agency	1,415,061	March 1, 2007, through June 30, 2010	424,943	
8	Public Health Foundation Enterprises	1,629,125	March 1, 2007, through June 30, 2010	489,227	
9	Santa Barbara County, Public Health Department	1,104,942	March 1, 2007, through June 30, 2010	331,814	
10	Scripps Health	1,104,942	March 1, 2007, through June 30, 2010	331,814	

	CONTRACT	TOTAL CONTRACT AMOUNT	CONTRACT TERM	AVERAGE CONTRACT AMOUNT PER YEAR	GENERAL DESCRIPTION OF SERVICES PROVIDED
Other Contracts					
11	Northern California Cancer Center	$3,193,001	July 1, 2005, through June 30, 2010	$638,600	Nonclinical Activities Administer a consumer 1-800 number for the Every Woman Counts (EWC) program to determine screening eligibility, refer callers to providers, and follow up with each caller two weeks after the referral to improve consumer satisfaction.
12	Regents of the University of California, San Francisco	4,660,600	February 1, 2006, through June 30, 2010	1,055,230	Nonclinical Activities • Develop and maintain a computerized system to track women and clinical services performed, assure the quality of data and clinical services, and create and submit standardized data to the Centers for Disease Control and Prevention. • Develop and evaluate methodologies to estimate and project the eligible population, caseload, and clinical costs associated with treatment.
13	San Diego State University Research Foundation	1,977,698	July 1, 2008, through June 30, 2011	659,233	Nonclinical Activities • Maintain a trained team to assist primary care providers who have submitted data to public health that indicate a need for clinical follow-up. • Conduct quality assurance activities at the request of Public Health through medical record training reviews, focus groups, key informant interviews, and tailored trainings. • Track data to monitor progress in obtaining quality assurance information for all federal records as needed. • Support primary care physicians in enrolling women with breast and cervical cancer into the Breast and Cervical Cancer Treatment program.
14	San Diego State University Research Foundation	6,277,500	July 1, 2008, through June 30, 2013	1,255,500	Nonclinical Activities • Plan and implement professional education trainings on topics such as clinical breast exams, abnormal cervical findings, and federal data requirements. • Maintain informational Web sites for providers and regional contractors. • Identify, develop, and/or revise patient education materials. • Publish articles in health care journals and newsletters regarding clinical breast exam evaluations.
15	Department of Health Care Services Interagency Agreement*	750,000	July 19, 2007, through June 30, 2010	250,000	Nonclinical Activities Reimburse the Department of Health Care Services for processing EWC clinical claims using the California Medicaid Management Information System.
	Totals	**$29,302,039**		**$7,595,269**	

Source: Public Health's contracts for the EWC program.

* The amount shown in the table represent the costs for processing the clinical claims. The total agreement amount is $112.2 million over the three-year period. Of this amount, $111.5 million is projected for payments to medical providers for clinical services rendered.

funding to save lives as opposed to maximizing the number of women served and claims paid—informs their considerations in choosing EWC's nonclinical activities and their depth.

Although Public Health may feel that it can rely on its staff's professional expertise to determine how much of its funding to invest in the nonclinical aspects of the EWC program, it would be in a better position to defend these funding decisions to the Legislature and other program stakeholders if it knew how much it spends on these nonclinical costs and could demonstrate why spending in these areas is a better choice than paying for additional screenings for eligible women. As was shown in Table 3, during fiscal year 2008–09, Public Health spent $52.1 million on the EWC program. Of this amount, it spent $2.7 million on consultants and professional services and about another $4.0 million on its regional contracts and telephone hotline. This total of $6.7 million exceeds the $6.3 million in additional funding that Public Health requested from the Legislature in June 2009 to address its expected funding shortfall to pay for clinical claims. Although Public Health may not have been able to redirect all $6.7 million to pay for screening services, its inability to demonstrate the costs and value of its nonclinical services raises the question of how much of Public Health's request to the Legislature for an additional $6.3 million was actually necessary. The EWC program chief indicated that the EWC program is currently planning for the fiscal year 2010–11 budget and is considering ways to scale back its contracts while continuing to meet federal and state requirements. According to its May 2010 request to reduce its funding for fiscal year 2010–11, Public Health indicated that it will negotiate with its regional contractors a reduction in funding and scope of work with an effective date of July 1, 2010. It further noted that some EWC program activities may be brought in-house or ceased altogether if its staff cannot absorb the additional workload.

Public Health's inability to demonstrate the costs and value of its nonclinical services raises the question of how much of its request to the Legislature for additional funds was actually necessary.

Public Health Needs to Provide the Legislature With Better Information Regarding Caseload and Cost

Although state law says that screening under the EWC program is not an entitlement, Public Health indicated that it has tried to provide all eligible women with screening services. However, rather than assess how much funding it needs to provide these services and how many women could be served as a result, Public Health instead bases its funding requests on past expenditure trends and projected growth factors. Public Health could provide greater transparency and help establish clearer expectations for program outcomes if it gave the Legislature information on its projected caseload and the related cost, as it does with its federal grant from the CDC. Further, recognizing that projections of caseload are only estimates, and that

more women could seek to access services than expected, we believe that Public Health should also seek legislation or other guidance from the Legislature to establish how it should respond when demand for screening services exceeds budget estimates.

Public Health follows the CDC's framework for developing a budget when determining how it will use federal funds to pay for the clinical screening aspect of the EWC program. This framework requires Public Health to annually establish the total cost of clinical screening by considering the costs for certain procedures, such as mammograms and ultrasounds, and projecting the number of these services to be provided during the fiscal year. For fiscal year 2008–09, Public Health informed the CDC that its goal was to serve more than 28,500 women using over $3.4 million in federal funds. The CDC used this information to set expectations for program outcomes during the year and will monitor the EWC program's performance against these goals when Public Health submits information on the actual number of women served. However, Public Health has not provided the Legislature with similar performance data on the EWC program—such as the number of women served—since 1996. If Public Health can provide this level of information to the CDC—thereby establishing expectations for program outcomes—it seems reasonable to expect that it could provide the Legislature with the same level of information and establish similar expectations regarding the level of service to be provided for the program as a whole.

Public Health has not provided the Legislature with performance data on the EWC program—such as the number of women served—since 1996, yet has consistently provided this information to the CDC.

The EWC program chief explained that, rather than using estimates similar to those it provides to the CDC, Public Health forecasts its clinical claims costs by determining a growth rate based on prior expenditure trends. Although such a growth rate for expenditures implicitly considers caseload and cost, it does not explicitly state these assumptions. The EWC program chief asserted that Public Health would like to use caseload data and be more precise in forecasting costs, but it has not done so because it lacks confidence in the reliability of the caseload data it collects. This lack of confidence is due to the fact that the EWC program does not collect Social Security numbers, making it difficult to ensure that each enrollee is counted only once. The EWC program chief explained that prior to fiscal year 2007–08, the EWC program's caseload data was linked to women's Social Security numbers; however, the EWC program ceased collecting Social Security numbers from enrollees thereafter due to a belief that EWC was not authorized to collect this information from enrollees. The EWC program chief further explained that Public Health has contracted with

UCSF to, in part, "clean" caseload data using probabilistic matching techniques[8] and to assign unique client ID numbers. Even though the costs of Public Health's contract with UCSF averages more than $1 million annually and uses the data to report to the CDC, the EWC program does not use these data for budgeting purposes or for developing annual performance reports to the Legislature. The next section of the audit report discusses Public Health's lack of reporting to the Legislature.

Public Health needs to work with the Legislature to establish how it should respond when the demand for screening exceeds budget assumptions.

Recognizing that its clinical claims budget is based on expenditure trends and growth rates, Public Health needs to work with the Legislature to establish how it should respond when the demand for screening exceeds budget assumptions. Public Health's decision to impose more stringent eligibility requirements beginning January 1, 2010, and to temporarily freeze new enrollment in the EWC program for a six-month period as a cost-containment measure caused frustration with certain members of the Legislature. A letter from one member of the Legislature to the director of Public Health in December 2009 noted, "While the [June 2009 request] included a proposal indicating the Department's intent to prioritize screening services, beginning with increasing the age eligibility for breast cancer screenings, the Conference Committee rejected this proposal and refused to place it on the agenda for hearing. Nor was an enrollment freeze for a full half of the budget year ever mentioned, discussed, proposed or voted on by anyone in the Legislature." Even though the Legislature ultimately appropriated additional funding for the EWC program for fiscal years 2008–09 and 2009–10, Public Health could have helped establish expectations for the EWC program up front during the budget process, stating how many women would be served at a certain level of funding, as it does with its federal award from CDC. If it had done so, Public Health would have been able to indicate whether or not the program had already served the agreed-upon number of women and help the Legislature decide whether the additional funding was necessary.

Public Health Needs to Provide More Transparency Regarding How It Administers the EWC Program to Promote Public Input and Enhance Legislative Oversight

State and federal law establish the EWC program and provide limited resources for the program to achieve its primary objective—funding breast and cervical cancer screening for

[8] According to its contractor, probabilistic matching techniques are used to link enrollment records based on the likelihood that matches or close matches in key fields mean that the records identify the same woman. For example, the method can account for the transposition of date data and the misspelling or transposition of names.

low-income and uninsured or underinsured women and assisting those who need help finding treatment. Given the limited resources for the EWC program, it is becoming increasingly important for the Legislature and the public to be able to provide input on how funding should be used to maximize the benefits of the program. However, our audit found that the Legislature and the public have had only limited access to information on how Public Health administers the EWC program and how effective it has been.

Specifically, Public Health is required under state law to establish regulations—which require input from interested parties and a public hearing, if requested—to implement the program. However, Public Health has not successfully established these regulations. If Public Health had promulgated regulations in accordance with Section 30461.6(k) of the Revenue and Taxation Code, which requires Public Health to adopt and implement regulations, in accordance with the Administrative Procedures Act (act), it would have been required to specify all the rules of general application for EWC, including establishing eligibility criteria and perhaps a framework for making policy changes. This regulatory framework was not in place when Public Health increased the minimum eligibility age for breast cancer screening services from 40 to 50 and froze all new enrollments for breast cancer screening services[9] for the period January 1 through June 30, 2010. Public Health also did not solicit sufficient public input before making these changes. Not surprisingly, some advocates of the EWC program criticized Public Health's decision to change the eligibility standards. Public Health's decision to modify eligibility requirements as a way to stay within the EWC program's budget implies that the eligibility requirements are subjective and can easily be changed, when in fact the law provides that such requirements must be established after careful consideration and input from the public and other interested parties through the regulatory process. Therefore, when Public Health identified a need to make key programmatic changes to contain its rising costs, it did not have a well-defined and publicly understood process for doing so.

According to Public Health's chief deputy director of operations, Public Health initiated work to develop and adopt regulations but has not completed its efforts due to staffing and budgetary limitations. Regardless of these constraints, it does not seem reasonable that Public Health has been unable to promulgate regulations in the 16 years since the program was established. Because Public Health failed to develop these important

Public Health modified eligibility requirements without first soliciting sufficient public input through a regulatory process—it has not promulgated regulations, as required, in the 16 years since the program was established.

[9] The policy to cease new enrollments does not apply to cervical cancer screenings. Further, women aged 40 through 49 who were enrolled in EWC as of December 31, 2009, and who had an abnormal breast screening will continue to receive services through EWC until a diagnosis is reached.

regulations, the general rules under which it operates the EWC program are underground regulations, which is contrary to law and the principles of public transparency.

Public Health has failed to comply with state reporting requirements related to the EWC program. Since 1994 it has only provided one report to the Legislature even though state law requires it to report certain information each year.

The Legislature's and the public's ability to monitor the success of the EWC program has also been limited by a lack of information on the number of women served by the program. State law requires Public Health to evaluate the effectiveness of the EWC program annually, providing information to the Legislature on the number of women served; their ethnicity, age, and geographic location; the severity of any cancer detected; and the treatment status of those screened. This reporting requirement was placed in state law in 1994. Since that time, Public Health has provided the Legislature only one report, in August 1996. Although state law suspended this reporting requirement between 2004 and 2008, and we noted that Public Health has provided some ad hoc caseload and expenditure information to the Legislature—through informal responses to questions from legislative staff—these communications did not contain all of the reporting information required in statute, such as geographic location, severity of cancer, or treatment status. In Appendix B we provide some of the detailed information requested by the Legislature on reported screening cycles and diagnostic outcomes for women screened for breast and cervical cancer by the EWC program.

When we asked Public Health for an explanation for its failure to comply with this reporting requirement, Public Health's chief deputy director of operations cited staff reductions and Public Health's inability to calculate the number of women served by the program, which is a requirement of the legislative report. Although Public Health has been drafting a new report since 2008, it has not finalized the report and does not know when it will be able to provide this information.

As we discussed earlier, the EWC program lacks Social Security numbers for women served by EWC, which limits its ability to uniquely identify and count the women served by the EWC program. As a result, the EWC program contracts with USCF to clean its data to minimize the number of duplicate records and assign unique client identification numbers to the women's records. According to the EWC program chief, although the probabilistic matching performed by UCSF is robust, much of its accuracy is based on the presence of an uncommon identifier—like a Social Security number—explaining that the reliability of its matching process decreases without such information. The EWC program chief further indicated that the use of the Social Security numbers was ceased in 2007 based on a belief that EWC was not authorized

to collect Social Security numbers from enrollees; however, the EWC program is reevaluating whether it is authorized to collect this information.

Despite its concerns surrounding the accuracy of these caseload estimates, Public Health submits regular reports to the federal government that rely on some of these data. We therefore question why Public Health feels confident enough in its data to provide them to CDC yet does not provide them to the Legislature or the public. Moreover, according to the Assembly Budget Committee, it has been difficult for the Legislature to provide adequate oversight of EWC due to the absence of sufficient detail in the governor's budgets on the program, as well as inadequate communication from Public Health. As a result, in May 2010, the Assembly Budget Subcommittee on Health and Human Services approved a motion to require Public Health to annually provide the Legislature with an estimate on the EWC program as required by other caseload‑driven programs, such as Medi‑Cal.

Recommendations

To ensure that Public Health maximizes its use of available funding for breast cancer screening services, it should evaluate each of the EWC program's existing contracts to determine whether the funds spent on nonclinical activities are a better use of taxpayer money than paying for a woman's breast or cervical cancer screening. To the extent that Public Health continues to fund its various contracts, it should establish clearer expectations with its contractors concerning how much money is to be spent directly on the different aspects of the EWC program and should monitor spending to confirm that these expectations are being met.

To ensure that Public Health can maintain fiscal control over the EWC program, we recommend that it take the following steps:

- Develop budgets for the EWC program that clearly communicate to the Legislature the level of service that it can provide based on available resources. One way Public Health could do this would be to estimate the number of women that can be screened at different levels of funding.

- Seek legislation or other guidance from the Legislature to define actions the program may take to ensure that spending stays within amounts appropriated for a fiscal year.

To ensure better public transparency and accountability for how the EWC program is administered, Public Health should do the following:

- Comply with state law to develop regulations, based on input from the public and interested parties, that will direct how Public Health administers the EWC program. At a minimum, such regulations should define the eligibility criteria for women seeking access to EWC screening services.

- Provide the Legislature and the public with a time frame indicating when Public Health will issue its annual report on the effectiveness of the EWC program. Further, Public Health should inform the Legislature and the public of the steps it is taking to continue to comply with the annual reporting requirement in the future.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of the report.

Respectfully submitted,

ELAINE M. HOWLE, CPA
State Auditor

Date: July 21, 2010

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Appendix A

THE DEPARTMENT OF PUBLIC HEALTH'S EXPENDITURES FOR THE EVERY WOMAN COUNTS PROGRAM

Table A below and on the following pages provides a breakdown of the Department of Public Health's expenditures for the Every Woman Counts program by funding source and transaction year. The expenditure information shown does not include encumbrances or obligations, which represent commitments made by the State that have not been paid. Since we exclude such amounts, the information presented in Table A differs from other documents prepared on an accrual or budgetary basis, such as the governor's annual budget proposal. A summarized version of these data is included in Table 3 on page 22 of our report.

Table A
Every Woman Counts Program Expenditures by Category and Funding Source
July 1, 2006, Through December 31, 2009

DESCRIPTION OF EXPENSE*	BREAST CANCER CONTROL ACCOUNT (0009)	UNALLOCATED ACCOUNT (0236)	FEDERAL TRUST FUND (0890)	ANNUAL COST CATEGORY TOTAL	PERCENTAGE OF TOTAL ANNUAL EXPENDITURES†
Transaction Year 2006–07					
Personal Services					
Salaries and wages	$948,588.86	–	$487,639.65	$1,436,228.51	3.14%
Staff benefits	331,128.64	–	164,999.21	496,127.85	1.09
Operating Expenses and Equipment					
Consultant and professional services—Interdepartmental‡	2,043,836.78	–	663,313.98	2,707,150.76	5.92
Central administrative services	21,887.00	–	43,061.66	64,948.66	0.14
Other services§	541,083.23	–	1,554,170.10	2,095,253.33	4.58
Other operating expenses and equipment	967,573.65	–	260,645.54	1,228,219.19	2.69
Special Items of Expensell	39,999.96	–	–	39,999.96	0.09
Local Costs					
Grants and subventions, governmental#	1,682,136.09	–	–	1,682,136.09	3.68
Grants and subventions, nongovernmental—Medical and health care payments**	2,629,215.45	30,691,881.50	2,335,705.26	35,656,802.21	78.02
Grants and subventions, nongovernmental—Other miscellaneous payments††	238,788.02	56,523.25	–	295,311.27	0.65
Annual Subtotals—Funding Source	**$9,444,237.68**	**$30,748,404.75**	**$5,509,535.40**		
Total Annual Expenditures				**$45,702,177.83**	

continued on next page . . .

DESCRIPTION OF EXPENSE*	BREAST CANCER CONTROL ACCOUNT (0009)	UNALLOCATED ACCOUNT (0236)	FEDERAL TRUST FUND (0890)	ANNUAL COST CATEGORY TOTAL	PERCENTAGE OF TOTAL ANNUAL EXPENDITURES†
Transaction Year 2007–08					
Personal Services					
Salaries and wages	$1,146,636.38	–	$599,947.27	$1,746,583.65	5.12%
Staff benefits	383,221.13	–	203,003.61	586,224.74	1.72
Operating Expenses and Equipment					
Consultant and professional services—Interdepartmental ‡	1,941,058.85	–	(379,989.78)	1,561,069.07	4.58
Central administrative services	284,087.00	–	41,071.27	325,158.27	0.95
Other services §	200,008.27	$(432.18)	333,582.08	533,158.17	1.56
Other operating expenses and equipment	955,835.38	(0.53)	339,490.97	1,295,325.82	3.80
Special Items of Expensell	26,666.64	–	–	26,666.64	0.08
Local Costs					
Grants and subventions, governmental#	2,851,846.01	–	–	2,851,846.01	8.36
Grants and subventions, nongovernmental—Medical and health care payments **	(3,375,975.72)	25,564,425.20	2,925,692.86	25,114,142.34	73.66
Grants and subventions, nongovernmental—Other miscellaneous payments ††	54,367.06	–	–	54,367.06	0.16
Annual Subtotals—Funding Source	**$4,467,751.00**	**$25,563,992.49**	**$4,062,798.28**		
Total Annual Expenditures				**$34,094,541.77**	
Transaction Year 2008–09					
Personal Services					
Salaries and wages	1,098,969.95	2,398.12	701,103.97	1,802,472.04	3.46
Staff benefits	351,974.68	–	250,921.90	602,896.58	1.16
Operating Expenses and Equipment					
Consultant and professional services—Interdepartmental ‡	749,410.56	380.00	1,976,674.76	2,726,465.32	5.23
Central administrative services	207,972.00	–	48,553.32	256,525.32	0.49
Other services §	1,384,332.83	–	1,046,456.28	2,430,789.11	4.67
Other operating expenses and equipment	867,669.18	–	364,054.26	1,231,723.44	2.36
Special Items of Expensell	–	–	–	–	–
Local Costs					
Grants and subventions, governmental#	1,581,546.86	–	–	1,581,546.86	3.04
Grants and subventions, nongovernmental—Medical and health care payments **	5,926,542.19	31,573,045.01	3,449,896.00	40,949,483.20	78.63
Grants and subventions, nongovernmental—Other miscellaneous payments ††	499,975.80	–	–	499,975.80	0.96
Annual Subtotals—Funding Source	**$12,668,394.05**	**$31,575,823.13**	**$7,837,660.49**		
Total Annual Expenditures				**$52,081,877.67**	

DESCRIPTION OF EXPENSE*	BREAST CANCER CONTROL ACCOUNT (0009)	UNALLOCATED ACCOUNT (0236)	FEDERAL TRUST FUND (0890)	ANNUAL COST CATEGORY TOTAL	PERCENTAGE OF TOTAL ANNUAL EXPENDITURES†
Transaction Year 2009–10‡‡					
Personal Services					
Salaries and wages	$552,538.46	–	$365,119.98	$917,658.44	4.85%
Staff benefits	189,883.77	–	130,620.93	320,504.70	1.69
Operating Expenses and Equipment					
Consultant and professional services—Interdepartmental ‡	1,180,292.36	–	747,579.14	1,927,871.50	10.19
Central administrative services	41,171.50	–	21,150.35	62,321.85	0.33
Other services §	162,910.68	–	116,346.38	279,257.06	1.48
Other operating expenses and equipment	304,616.36	–	169,941.78	474,558.14	2.51
Special Items of Expensell	–	–	–	–	–
Local Costs					
Grants and subventions, governmental#	6,836,292.25	5,737,106.98	1,170,545.60	13,743,944.83	72.64
Grants and subventions, nongovernmental—Medical and health care payments **	1,195,365.45	–	–	1,195,365.45	6.32
Grants and subventions, nongovernmental—Other miscellaneous payments ††	–	–	–	–	–
Annual Subtotals—Funding Source	**$10,463,070.83**	**$5,737,106.98**	**$2,721,304.16**		
Total Annual Expenditures				**$18,921,481.97**	

Source: Department of Public Health's (Public Health) and Department of Health Care Services' accounting records.

* Accounting code descriptions come from the Department of Finance's *Uniform Codes Manual*.

† Percentage total may not equal 100 percent due to rounding.

‡ These expenses include the Every Woman Counts (EWC) program's contracts with the University of California, San Francisco, and the San Diego State University Research Foundation. Beginning in fiscal year 2009–10, Public Health began capturing its costs related to processing clinical claims in this category.

§ Support costs for the EWC program's contracts with 10 regional partners and its hotline administered by the Northern California Cancer Center are included in this category.

ll These expenses were for student financial aid.

Local assistance costs for the regional contracts and hotline are captured here. Beginning in fiscal year 2009–10, Public Health also started using this category for clinical claims.

** This category accounts for clinical claims costs—medical services and case management provided to women—during fiscal years 2006–07 through 2008–09.

†† This category included fees related to the fiscal intermediary's processing of EWC program clinical claims through fiscal year 2008–09.

‡‡ Data reflect the half-year period from July 1, 2009, through December 31, 2009.

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Appendix B

DIAGNOSTIC OUTCOMES OF WOMEN SCREENED FOR BREAST AND CERVICAL CANCER THROUGH THE EVERY WOMAN COUNTS PROGRAM

This appendix provides information on reported screening cycles and diagnostic outcomes for women screened for breast and cervical cancer through the Every Woman Counts (EWC) program. A screening cycle is defined as an event that spans a woman's first screening test to the point of a clinical determination of the probability of cancer. If the woman does not have any suspicious abnormalities during a screening and the physician did not intend to perform further diagnostics tests, the screening cycle is complete and the woman is instructed to return for screening during the next screening interval. If the woman is not available to complete the diagnostic tests, the screening cycle ends, but the screening is not considered complete. Tables B.1 and B.2 on the following pages present the reported diagnostic outcomes in women receiving screening for breast and cervical cancer. They do not capture the number of women for whom follow-up screenings were pending, nor do they reflect those who did not complete their screening cycle. As a result, differences exist in the total number of women served by the EWC program as shown in Table 2 on page 18 and the total number of women shown in these tables as having a reported diagnostic outcome.

Table B.1

Reported Diagnostic Outcome of Breast Cancer Screening Cycles Provided by the Every Woman Counts Program July 1, 2006, Through December 31, 2009

	DIAGNOSTIC OUTCOME*		
	BREAST CANCER NOT DETECTED†	BREAST CANCER OR OTHER RELATED CONDITION DETECTED THAT REQUIRES TREATMENT ‡	BREAST CONDITION DETECTED FOR WHICH TREATMENT MAY BE COMPLETED §
Fiscal Year 2006–07			
Age 39 and under‖	77	6	0
Age 40 to 49	10,068	252	12
Age 50+	10,324	471	27
Totals	**20,469**	**729**	**39**
Fiscal Year 2007–08			
Age 39 and under‖	87	1	0
Age 40 to 49	12,088	243	16
Age 50+	12,445	507	20
Totals	**24,620**	**751**	**36**
Fiscal Year 2008–09			
Age 39 and under‖	18	1	0
Age 40 to 49	12,643	300	21
Age 50+	12,627	607	34
Totals	**25,288**	**908**	**55**
July 1, 2009, to December 31, 2009			
Age 39 and under‖	0	0	0
Age 40 to 49	6,528	173	16
Age 50+	6,909	293	19
Totals	**13,437**	**466**	**35**

Source: Bureau of State Audits' analysis of the Department of Public Health's (Public Health) Detecting Early Cancer system.

Note: This analysis was performed using data that the University of California, San Francisco (UCSF)—the Every Woman Counts (EWC) program's data contractor—had "cleaned" to eliminate duplicate records.

* These data present the screening outcomes for women for whom an outcome was reported. A screening cycle is defined as an event that spans a woman's first screening test to the point of a clinical determination of the probability of cancer. Because screening cycles may not always be reported as completed, differences exist in the total number of women served by the EWC program, as shown in Table 2 on page 18, and the total number of women shown in this table as having a reported diagnostic outcome.

† This category includes cycles in which breast cancer was not diagnosed, a benign growth or abnormality was detected and the provider recommended follow-up within less than a year, or an initial screening did not reveal any abnormalities that required additional diagnostic procedures.

‡ Diagnostic outcomes reported in this category include carcinoma in situ, invasive breast cancer, and ductal carcinoma in situ.

§ The diagnosis in this category was lobular carcinoma in situ. This condition is recognized as increasing a woman's risk of developing invasive breast cancer. As a result, a woman and her provider may choose to begin treatment to prevent invasive breast cancer from developing.

‖ During our audit period, women under the age of 40 were not eligible for breast cancer screening services under the EWC program. However, our analysis revealed that outcomes were reported for some women under the age of 40. This may be due to data errors, as these data were of undetermined reliability. Further, according to UCSF, until December 2008, providers were able to report breast cancer screening cycle outcomes to Public Health, regardless of the woman's age, but would not be reimbursed for the services provided.

Table B.2
Reported Diagnostic Outcome of Cervical Cancer Screening Cycles Provided by the Every Woman Counts Program July 1, 2006, Through December 31, 2009

	Diagnostic Outcome*			
	Cervical Cancer Not Detected†	Cervical Cancer Detected That Requires Treatment ‡	Precancerous Cervical Condition Detected That Is Likely to Progress Into Cancer Without Treatment§	Precancerous Cervical Condition Detected ll
Fiscal Year 2006–07				
Age 39 and under	166	1	24	36
Age 40 to 49	375	2	42	54
Age 50+	465	7	47	49
Totals	**1,006**	**10**	**113**	**139**
Fiscal Year 2007–08				
Age 39 and under	170	2	31	41
Age 40 to 49	432	1	61	70
Age 50+	549	10	62	75
Totals	**1,151**	**13**	**154**	**186**
Fiscal Year 2008–09				
Age 39 and under	196	2	36	88
Age 40 to 49	417	2	64	137
Age 50+	607	15	73	125
Totals	**1,220**	**19**	**173**	**350**
July 1, 2009, to December 31, 2009				
Age 39 and under	79	0	21	44
Age 40 to 49	200	1	28	71
Age 50+	321	7	47	88
Totals	**600**	**8**	**96**	**203**

Source: Bureau of State Audits' analysis of the Department of Public Heath's (Public Health) Detecting Early Cancer system.

Note: This analysis was performed using data that the University of California, San Francisco (UCSF)—the Every Woman Counts (EWC) program's data contractor—had "cleaned" to eliminate duplicate records.

* These data present the screening outcomes for women for whom an outcome was reported. A screening cycle is defined as an event that spans a woman's first screening test to the point of a clinical determination of the probability of cancer. Because screening cycles may not always be reported as completed, differences exist in the total number of women served by the EWC program, as shown in Table 2 on page 18, and the total number of women shown in this table as having a reported diagnostic outcome.

† This category includes cycles in which the outcome was normal or there was a benign reaction or inflammation, human papillomavirus, condylomata, atypia, or some other noncancerous result. Additionally, the provider may have determined that any abnormalities detected did not require additional diagnostic procedures.

‡ Invasive cervical carcinoma was the diagnostic outcome reported in this category.

§ Diagnoses reported in this category include cervical intraepithelial neoplasia grade II and grade III (moderate and severe dyplasia, respectively) and high-grade synamous intraepithelial lesion (which indicates moderate to severe dysplasia or carcinoma insitu). For such diagnoses, treatment should be completed.

ll The diagnosis in this category was intraepithelial neoplasia grade I (mild dysplasia) or low-grade squamous intraepithelial lesion (which indicates mild dysplasia). These conditions are recognized as increasing a woman's risk of developing invasive cervical cancer. As a result, a woman and her provider may choose to begin treatment to prevent invasive cervical cancer from developing.

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(Agency response provided as text only.)

California Department of Public Health
P.O. Box 997377
Sacramento, CA 95899-7377

May 25, 2010

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Public Health (CDPH) has prepared its response to the Bureau of State Audits (BSA) draft report entitled, "Department of Public Health: It Faces Significant Fiscal Challenges and Lacks Transparency in Its Administration of the Every Woman Counts Program June 2010 Report 2010-103." The CDPH appreciates the opportunity to provide the Bureau of State Audits with a response to the draft report.

If you have any questions, please contact Karen Petruzzi, CDPH Audit Coordinator (916) 650-0266.

Sincerely,

(Signed by Jose Ortiz for)

Mark B Horton, MD, MSPH
Director

Enclosure

* California State Auditor's comments appear on page 45.

CDPH Response to: Draft Report- Department of Public Health:
It Faces Significant Fiscal Challenges and Lacks Transparency in Its Administration of
the Every Woman Counts Program
Bureau of State Audits June 2010 Report 2010-103

Recommendation 1:

To ensure that Public Health maximizes its use of available funding for breast cancer screening services, it should evaluate each of the EWC program's existing contracts to determine whether the funds spent on nonscreening activities are a better use of taxpayer funds than paying for a woman's breast or cervical cancer screening. To the extent that Public Health continues to fund its various contracts, it should establish clearer expectations with its contractors concerning how much money is to be spent directly on the different aspects of the EWC program and monitor to confirm such expectations are being met.

CDPH Response 1:

CDPH agrees that providing clinical services is a priority for this program, and over the past six years the Every Woman Counts program has reduced non-clinical expenditures by 25 percent in order to serve more women. In addition, the Administration's May Revision proposal includes redirecting funds from case management to clinical services, and the program is further reviewing contracts and policies to maximize the number of screenings provided to women. CDPH also agrees with the audit's finding that there is flexibility in how the EWC program spends its federal grant, but disagrees that the program would be able to serve more women and still meet the grant's requirements as the audit suggests. (1)

The EWC program is required by the Centers for Disease Control and Prevention (CDC) grant to administer non-clinical services and support. The CDC guidelines state, "every funded program is responsible for educating and motivating women to seek screening; ensuring that services are convenient, accessible, and provided in a respectful, culturally competent manner; effectively communicating results; and recalling and assisting women who need additional services." While screening services are essential to the program, CDC guidelines state that "the existence of these services is not sufficient to achieve a reduction in the illness and death associated with these diseases—other activities must also occur to support direct screening services. These activities are reflected in the eight major components of the NBCCEDP [National Breast Cancer and Cervical Cancer Early Detection Program] conceptual framework." The required framework includes professional development, recruitment, evaluation, partnerships, and quality assurance in addition to screening, and are executed in California through a series of regional contracts. As these contracts have been reduced as noted above, it has become more challenging for the program to fulfill it's federal grant requirements. Despite these challenges, however, CDPH will continue to review contracts and other non-clinical services to maximize the number of women served through the program.

Recommendation 2:

To the extent that Public Health continues to fund its various contracts, it should establish clearer expectations with its contractors concerning how much money is to be spent directly on the different aspects of the EWC program and monitor to confirm such expectations are being met.

CDPH Response 2:

CDPH agrees to continue reviewing the program's contract management process to better quantify and categorize contract activities and deliverables. Currently, CDPH conducts detailed evaluation of its contractors to ensure successful completion of deliverables. While each contract is different, key management activities include: (2)

CDPH Response to: Draft Report- Department of Public Health:
It Faces Significant Fiscal Challenges and Lacks Transparency in Its Administration of
the Every Woman Counts Program
Bureau of State Audits June 2010 Report 2010-103

- Detailed scopes of work and associated contract budgets
- Site visits and in-person compliance monitoring, including compliance with privacy laws and other standards of practice
- Technical assistance workshops
- Contractor progress reports
- Data collection through an electronic data system

Since FY 2007-2008, the EWC program has improved its contracts by including more stringent performance measures and evaluation requirements based on the federal program requirements and continues to look for opportunities to improve contract management and evaluation.

Recommendation 3:

To ensure that Public Health can maintain fiscal control over the EWC program, we recommend that it take the following steps:

- Develop budgets for the EWC program that clearly communicate to the Legislature the level of service that it can provide based on available resources. One way Public Health could do this would be to estimate the number of women that can be screened at different levels of funding.

CDPH Response 3:

CDPH agrees to perform an estimate of the number of women that can be screened at different levels of funding. CDPH will develop rough caseload estimates based on available data and expects to provide more accurate detail upon implementation of a formal estimating process and program changes to improve data quality.

Currently, the EWC program has a decentralized enrollment process and does not use unique identifiers, such as social security numbers, to identify enrolled women, making it difficult for the program to accurately track caseload data. In addition, EWC is not an entitlement program; as such, the program has not previously been required to develop a formal estimate process. In order to provide the most accurate data possible given these challenges, the program evaluates claims and enrollment data to estimate the number of women who have received or will receive services.

Recognizing these program challenges, CDPH has already started developing plans to create a single point of enrollment, implement the use of unique identifiers, and develop a formal estimates process in order to provide more accurate data.

Recommendation 4:

- Seek legislation or other guidance from the Legislature to define actions the program may take to ensure that spending stays within amounts appropriated for a fiscal year.

CDPH Response to: Draft Report- Department of Public Health:
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Bureau of State Audits June 2010 Report 2010-103

CDPH Response 4:

CDPH agrees with the recommendation to seek legislation or other guidance from the Legislature to define actions that the program may take to ensure that spending stays within the amounts appropriated for a fiscal year.

Historically, CDPH has used the annual Budget process to communicate to the legislature proposed budgets for the program. That process has also included requests for funding changes and plans for remaining within their appropriation. CDPH agrees with the audit's finding that the program is not an entitlement, and cannot spend beyond what has been appropriated by the Legislature. In order to better communicate with the Legislature, CDPH will provide reports to the Legislature, promulgate regulations to direct EWC program administration, and implement a formal estimating process in addition to using the budget process.

Recommendation 5:

To ensure better public transparency and accountability for how the EWC program is administered, Public Health should do the following:

- Comply with state law to develop regulations, based on input from the public and interested parties, that will direct how Public Health will administer the EWC program. At a minimum, such regulations should define the eligibility criteria for women seeking access to EWC screening services.

CDPH Response 5:

CDPH agrees with the recommendation to develop regulations for the EWC program. CDPH recognizes the importance of establishing regulations for the program and has prioritized development of EWC regulations. CDPH is currently developing a plan for regulation development and assessing timelines, resource needs, and other impacts of establishing regulations for the program.

Recommendation 6:

- Provide the Legislature and the public with a time frame indicating when Public Health will issue its annual report on the effectiveness of the EWC program. Further, Public Health should inform the Legislature and the public of the steps it is taking to continue to comply with the annual reporting requirement in the future.

CDPH Response 6:

(3) CDPH agrees to provide the Legislature and the public with a time frame indicating when a report to the Legislature can be completed. At this time, CDPH projects that a Report to the Legislature for 2008-09 program services can be submitted by February 1, 2011.

CDPH is redirecting staff to compile data and complete the report. As noted in Response 3, the program has been challenged by limited data collection which impacts the quality of data available. As also noted in Response 3, however, program will provide the best data available and will continue to develop improvements to the program to enable more comprehensive and accurate data to be shared with the Legislature and the public.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF PUBLIC HEALTH

To provide clarity and perspective, we are commenting on the response to our audit from the Department of Public Health (Public Health). The numbers below correspond with the numbers we have placed in the margin of Public Health's response.

① Public Health is incorrect when it says that the Every Woman Counts (EWC) program would not be able to serve more women and still meet the Centers for Disease Control and Prevention (CDC) grant's requirements. As we state on page 20, our review of federal requirements and discussions with the CDC indicate that Public Health has the flexibility to redirect funding to screening activities without risking the loss of federal funds. Even though Public Health's response cites the CDC guidelines, CDC makes it clear that screening is the focus of the program. As we state on page 21, the CDC's program guidance indicates that despite the inherent value of these nonclinical activities, Public Health must ensure that federal grant money remains focused on screenings.

② Public Health's response does not fully address our recommendation. As we note on page 23, Public Health does not know what proportion of the contractors' efforts were for the specific activities identified in Table 4. The contract agreements are also silent on this matter, specifying only a budget for the total personnel, operating, travel, and indirect costs. As a result, Public Health cannot measure the true cost of specific contractor activities and evaluate whether its spending on these areas is the best possible use of program funds.

③ Notwithstanding Public Health's assertion that it can submit its report to the Legislature for fiscal year 2008–09 program services by February 1, 2011, it is our opinion that Public Health should provide more timely information. As shown in Appendix B, we were able to analyze and provide some of the data required by the law. Even though Public Health may believe that it is unable to provide all required information until February 2011, it could still foster transparency by providing what information it does have on the effectiveness of the program.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press