Implementation of State Auditor's Recommendations

Audits Released in January 2002 Through December 2003

Special Report to

Senate Budget and Fiscal Review Subcommittee #3—Health, Human Services, Labor, and Veterans Affairs

February 2004
Report No. 2004-406 S3

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February 25, 2004 2004-406 S3

The Governor of California
Members of the Legislature
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

The Bureau of State Audits presents its special report for the Senate Budget and Fiscal Review Subcommittee No. 3—Health, Human Services, Labor, and Veterans Affairs. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations.

This information is also available in a special report that is organized by policy areas that generally correspond to the Assembly and Senate standing committees. This special policy area report includes appendices that summarize recommendations that warrant legislative consideration and monetary benefits that auditees could realize if they implemented our recommendations. This special policy area report is available on our Web site at www.bsa.ca.gov/bsa/reports/subcom2004-policy.html. Finally, we notify auditees of the release of these special reports.

Our audit efforts bring the greatest returns when the auditee acts upon our findings and recommendations. This report is one vehicle to ensure that the State's policy makers and managers are aware of the status of corrective action agencies and departments report they have taken. Further, we believe the State's budget process is a good opportunity for the Legislature to explore these issues and, to the extent necessary, reinforce the need for corrective action.

Respectfully Submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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INTRODUCTION

This report summarizes the major findings and recommendations from audit and investigative reports we issued from January 2002 through December 2003, that relate to agencies and departments under the purview of the Senate Budget and Fiscal Review Subcommittee No. 3—Health, Human Services, Labor, and Veterans Affairs. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the left-hand margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

For this report, we have relied upon periodic written responses prepared by auditees to determine whether corrective action has been taken. The Bureau of State Audits' (bureau) policy requests that auditees provide a written response to the audit findings and recommendations before the audit report is initially issued publicly. As a follow-up, we request the auditee to respond at least three times subsequently: at 60 days, six months, and one year after the public release of the audit report. However, we may request an auditee provide a response beyond one year or initiate a follow-up audit if deemed necessary.

We report all instances of substantiated improper governmental activities resulting from our investigative activities to the cognizant state department for corrective action. These departments are required to report the status of their corrective actions every 30 days until all such actions are complete.

Unless otherwise noted, we have not performed any type of review or validation of the corrective actions reported by the auditees. All corrective actions noted in this report were based on responses received by our office as of February 2, 2004.

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DEPARTMENT OF DEVELOPMENTAL SERVICES, PORTERVILLE DEVELOPMENTAL CENTER

Investigations of Improper Activities by State Employees, August 2002 Through January 2003

ALLEGATION I2002-952 (REPORT I2003-1), APRIL 2003

Department of Developmental Services response as of October 2002[1]

Investigative Highlights . . .

Porterville Developmental Center:

- ☑ *Failed to verify whether two employees had completed the education requirements for the positions to which they were appointed.*
- ☑ *Accepted two additional applications after the final filing date had already passed.*

The Department of Developmental Services (department) investigated and substantiated an allegation that the Porterville Developmental Center (center) illegally appointed two individuals to psychologist positions.

Finding #1: The center illegally appointed two individuals to psychologist positions.

In violation of state law, the center appointed two individuals, employee A and employee B, to psychologist positions, even though neither of the individuals met the educational requirements for the position.

Specifically, employee A began working for the center as a psychology intern in October 1999. That position required enrollment in and completion of at least one year of a postgraduate program leading to a doctoral degree in psychology. When employee A applied for the intern position, she projected a completion date of May 2000 for her doctorate. In August 2000, employee A applied for the psychologist position and revised her projected completion date for her degree to September 2000. Although the center appointed employee A to a psychologist position in October 2000, no one verified that she had completed her doctoral degree, even though completion of the degree is required prior to

[1] Since we report the results of our investigative audits only twice a year, we may receive the status of an auditee's corrective action prior to a report being issued. However, the auditee should report to us monthly until its corrective action has been implemented. As of January 2004, this is the date of the auditee's latest response.

such an appointment. As of July 31, 2002, employee A still had not met the educational requirements for the position she had been working in for nearly two years.

Similar to the situation with employee A, no one at the center verified whether employee B had completed his doctoral degree prior to his appointment as a psychologist.

Finding #2: Employee A and center employees failed to follow other center hiring procedures.

On July 28, 2000, a program within the center advertised a vacancy for a psychologist position. As of the August 4, 2000, final filing date, the exams unit had received two applications, one from employee C and one from employee D, which it forwarded to the appropriate program to schedule interviews. Subsequently, a nursing coordinator for the program directly accepted applications from employee A and another employee, employee E. The exam analyst later wrote a note on employee E's application form acknowledging that the employee had changed his mind and decided to apply for the position. Center procedures state that an applicant submitting an application after the final filing date must obtain approval from the center's personnel officer for admission to the interview process.

However, no record indicates that the exams unit was aware that the nursing coordinator also directly accepted an application from employee A. Neither employee A nor the nursing coordinator notified the exams unit of employee A's application; as a result, the exams unit did not find out about the application until after it had interviewed employee A and approved her appointment to the position.

Center and Department Action: Corrective action taken.

The department conferred with the State Personnel Board and has taken corrective action by having employees A and B voluntarily transfer to psychology-associate positions. In addition, the center has implemented new procedures to prevent this type of illegal appointment from occurring in the future. The new procedures include a stringent process for review of applicants' credentials by at least three levels of personnel, including two levels at the center and one at the department.

DEPARTMENT OF HEALTH SERVICES

It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process

REPORT NUMBER 2001-129, MAY 2002

Department of Health Services' response as of April 2003

Audit Highlights . . .

Our review of the Department of Health Services' Provider Enrollment Branch's management of the Medi-Cal provider enrollment process revealed that:

- ☑ *It lacks reliable data to determine the size of its backlog.*
- ☑ *It could not substantiate its decisions to designate certain providers as being at high risk for fraud.*
- ☑ *It did not always review disclosure statements required by the federal Health and Human Services Agency, aimed at identifying applicants with a history of defrauding or abusing the Medicaid system.*
- ☑ *It will continue to have difficulty effectively managing its operations until it develops a strategic plan and fully implements its data tracking system.*

The state Department of Health Services (department) administers California's Medicaid program, referred to as Medi-Cal, which accounts for almost $27 billion in annual expenditures. A provider must obtain a valid Medi-Cal provider number in order to bill the Medi-Cal program for services provided to an eligible Medi-Cal beneficiary. The department's Provider Enrollment Branch (branch) is responsible for reviewing applications for providers such as physicians, physician groups, pharmacies, and clinical laboratories. The branch received more than 27,000 applications between February 14, 2001, and January 31, 2002.

The Joint Legislative Audit Committee requested that we examine the process used by the department for enrolling Medi-Cal providers. Our audit concluded that until the branch addresses certain deficiencies, it would continue to have difficulty meeting its regulatory timelines, securing additional staff, and effectively managing its operations. Specifically:

Finding #1: The branch cannot determine the number of applications remaining to be processed.

The branch does not know how many of the roughly 27,000 applications it received between February 14, 2001, and January 31, 2002, have been approved, denied, or remain to be processed. In February 2001, the branch instituted a new database—the Provider Enrollment Tracking System (PETS)—which can provide such information. However, branch management is unable to use PETS to provide management reports that will allow it to determine the number of applications awaiting final disposition because staff have not always entered data into the database consistently. Although

the branch had devoted time and resources to develop PETS and train staff, we found no evidence that the branch has implemented a procedure to review periodically the data that staff input into PETS. Because staff do not enter data into PETS consistently, the branch can neither effectively track the applications it processes nor use the reports PETS is capable of producing to identify its backlog and manage its operations.

We recommended that to improve the management of the Medi-Cal provider enrollment process, the branch should use PETS more effectively to track how long an application has been in a certain step of the enrollment process, making sure that notification is sent to the applicant at proper intervals; and modify PETS so it can track the status of high- or low-risk provider types and determine whether the average processing times vary. The branch also should identify all applications that, according to PETS, are still in progress, determine their actual status, and update PETS, if necessary. Further, the branch should review PETS-generated reports at least monthly and perform analyses to determine whether staff are entering data accurately and consistently. Finally, it should fully use the capabilities of PETS for developing reports on a variety of productivity indicators, including, for example, aging reports and reports showing the number of applications approved, denied, and in progress.

Department Action: Corrective action taken.

In its one-year response dated April 23, 2003, the department stated that PETS is now used to determine the length of time an application is in progress, track the status of high- and low-risk provider types, and determine the average processing time for both. Additionally, in order to conform to the timeframes required by the enrollment regulations, PETS now generates several reports for department staff to use to track the progress and status of pending applications. Further, PETS has been modified to allow staff to track those applications that are resubmitted within 35 days, because when initially submitted the applications were not complete.

At the end of December 2002, the department completed the establishment of additional edits in the PETS database to ensure data entered is valid. The branch will continue to monitor and review reports produced by PETS and add edits to meet program report needs as required.

Finding #2: The branch does not ensure that it reviews applications within 180 days.

Although PETS cannot provide meaningful information for those applications that are pending branch action, it does show that the branch frequently took more than 180 days to process some applications. We found that the data was reliable when branch staff entered both the receipt and completion date. In addition to not consistently tracking the applications it processes internally, the branch also does not monitor applications it refers to the department's Audits and Investigations (A&I) unit for on-site reviews. The branch does not use PETS to establish or track dates indicating when it should receive a response back from A&I so that it can meet its regulatory deadlines.

We recommended that to improve its monitoring of referrals, the branch should use PETS to track applications it refers to A&I. Also, the branch should work closely with A&I to monitor the status of its referrals to ensure that the total review time for applications does not exceed regulatory requirements. In addition, the department should establish policies and procedures for the branch and A&I to coordinate their review processes so it is able to meet regulatory requirements and ensure that A&I implements its new case-tracking system by late 2002.

Department Action: Corrective action taken.

The department reported that, in addition to having the data in PETS, the branch entered all of its referrals directly into A&I case-tracking system, which was implemented in October 2002. The department also stated that branch staff have been trained to use the system and have direct access to check the status of pending referrals.

Finding #3: The branch could not substantiate its decisions to designate certain providers as high- or low-risk.

The branch's objective is to prevent providers with fraudulent intent from participating in the Medi-Cal program. Consequently, it is reasonable that the branch should use relevant and available information to identify those provider types that pose a greater risk of fraud. Further, the branch should document these decisions and review them periodically to ensure that they are still relevant. However, the branch could not substantiate how it determines the risk that it assigns to certain provider types, nor does it reevaluate its risk assessment periodically.

We recommended that the branch periodically perform an analysis to justify its existing risk assessments for high- and low-risk provider types and submit its analysis for department approval. Upon approval of the analysis, the branch should issue a policy memo to staff. Further, the department should formalize its process for determining which provider types should be subject to increased scrutiny and when, based upon the most recent anti-fraud trend information available.

Department Action: Partial corrective action taken.

The department stated that informally it continually evaluates risk assessments for effectiveness and applicability. The department told us that it will continue to work with its partners to identify and evaluate risk indicators and trends. If any significant changes in current assessments of high- and low-risk providers are proposed, formal documentation will occur. Also, A&I and the branch have established monthly meetings with the first meeting occurring in December 2002, to address anti-fraud issues and to review all provider types that need closer scrutiny.

Finding #4: The branch needs to rectify its poor decision to cease reviewing certain provider disclosure statements, which exposes the State to loss of federal funds.

Although both state and federal regulations require applicants or providers to submit disclosure statements with their applications, in its effort to reduce its backlog, the branch inappropriately stopped reviewing disclosure statements for certain applicants or providers. Specifically, the branch did not review all disclosure statements received between October 2000 and September 2001 for physician and allied group applicants or providers. As a result, the branch increased the risk of enrolling providers who may have disclosed questionable financial relationships or a past history of fraud, abuse, or criminal convictions relating to other Medicare or Medicaid programs.

We recommended that the branch identify all physician providers who were enrolled between October 2000 and September 2001 and review their disclosure statements in accordance with federal requirements. The branch should direct staff to continue to review disclosure statements for all providers.

Department Action: Partial corrective action taken.

The department reported that it plans to implement this recommendation on a flow basis. Specifically, as the branch receives requests or inquiries from providers who enrolled between October 2000 and September 2001, staff will review the initial application. If the initial application does not include a disclosure statement, one will be requested and reviewed.

Finding #5: Reenrollment of existing providers could strengthen the Medi-Cal enrollment process.

To strengthen the enrollment process and weed out potentially fraudulent providers, the branch should expand its efforts to reenroll existing providers. In August 1999, the department began to reenroll certain provider types identified as problematic. The branch is continuing its efforts to reenroll durable medical equipment and non-emergency medical transportation providers. However, due to the increase in workload resulting from its reenrollment efforts, the branch has postponed its reenrollment of independent pharmacies until summer 2002.

We recommended that the branch complete its current reenrollment efforts and consider expanding these efforts to include all provider types to ensure provider integrity in the Medi-Cal program.

Department Action: Partial corrective action taken.

The department told us that its reenrollment efforts for durable medical equipment, orthotics and prosthetics, and non-emergency medical transportation providers is substantially complete. The department received approval to create a reenrollment section in fiscal year 2002–03. Initial mailings to reenroll pharmacy and physician providers were sent in February 2003 and as of March 2003 the branch had notified approximately 1,000 of these providers and was awaiting either responses or application packages.

Finding #6: A strategic plan would help the branch address its performance deficiencies.

The branch has addressed only a few of the essential elements of strategic planning such as defining its mission and establishing its top priorities. However, the branch has not described the

actions necessary to achieve its top priorities. For example, the branch states that it will reduce the backlog of physician applications, but does not address critical questions relevant to doing so, such as how it will determine the number of applications in progress and whether it has sufficient staff.

We recommended that the branch develop a strategic plan to identify key responsibilities and establish priorities. This plan should clearly describe how the organization would address its many short- and long-term responsibilities, particularly those that we observed it has not sufficiently accomplished. In addition, the branch should conduct a study to determine how long it takes staff, on average, to process applications for the various provider types. Using results from the study and accurate workload standards, the branch should assess whether it has the appropriate staffing levels.

Branch Action: Corrective action taken.

The branch reports that it has developed a strategic plan, which is currently in place.

Finding #7: The department did not adhere to state hiring practices in its efforts to seek additional resources for the branch.

Although state laws establish the standards to use in contracting for personal services, the department did not follow these standards when attempting to secure employees to assist the branch with processing provider enrollment applications. Specifically, the department had not obtained approval to use up to 10 contractor staff to assist the branch during the period of July 2001 through January 2002, but had incurred costs of roughly $490,000. Also, the department may not have met the State's standards for using personal services contracts when it hired student assistants through contracts with the California State University Sacramento Foundation (foundation). Between March 1, 2001, and January 31, 2002, the branch incurred costs of more than $138,000 in salaries, employment taxes, and fees to reimburse the foundation for the 22 student assistants it hired. However, the department did not prepare an analysis to demonstrate that contracting with the foundation could result in actual overall cost savings to the State.

We recommended that the department should discontinue its use of contractor staff to assist the branch in processing provider enrollment applications. It should also ensure that it adheres to state standards for using personal services contracts when hiring employees such as student assistants.

Department Action: Corrective action taken.

The department stated it discontinued its use of contractor staff effective May 31, 2002. Further, the department contends that it does adhere to state standards for using personal service contracts when hiring employees such as student assistants and will continue to do so.

DISABLED VETERAN BUSINESS ENTERPRISE PROGRAM

Few Departments That Award Contracts Have Met the Potentially Unreasonable Participation Goal, and Weak Implementation of the Program Further Hampers Success

Audit Highlights . . .

Our review of the Disabled Veteran Business Enterprise (DVBE) program found that:

- ☑ *Many awarding departments do not report their DVBE participation levels; of those that do report, most do not meet the 3 percent participation goal.*
- ☑ *The reasonableness of the 3 percent goal itself is not clear.*
- ☑ *Outreach to potential DVBEs should be more aggressive.*

Other factors that contribute to the State's failure to meet the DVBE goal are:

- ☑ *The program's overly flexible legal structure and limited clarifying regulations.*
- ☑ *The frequency with which certain departments exercise their discretion to exempt contracts from DVBE participation.*
- ☑ *Lack of effective evaluation of bidders' good-faith efforts and monitoring of contractors' compliance with contract DVBE requirements.*

REPORT NUMBER 2001-127, JULY 2002

Audit responses as of July 2003 and October 2003[1]

The Joint Legislative Audit Committee requested that we determine the extent to which departments that award contracts (awarding departments) are meeting the 3 percent Disabled Veteran Business Enterprise Program (DVBE) participation goal and to identify statutory and procedural mechanisms that could assist in overcoming any barriers to fulfilling this goal. We found that many awarding departments do not report DVBE participation as required under law, and even fewer departments actually meet the goal. Specifically, we found:

Finding #1: Awarding departments' DVBE participation statistics are not always accurate, and the methodologies they employ are at times flawed.

State law requires each awarding department to report to the governor, Legislature, the Department of General Services (General Services), and the Department of Veterans Affairs (Veterans Affairs) by January 1 each year on the level of participation by DVBEs in state contracting. General Services then issues a summary report.

Our own review showed that some awarding departments did not report DVBE statistics and others could not always provide supporting documentation for the DVBE statistics they reported. For example, for fiscal year 2000–01, the Department

[1] Business, Transportation and Housing; State and Consumer Services; and Youth and Adult Correctional agencies and Departments of General Services, Transportation, and Veterans Affairs responses as of July 2003. Departments of Fish and Game and Health Services and Health and Human Services Agency responses as of October 2003.

of Fish and Game (Fish and Game) reported $12.1 million in DVBE participation but could identify only $431,000 in specific contracts, or less than 3.6 percent of the total. In addition, the Department of Health Services (Health Services) could not provide any summarized documentation for the numbers it reported. Health Services asserted that it had documentation in individual contract files to support its figures, but indicated it would be too time intensive to tally the information for our review.

Additional problems with the accuracy of DVBE participation information exist. The reporting methodology General Services established is contrary to statutory requirements. According to statute, the 3 percent DVBE participation goal applies to the overall dollar amount expended each year by the awarding department. However, under current reporting regulations issued by General Services, awarding departments must report the amount winning bidders "claim" they will pay to DVBEs under the contract. In its clarifying instructions, General Services has asked awarding departments to report the amounts "awarded" in contracts, rather than amounts actually paid to DVBEs.

To ensure DVBE statistics are accurate and meaningful, we recommended General Services require awarding departments to report actual participation and maintain appropriate documentation of statistics, continue its periodic audits of these figures for accuracy, and, if the audits reveal a pattern of inconsistencies or inaccuracies, address the causes in its reporting instructions.

General Services' Action: Partial corrective action taken.

General Services has interpreted the statutes governing DVBE reporting to provide participation statistics to be reported based on the value of contracts awarded instead of dollars actually expended. According to General Services, this is the same methodology used in the small business participation report (California Government Code, Section 14840). General Services believes it is important to use consistent reporting standards to allow for program comparisons. Since its six-month response, based on the concerns raised by our office, General Services has revisited the issue and concluded that its own interpretation of the DVBE reporting requirements is reasonable and appropriate. We disagree with General Services' interpretation of the DVBE reporting requirements. As we state on page 18 of the audit report, departmental reporting of actual payments [to DVBEs] provides more useful information because it focuses on the realized benefit to DVBEs.

As to the issue of requiring departments to maintain documentation of participation statistics, to reemphasize this administrative control procedure, General Services indicates it has added an instruction to the new participation report form that addresses the necessity of maintaining supporting documentation. Departments used this new form in reporting fiscal year 2001–02 cumulative participation statistics. General Services is also continuing to include the audit of the DVBE reporting process within its comprehensive external compliance audit program performed of other state agencies. It indicates it uses the results of these audits to identify areas for possible improvement within the reporting process.

Finding #2: Not all state agencies have finalized and implemented their plans to monitor their departments' reporting of DVBE statistics and, for those failing to meet the 3 percent goal, require a DVBE improvement plan.

In June 2001, the governor issued executive order D-43-01, which requires all state agency secretaries to review the DVBE participation levels achieved by the awarding departments within their agencies. Further, the executive order requires each secretary to require awarding departments to develop an improvement plan if the 3 percent goal is not achieved or the data is not reported. Three of five state agencies responding to our survey indicated that they were still developing procedures to monitor the DVBE participation levels of their subordinate awarding departments.

We recommended those state agencies that have not already done so should finalize and implement their plans to monitor awarding departments' reporting of DVBE statistics and, for those failing to meet the 3 percent goal, monitor their efforts to improve DVBE participation.

Agency Action: Partial corrective action taken.

On June 28, 2002, the governor directed that all state departments and agencies submit monthly reports to the State and Consumer Services Agency regarding DVBE participation. Based on the reporting forms developed by the State and Consumer Services Agency, state departments and agencies are required to report total contracting dollars,

dollars paid to DVBEs, and DVBE participation percentages. In addition, departments that have not met the 3 percent DVBE participation goal are required to explain why.

Each of the following state agencies indicates the development of plans to monitor awarding departments' reporting of DVBE statistics: State and Consumer Services Agency; Business, Transportation and Housing Agency; Health and Human Services Agency; and the Youth and Adult Correctional Agency. The Resources Agency did not provide a one-year update on its efforts to implement this recommendation. Some agencies reported increases in DVBE participation during the fiscal year 2001–02. In particular, the State and Consumer Services Agency reported a DVBE participation rate of 3.3 percent in 2002, which is an increase from 1.5 percent in the prior year. Further, the Business, Transportation and Housing Agency similarly reported an increase in DVBE participation, indicating 3.7 percent participation during the fiscal year 2001–02.

Finding #3: The State does not know how many DVBEs can be certified and the extent to which they can provide needed goods and services to the State. As a result, the reasonableness of the 3 percent goal is uncertain.

Even though the law establishes a 3 percent participation goal for every awarding department, our review did not find sufficient evidence to support the assumption that this is an equitable share of contracts for DVBEs. When the DVBE legislation was being drafted in 1989, several awarding departments opposed the bill on the grounds that the 3 percent goal was unrealistic.

The awarding departments' concern about enough DVBEs to justify the 3 percent goal seems to have been valid. As of May 2002, General Services had only 797 DVBEs certified and available for contracting. The services these DVBEs offered and their geographical distribution did not always match the State's needs. All five agencies responding to our survey and many awarding departments' improvement plans identified a limited pool of DVBEs as one of the impediments to meeting the 3 percent DVBE participation goal.

To determine if the 3 percent DVBE goal is reasonable, the Legislature may wish to consider requiring either General Services or Veterans Affairs to commission a study on the

potential number of DVBE-eligible firms in the State, the services they provide, and their geographic distribution, and compare this information to the State's contracting needs.

Based on the results of this study, the Legislature may wish to consider doing the following:

- Modify the current DVBE participation goal.
- Allow General Services to negotiate department-specific goals based on individual contracting needs and the ability of the current or potential DVBE pool to satisfy those needs.

Legislative Action: None.

We have found no indication that any study on DVBE-eligible firms has been commissioned. Further, the statutory requirement for the DVBE participation rate remains at 3 percent, while the reasonableness of this goal remains unclear.

Veterans Affairs' Action: None.

According to Veterans Affairs' September 2002 response to this recommendation, it appears that the department was intending to commission a study on the number of potentially DVBE-eligible firms in the State. However, the department's July 2003 update does not specifically address this recommendation.

Finding #4: General Services is not sufficiently aggressive or focused in its outreach and promotional efforts for the DVBE program.

As the administering agency for the DVBE program, General Services has been responsible for certifying eligible businesses as DVBEs and conducting promotional and outreach efforts to increase the number of certified DVBE firms.

It is unclear to what extent General Services' outreach activities target disabled veterans' groups. General Services was also unable to readily quantify its outreach activities. The information it ultimately provided was based on old personal calendars and planners. We also could not evaluate the effectiveness of these outreach activities since General Services only selectively monitors the results.

To ensure the DVBE program is promoted to the fullest extent possible, we recommended General Services aggressively explore outreach opportunities with the U.S. Department of Veterans Affairs and organizations such as the American Legion, Disabled American Veterans, and Veterans of Foreign Wars. In particular, General Services should cultivate a clear working relationship with county veteran service officers. It should also maintain complete records of its outreach and set up a system to track effectiveness. For example, General Services could consistently survey newly certified DVBEs to determine how they heard about the program and what convinced them to apply for certification. Finally, General Services and Veterans Affairs should continue to work to develop their joint plan for improving the DVBE program, finalizing and implementing it as soon as possible.

General Services' and Veterans Affairs' Action: Partial corrective action taken.

On June 28, 2002, the governor directed the implementation of a more intensive DVBE outreach effort, with the staff dedicated to that effort moved from General Services to Veterans Affairs. According to General Services, on August 1, 2002, the two DGS staff members performing the outreach function physically transferred to Veterans Affairs.

According to the July 2003 response from Veterans Affairs, it has completed the CDVA Disabled Veterans Business Enterprise Outreach Program Plan, which became effective April 1, 2003. The plan indicates that Veterans Affairs will introduce General Services "outreach team members" to veteran organizations' leadership and local county veteran services officers. However, Veterans Affairs also indicated that in May 2003, the two employees working on DVBE outreach, formerly from General Services, returned to that department. The plan also indicates that Veterans Affairs will establish working relationships with veteran service representatives and local county veteran service organizations.

Finding #5: Some awarding departments exempt a significant number of contracts, potentially limiting their ability to maximize DVBE participation rates.

Under statute, the DVBE participation goal applies to an awarding departments' overall expenditures in a given year. Therefore, awarding departments have the discretion to apply DVBE participation requirements on a contract-by-contract basis.

The frequency with which certain awarding departments exempt contracts from DVBE requirements is significant. Further, some of these awarding departments are not tracking the value of the contracts they exempt or the required compensating increase in participation goals for their remaining non-exempt contracts. For fiscal year 2000–01, two of the five awarding departments we reviewed, Health Services and Caltrans, did not compensate for these exemptions with increased participation on other contracts, and subsequently reported they did not meet the participation goal. According to our calculations, Health Services exempted 48 percent of DVBE-eligible contract dollars it reported in fiscal year 2000–01, which means it would have had to average almost 6 percent on all remaining eligible contracts to meet the goal. Similarly, General Services' procurement division estimated that it exempted over 50 percent of its contracts during fiscal year 2000–01.

Awarding departments offer varying reasons for their exemption decisions. Some departments we reviewed exempt all contracts with certain characteristics, and the reasonableness of these blanket decisions may not be clear. For example, at least one unit within four of the five departments we reviewed has indicated it exempts all contracts it believes do not offer a subcontracting opportunity for DVBEs. However, this practice may significantly reduce a department's chances for obtaining more DVBE participation.

To maximize DVBE participation, we recommended awarding departments attempt to use DVBEs as prime contractors instead of viewing them only as subcontractors. Further, the awarding departments should periodically examine the basis for their assumptions behind blanket exemptions for whole categories of contracts to ensure the exemptions are justified.

General Services', Caltrans', Health Services', and Fish and Game's Action: Partial corrective action taken.

General Services indicates it has policies and practices that actively encourage the use of DVBEs as prime contractors. Further, General Services has asserted that its chief deputy director stressed to General Services staff that all contracts include DVBE participation unless specifically exempted. Caltrans indicates that its DVBE exemption requests are researched to verify that no certified DVBEs are available in the particular geographic area specified to perform the work. Caltrans also indicates that it mails DVBE solicitation

materials to contractors who are on a special list of DVBEs and who provide services in the geographical area. Health Services similarly reported that it now reviews each DVBE exemption request by requiring its programs to explain why DVBE participation is not viable or possible. Health Services also requires that General Services' Web site be verified to ensure no DVBEs are available to perform likely subcontract services in the service location. Fish and Game asserts it does not have a blanket exemption by category type. However, it indicates that it does exempt contracts under $10,000 from DVBE participation requirements. Fish and Game has determined that requiring bidders to undergo a good-faith effort to find and use a DVBE under these circumstances is not cost-effective. Fish and Game also indicates that if the lowest bidder on a contract is a DVBE, it awards the contract to the DVBE acting as a prime contractor.

Finding #6: Awarding departments do not consistently scrutinize and evaluate good-faith effort documentation or ensure that DVBEs are actually being used as called for in contracts.

The effectiveness of the implementation of the good-faith effort may be diminished by the lack of consistent or meaningful standards for awarding departments to follow when evaluating bidders' documentation of such efforts. Although statute requires General Services to adopt standards, it has not issued much direction to awarding departments on how to evaluate a bidder's good-faith effort. The State Contracting Manual offers appropriate suggestions for procedures in assessing good-faith effort, but the suggestions are not binding. There is also no clear requirement in statute requiring awarding departments to monitor actual DVBE participation to ensure the contractor is complying with the contract's DVBE requirements.

A common result of this lack of direction is the cursory evaluation of a bidder's good-faith effort documentation and inconsistent monitoring of actual DVBE usage. For example, Health Services does not instruct staff to independently verify bidders' statements that they solicited DVBEs to participate as subcontractors. Before February 2002, Health Services also lacked policy to monitor actual DVBE participation. Caltrans also does not follow up to ensure the DVBEs that the bidder claimed to have solicited were actually contacted. Although

Caltrans' procurement unit did have a policy to monitor actual DVBE participation to ensure contract compliance, we saw no monitoring consistent with this policy in a sample of their contract files.

To ensure that prime contractors make a genuine good-faith effort to find a DVBE, we recommended the Legislature consider requiring awarding departments to follow General Services' policies. General Services should issue regulations on what documentation the awarding departments should require and how they should evaluate that documentation. These standards should include steps that ensure the documentation submitted is accurate. Similarly, General Services should issue regulations on what steps departments should take to ensure contractors meet DVBE program requirements. These steps might include requiring awarding departments to monitor vendor invoices that detail DVBE participation or requiring the vendor and DVBE to submit a joint DVBE utilization report.

Legislative Action: None.

We found no indication that the Legislature has required awarding departments to follow General Services' policies regarding the evaluation of bidders' good-faith effort documentation.

General Services' Action: Partial corrective action taken.

Effective April 1, 2003, the procurement division of General Services revised its solicitation instructions and forms to require bidders to provide additional information and documentation on their compliance with DVBE program requirements. These new bidder instructions are available on General Services' Web site and are available for use by other state agencies. Further, General Services states that it has begun the process of reviewing DVBE program regulations to identify areas of improvement.

Finding #7: The efficiency and effectiveness of the DVBE program could be improved with legislation aimed at providing incentives for DVBE participation and penalties for bidders who do not comply with program requirements.

Legislation establishing the DVBE program does not have adequate provisions to ensure compliance with program goals.

To increase the efficiency and effectiveness of the DVBE program, we recommended the Legislature consider doing the following:

- Replace the current good-faith effort step requiring bidders to contact the federal government with a step directing bidders to contact General Services for a list of certified DVBEs.
- Enact a contracting preference for DVBEs similar to the one for the small business program—that is, allow an artificial downward adjustment to the bids from contractors that plan to use a DVBE to make the bids more competitive.
- Require awarding departments to go through their own good-faith effort in seeking DVBE contractors.
- Provide awarding departments with the authority to withhold a portion of the payments due to contractors when they fail to use DVBEs to the extent specified in their contracts.

➲ ***Legislative Action: None.***

We found no indication that the Legislature has passed legislation addressing the recommendations presented above.

OFFICE OF CRIMINAL JUSTICE PLANNING

Experiences Problems in Program Administration, and Alternative Administrative Structures for the Domestic Violence Program Might Improve Program Delivery

Audit Highlights . . .

The Office of Criminal Justice Planning (OCJP) has not fulfilled all of its responsibilities in administering state and federal grants, including the domestic violence program. Specifically, OCJP:

- ☑ *Has not adopted guidelines to determine the extent it weighs grant recipients past performance when awarding funds.*
- ☑ *Does not always provide grant applicants the necessary information or time to challenge its award decisions.*
- ☑ *Missed opportunities to seek guidance an advisory committee could provide regarding program administration.*
- ☑ *Has not consistently monitored grant recipients.*
- ☑ *Spent $2.1 million during the last three years on program evaluations of uneven quality, content and usefulness.*

continued on next page

REPORT NUMBER 2002-107, OCTOBER 2002

Office of Criminal Justice Planning and Department of Health Services' responses as of November 2003

The Joint Legislative Audit Committee (audit committee) requested an audit of Office of Criminal Justice Planning's (OCJP) administration of its grant programs in general and of its and the Department of Health Services' (DHS) administration of their respective domestic violence programs in particular. The audit committee also asked us to identify alternatives to the current administrative structures for the domestic violence programs. We reported the following findings:

Finding #1: Weaknesses in OCJP's process for awarding grants may result in the appearance that its awards are arbitrary or unfair.

OCJP has not adopted guidelines weighing grant recipients' past performance when awarding funds, nor is its review process systematic enough to identify grant recipients with poor past performance. Moreover, OCJP does not always provide unsuccessful grant applicants the necessary information or time to challenge its award decisions, and it has missed opportunities to seek the guidance an advisory committee could provide regarding certain decisions that affect program administration.

To ensure its application process is perceived as fair and impartial, we recommended that OCJP take the following steps:

- Create guidelines and criteria to determine when an applicant's past performance issues rise to the level that OCJP will consider those issues when deciding whether or not to continue the applicant's funding.

Our review of the domestic violence programs administered by OCJP and the Department of Health Services (DHS) revealed that:

- ☑ *OCJP decided not to correct an inconsistency in its 2001 request for proposals, which resulted in fewer shelters receiving funding.*
- ☑ *DHS has not established guidelines as to how past performance will be considered when awarding grants.*
- ☑ *OCJP and DHS award the majority of their domestic violence funds to shelters for the provision of similar services.*
- ☑ *OCJP's and DHS's activities for awarding grants and providing oversight of recipients sometimes overlap.*

- Conduct a periodic uniform review of all applicants with regard to past performance issues that includes applying weighting factors that indicate the relative importance of each such issue as it relates to future funding.
- Promptly inform grant recipients when their past performances are jeopardizing their chances for future funding.
- Properly document the rationale not to fund grant recipients and clearly state in the rejection letters sent to the applicants the reasons that they were denied funding.
- Change the process for the filing of appeals so that an applicant has 10 to 14 calendar days, depending on the type of grant award, from the registered receipt of the notification letter in which to justify and file an appeal.

To improve outreach to its grant recipients and comply with legislation that is soon to take effect, we recommended that OCJP create an advisory committee for the domestic violence program that could provide guidance on key program decisions.

OCJP Action: Partial corrective action taken.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its grant programs will be transferred to other state agencies. Prior to its closure, OCJP stated that it had created a formal written policy to use when considering the past performance of an applicant as a factor in its funding decisions and that the new policy will be used for those applying for competitive funding under OCJP's next request for proposal. However, we reviewed the new policy and, while we believe it is a good first step, it is still too vague and subject to varying interpretation.

In order to address the possible view that the current appeals guidelines are overly strict in terms of the time allowed to file an appeal and that the denial notice is too limited concerning the reasons for the denial, OCJP has revised its appeals guidelines. The guidelines were reviewed and approved by an independent council that hears such appeals at the end of July 2003. The new guidelines, which were implemented August 1, 2003, permit more time to appeal and provide more information to those applicants that are denied.

Finally, OCJP stated it would work with the agency that will be administering the domestic violence program beginning in 2004—the Office of Emergency Services—to establish a Domestic Violence Advisory Committee that will provide insight and guidance in administering the domestic violence program.

Finding #2: OCJP does not provide consistent and prompt oversight of grant recipients.

Although OCJP conducts a variety of oversight activities, its efforts lack consistency and timeliness. It has not visited grant recipients as planned and has not considered prioritizing its visits to first monitor recipients with the highest risk of problems. It has also been inconsistent in following up on its grant recipients' submission of required reports, and it has not always reviewed required reports promptly and consistently. In addition, it has spent nearly $23,000 per year to review audit reports that another state agency also reviews. Finally, it has not always conducted sufficient follow-up on reports once it notified grant recipients of performance problems.

We recommended that OCJP take several actions to improve its oversight of grant recipients, including:

- Ensure prompt site visits of newly funded grant recipients.
- Establish a risk-based process for identifying the grant recipients it should visit first when it conducts monitoring visits.
- Develop written guidelines to determine when and how staff should follow up on late progress reports and ensure that existing guidelines are followed regarding the prompt follow up on late audit reports.
- Ensure that it reviews audit reports within six months of receipt in order to comply with federal guidelines and promptly follow up on audit findings until they are resolved.
- Revise its process for reviewing the audit reports for municipalities to eliminate duplicating the State Controller's Office's (SCO) efforts.
- Establish written guidelines to address how staff should follow up on problems identified in progress reports or during site visits to ensure they are resolved.

- Require that its monitors review grant recipients' corrective action plans to ensure problems identified during monitoring visits have been appropriately addressed through problem-specific narratives.

OCJP Action: Partial corrective action taken.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its grant programs will be transferred to other state agencies. Prior to its closure, OCJP stated that it has a goal of conducting one technical site visit for a new grant recipient within the first six months of the grant period and one monitoring visit within the three-year grant period. Therefore, at a minimum, every grant recipient should receive a visit at least once every three years. OCJP also stated it was continuing to implement its plan to prioritize monitoring visits based on identified problems, the length of time since the last visit, and the dollar value of the project. Once its grant programs are transferred to other agencies, OCJP stated it would work with the receiving agencies to ensure a smooth transition of the monitoring function.

OCJP stated that it has made significant progress in reducing its backlog of pending reviews of grantee audit reports. For example, OCJP reports it has reviewed 235 audit reports as of October 2003, and anticipates it will complete reviews of 269 more before it ceases operations at the end of the year, and will work with the agencies taking over its grant programs so that work continues on reducing the backlog. Finally, OCJP stated it intends to provide the written guidelines for its grant programs to those agencies slated to administer them once they are transitioned and will also help those agencies develop procedures for following up on problems identified in grantee progress reports, technical or monitoring site visits, or other sources such as audit reports.

Finding #3: OCJP has not properly planned its evaluations or managed its evaluation contracts.

During the last three years, OCJP's evaluation branch spent $2.1 million on activities that culminated in evaluations of uneven quality, content, and usefulness. The branch lacks a process that would help it determine what programs would profit most from evaluations, how detailed evaluations should be, what criteria evaluations must satisfy, and, until recently, how to ensure they contain workable recommendations. The branch has been lax in management of its contracts; as a result,

it did not include measurable deliverables in one contract and failed to ensure that it received the deliverables contained in others. It also circumvented competitive bidding rules in entering an agreement with a University of California extension school.

To improve its evaluations branch, we recommended that OCJP:

- Develop a planning process to determine what programs would profit most from evaluations, how rigorous evaluations should be, and that it follow its new process for discussing the relevance and feasibility of proposed recommendations to improve their chances for implementation.
- Develop general criteria establishing what evaluations should accomplish.
- Include measurable deliverables and timelines in its contracts with evaluators and hold evaluators to their contracts.
- Withhold payments to contractors whenever they do not provide established deliverables or when the deliverables are not of the quality expected.
- Ensure that interagency agreements with university campuses comply with state guidelines regarding competitive bidding.

OCJP Action: Partial corrective action taken.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its grant programs will be transferred to other state agencies. Prior to its closure, OCJP stated that significant efforts have been make to identify and prioritize those evaluations that are mandated, and it is working to ensure that evaluation criteria and requirements are met. A new interim chief was assigned to oversee evaluation activities and has since issued five evaluation reports with plans to issue one more before OCJP ceases operations at the end of the year.

Finding #4: OCJP's allocation of indirect and personnel costs may have resulted in some programs paying for the administration of others.

OCJP's method for assigning indirect and personnel costs to the various programs it administers may result in some programs paying the administrative costs for others. Its allocation of indirect costs has been inconsistent, and it has not kept adequate records of

its allocation decisions to demonstrate that they were appropriate. OCJP has also failed to require its employees to record their activities when working on multiple programs as required by federal grant guidelines.

We recommended that OCJP ensure that it equitably allocates all indirect costs to the appropriate units and maintains sufficient documentation to support the basis for its cost allocation. OCJP also should establish an adequate time-reporting system that uses activity reports or certifications, as appropriate, to document the total activity for each employee and then use such reports or certifications as the basis for allocating personnel costs.

OCJP Action: Corrective action taken.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its grant programs will be transferred to other state agencies. Prior to its closure, OCJP stated that it had designed a functional timesheet modeled after those used by other state agencies, trained its staff on its use, and fully implemented the timekeeping system as of May 2003. The timesheets better ensure that costs are accurately recorded in the accounting system.

Finding #5: OCJP's decision not to correct an inconsistency in its request for proposals resulted in fewer domestic violence shelters receiving funding.

OCJP funded almost three fewer domestic violence shelters than it could have in fiscal year 2001–02 because it chose not to correct an inconsistency in the 2001 request for proposals for its domestic violence grant. This decision resulted in a reduction of nearly $450,000 a year of funds available for shelters. The error occurred during the development of its request for proposals, when program staff set the minimum amount that a small shelter would receive at $185,000 a year, even though an adjoining table within the proposal stated that $185,000 was the maximum amount that a small shelter could receive. The minimum amount was over $30,000 more for some small shelters than the minimum OCJP had previously awarded.

OCJP could provide no documentation of the decision-making process it used to arrive at the $185,000 funding minimum, such as written input from the shelters stating that the previous minimum amount was insufficient. Furthermore, OCJP provided

no indication that it had considered the consequences that raising the minimum funding amount of some shelters by as much as $30,000 would produce.

So that it can support and defend future funding decisions affecting the domestic violence program, we recommended that OCJP document and retain the reasons for changing funding levels.

OCJP Action: Pending.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its grant programs will be transferred to other state agencies. Prior to its closure, OCJP stated that Senate Bill 1895 provided the authority to create an advisory council effective January 1, 2003, that could recommend specific future funding levels for all shelters in OCJP's domestic violence program. Further, OCJP stated it would work with the agency that will be administering the domestic violence program beginning in 2004—the Office of Emergency Services—to establish a Domestic Violence Advisory Committee that can provide such insight and guidance.

Finding #6: DHS has not considered past performance or been able to use its advisory committee when awarding grants.

DHS has not adopted guidelines or criteria to establish when a grant recipient's past performance has been sufficiently poor to prevent it from being awarded funds during the next grant cycle, nor has it established a systematic review process to identify grant recipients with poor past performance. Further, forces outside of its control precluded DHS from seeking counsel from a domestic violence advisory committee as required by state law.

We recommended that DHS develop guidelines and criteria to determine when a grantee's past performance warrants denying it funding in the next grant cycle, which would include performing a periodic uniform review of all grant recipients' past performance. Also, now that enough appointments have been made to the advisory council to create a quorum, DHS should meet frequently with the council to seek its input as required by law.

DHS Action: Partial corrective action taken.

DHS stated that it has begun to meet regularly with the domestic violence advisory council and will request that the council consider whether it should use the past performance of grant recipients in preparation for awarding funds in future Request for Applications (RFA). If past performance is to be used in determining grant awards, DHS will develop specific criteria.

Finding #7: DHS has not fully met its responsibility to oversee grant recipients.

DHS does not have a process to conduct state-mandated site visits of its grant recipients. Moreover, it has not considered prioritizing its visits to first monitor those with the highest risk of problems. It has also been inconsistent in following up on its grant recipients' late submission of required reports, and it has not always reviewed required reports promptly and consistently.

To ensure better oversight of its shelters, we recommended that DHS:

- More efficiently use its resources when complying with state law mandating technical site visits to all its shelters by establishing a risk-based process for identifying which shelters it should visit first.
- Develop a structured process for staff to use to follow up on late progress reports. This process should include documenting follow-up efforts.
- Ensure that staff follow existing guidelines regarding the prompt follow-up of late audit reports.
- Ensure that it reviews all submitted progress reports promptly.

DHS Action: Corrective action taken.

DHS stated that it has put a system in place to ensure that timely review and follow up of progress reports occurs and that the system includes a status log that lists all the deliverables required from the shelters, including progress reports. The status log contains a "notes" column to record staff follow-up efforts regarding late reports, and all written communication or e-mail contacts with the shelters will be maintained in the working file.

In addition, DHS stated that it had developed and maintains an audit-tracking log to monitor the receipt of audit reports, and has developed guidelines to ensure that audit reports are received on time. Finally, DHS stated that it is on schedule to complete at least one site visit to each shelter within the current grant cycle as required by law.

Finding #8: OCJP and DHS require separate grant applications for similar activities.

OCJP and DHS conduct separate grant application processes. As a result, shelters must submit separate applications describing how they will use each program's funds, although the applications and the services themselves are similar.

To reduce the administrative burden for the shelters, we recommended that OCJP and DHS coordinate the development of the application processes for their shelter-based programs and identify areas common to both where they could share information or agree to request the information in a similar format.

OCJP's and DHS's Actions: Pending.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its domestic violence programs will be transferred to the Office of Emergency Services. DHS stated it would continue its efforts to coordinate the application process for the shelter-based program with this new administering agency.

Finding #9: OCJP and DHS perform some of the same oversight activities.

OCJP and DHS require shelters to submit periodic progress reports containing similar information, except that each requires the information for a different time period. Furthermore, as a result of a new legislative requirement, DHS will perform site visits to shelters to assess their activities and provide technical assistance, even though OCJP already conducts such visits.

To avoid duplicate oversight activities, we recommended that OCJP and DHS consider the following changes to their administrative activities and requirements:

- Align the reporting periods for their progress reports so that shelters do not have to recalculate and summarize the same data for different periods.

- Coordinate technical site visits, monitoring site visits, and audits that they schedule for the same shelters.

- Establish procedures for formally communicating on a regular basis with each other their ideas, concerns, or challenges regarding the shelters.

OCJP's and DHS's Actions: Pending.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its domestic violence programs will be transferred to the Office of Emergency Services. DHS stated it would continue its efforts to coordinate the oversight process for the shelter-based program with this new administering agency to avoid duplication.

Finding #10: Greater cooperation or consolidation between OCJP's and DHS's programs could increase efficiency.

Because of the similarity of OCJP's and DHS's programs and the overlap between their application and oversight activities, adopting an alternative administrative structure could improve the efficiency of the State's approach to funding domestic violence services.

To improve the efficiency of the State's domestic violence programs and reduce overlap of OCJP's and DHS's administrative activities, we recommended OCJP and DHS, along with the Legislature, should consider implementing one of the following alternatives:

- Increase coordination between the departments.

- Develop a joint grant application for the two departments' shelter-based programs.

- Combine the two shelter-based programs at one department.

- Completely consolidate all OCJP's and DHS's domestic violence programs.

OCJP's and DHS's Actions: Pending.

According to the 2003–04 Budget Act, OCJP will be eliminated effective January 1, 2004, and its domestic violence programs will be transferred to the Office of Emergency Services. DHS stated it would continue its efforts to coordinate the process for administering the shelter-based program with this new agency to avoid duplication.

Legislative Action: Unknown.

We are not aware of any legislative action with regard to this recommendation.

DEPARTMENT OF HEALTH SERVICES

It Needs to Better Control the Pricing of Durable Medical Equipment and Medical Supplies and More Carefully Consider Its Plans to Reduce Expenditures on These Items

Audit Highlights . . .

Our review of the Department of Health Services' (department) purchasing and contracting practices for durable medical equipment (DME) and medical supplies under the California Medical Assistance Program (Medi-Cal) revealed that:

- ☑ *While the number of beneficiaries and related expenditures are increasing, federal funding for Medi-Cal is likely to decrease by $222 million in fiscal year 2002–03.*
- ☑ *The department's cost control procedures have not prevented significant spending increases for unlisted items—those with no established maximum allowable product costs (MAPCs).*
- ☑ *It has been more than 15 years on average since the department last updated the MAPCs for many medical supplies.*
- ☑ *The department's inadequate planning for two initiatives it believes will reduce its DME and medical supply costs—converting its medical supply billing codes to universal product numbers and negotiating contracts with manufacturers—may undermine their success.*

REPORT NUMBER 2002-109, DECEMBER 2002

Department of Health Services' response as of January 2004

The Joint Legislative Audit Committee asked us to examine the Department of Health Services' (department) purchasing and contracting practices for durable medical equipment (DME) and medical supplies under the California Medical Assistance Program (Medi-Cal). We found that the department's cost control procedures have been ineffective in reining in spending for items with no maximum allowable prices (unlisted items). In addition, the department has failed to ensure that it does not approve expenditures for unlisted DME items that should be charged under listed codes at a lower cost. Further, the department has delayed price updates for its medical supplies for an average of 15.5 years, and many of its product codes may be obsolete. Finally, the department's inadequate planning for two initiatives it believes will reduce its DME and medical supply costs may result in increased administrative costs and a failure to reduce expenditures.

Finding #1: The department's cost control procedures have been ineffective in reining in spending for unlisted items.

The department's expenditures for unlisted DME and medical supplies have increased significantly over the past four years, and its cost control procedures have done little to rein in these expenditures. Specific areas our audit identified include:

- The department's payments for unlisted DME items accounted for most of the increases in expenditures for all DME. From 1998 through 2001, expenditures for unlisted DME increased by $34.3 million, or 89.4 percent. Similarly, the department's expenditures for unlisted medical supplies increased, even though total medical supply expenditures have decreased in recent years. In 2001, the department paid 11.1 percent less

for medical supplies with established maximum prices, but 27.5 percent more for medical supplies without such prices than it did in 1998.

- Although state regulations require providers and manufacturers to provide Medi-Cal with rates that do not exceed the price they charge to the general public, in December 1997, the department instructed its field office staff to discontinue reviewing authorization requests for cost.

- Field office staff lack cost-comparison tools, such as functional equivalence tables, that would allow them to compare requested items to other items that perform the same essential functions. Because they lack this information, the field office staff must rely on their experience and judgment to determine whether amounts are appropriate. Further, because the department lacks cost-comparison tools that will allow its field office staff to make meaningful comparisons of the requested items with other available products, field office staff tends to approve a product regardless of cost as long as it is medically necessary.

- We found that other states have some procedures that the department may wish to consider adopting. For example, we found that New York's Medicaid program caps reimbursement for unlisted items at the lesser of 150 percent of the provider's acquisition cost, or the provider's usual and customary charge to the general public. Further, New York uses a voice-activated authorization system to process routine authorization requests and thus free up staff resources to perform other reviews.

- Field office staff do not ensure that providers use listed codes whenever possible or justify why they do not. By not doing so, the department may pay more for an unlisted item than it would pay for another listed or unlisted item that meets the patient's needs. In fiscal year 2001–02, the department paid an average of $622 for wheelchairs with listed codes, but an average of $3,121 for unlisted wheelchairs.

- While the department attributed the large difference in average prices for listed versus unlisted wheelchairs to obsolete maximum allowable product costs (MAPCs)—the department last updated its MAPCs for listed wheelchairs in 1985 (17 years ago)—we found that the department's failure to enforce cost control procedures also contributed to the rising cost of unlisted wheelchairs. For example, the department's June 1998 policy statement requires field

office staff to approve unlisted wheelchairs only if providers document information including why a listed code cannot be used for the equipment the patient needs, and that the requested wheelchair is the lowest cost item among other comparable brands or types that meet the patient's medical needs. However, field office staff apparently approve requests for prior authorization for all wheelchairs as long as the requests are accompanied by a physician prescription. Staff also allow the use of unlisted codes for all wheelchairs and components. Consequently, the department may be paying more than necessary for customized wheelchairs.

We recommended that the department should do the following to ensure that it receives a fair and reasonable price for DME, medical supplies, and hearing aids:

- Analyze its payments for unlisted DME and medical supplies to determine whether it should establish maximum allowable product costs for any of these items.

- Analyze periodically its expenditures to determine utilization of high-dollar items and possible causes for increases in expenditures.

- Consider developing a voice-activated authorization system for straightforward transactions to free staff resources for more complex prior authorizations or cost analyses.

- Develop tools, such as functional equivalence and price comparison tools, for its field office staff to compare prices among similar items for unlisted DME and medical supplies.

- Cap reimbursement for unlisted items at the lesser of a department-determined percentage of the provider's cost (e.g. 150 percent of cost) or the provider's usual and customary cost charged to the general public, and require providers to submit their cost information with claims for reimbursement.

- If the department does not wish to set this cap and require providers to submit cost information, it should enforce its requirement that providers of unlisted wheelchairs document why the wheelchair cannot be billed under listed codes and that the recommended wheelchair is the least costly of alternative items that meet patient needs.

Department Action: Partial corrective action taken.

The department reports that it has taken the following actions:

- The department continues to convert its current billing codes to the national Healthcare Common Procedures Coding System codes (national codes) as required by the federal government for compliance with the Health Insurance Portability and Accountability Act, and has already implemented eight of these national codes for pediatric wheelchairs. It expects to finish converting to the national codes by summer 2004, and once fully implemented, the department will use only national codes for all DME. The national codes clearly define specific products with established Medicare reimbursement rates, which the department will use when reimbursing Medi-Cal providers.
- The department has also sponsored legislation establishing DME maximum reimbursement rates at either 80 percent (non-wheelchairs) or 100 percent (wheelchairs) of the established Medicare rate. Consequently, once it finishes converting its billing codes to the national codes, the department will eliminate its current practice of reimbursing certain billing codes without an established Medicare maximum rate at up to 90 percent of the manufacturer's suggested retail price.
- The department established maximum quantity and frequency limits for 35 additional medical supply items.
- The department changed its pricing policy for medical supplies. Instead of setting reimbursement rates using the highest priced manufacturer's item within a given category, the department now uses the median priced manufacturer's item.
- In some instances, the department has reduced the mark-up a manufacturer can use to establish the average wholesale price from 35 percent above the dealer cost listed in the dealer catalog to 25 percent.
- The department now requires a copy of an approved treatment authorization request to accompany all claims for miscellaneous medical supplies billed to the program using unlisted codes.

- EDS, the Medi-Cal fiscal intermediary, now reviews expenditure data on a weekly basis to determine changes in payment patterns. The department assists with this review. It also uses EDS systems to track payment changes weekly and over time.
- In lieu of creating a voice-activated system, the department developed a less-costly way to implement authorization controls to prevent recipients exceeding the department's limit for selected medical supplies. It established a per-beneficiary, per provider limitation on certain supplies and uses the claims processing system to check claims for beneficiaries who exceed the department's limit by using multiple providers.
- The department is reviewing price data, product specifications, features, and other product information for DME as part of its contracting activities. The department plans to use this data to revamp and update field office tools that staff can use to select the least expensive type of item that meets the patient's needs.
- With the passage of the 2003-04 Budget Trailer Bill, the department changed its reimbursement methodology for all DME. For those items with a maximum allowable rate for California established under the Medicare program (maximum allowable rate), the new reimbursement rates are generally stated as a percentage of the lowest maximum allowable rate. For those DME items without a maximum allowable rate, the reimbursement rate is generally the lower of the amount billed, a percentage of the manufacturer's suggested retail price, or cost plus a percentage markup.

Finding #2: The department overpaid for some rentals.

Field office staff's misunderstanding of regulations may have caused the department to pay $8.3 million more for renting stationary volume ventilators over three years than the department would have paid by purchasing these items. Our review found that the department would have paid $4.1 million if it had purchased these items, rather than the $12.4 million it paid for renting them. Field office staff stated that regulations require them to approve only rentals of ventilators and prohibit them from purchasing them, which we found to be a misunderstanding of the regulations.

We recommended that the department clarify its rental policies with its field office staff to ensure that overpayments for DME rentals are not occurring.

Department Action: Partial corrective action taken.

The department states that it is currently exploring implementing a "capped" rental reimbursement methodology on some DME items.

Finding #3: The department has not kept its codes and prices current and may not be receiving the lowest rates offered by providers or manufacturers.

The department has been lax in updating its prices for items with MAPCs, and it may not be getting the same rates offered by providers or manufacturers to the general public. Specifically, we found the following:

- While technology improvements have made some items less expensive, the department has been lax in updating its prices for these items, and may be missing out on savings opportunities on these items. For example, the department issued only 10 operational instructional letters to its fiscal intermediary in the past three years. Of these 10 letters, only four actually updated a price on file, and those updates affected the MAPC for only seven of thousands of product codes for DME, medical supplies, and hearing aids.

- The department may be hampered in updating DME and hearing aid rates on a timely basis because these rates are established in regulations. In order to change these rates, the department must initiate and obtain approval for a change to the regulations, which can be a lengthy process.

- Although state regulations require the department to update its medical supply rates no less than every 60 days, on average for those medical supply product codes billed during fiscal year 2001–02, the department allowed 5,720 days, or about 15.5 years to elapse between price updates. This could potentially cost the department money. For example, we found that for two product codes the department could save an additional $911,000 by making sure to update its prices in fiscal year 2002–03.

For those items for which it has established maximum allowable product costs, the department should ensure that it reviews and updates these rates on a regular and frequent basis. Further, to enable the department to become more responsive to changes in prices, the department should seek legislation to remove prices for DME and hearing aid items from regulations.

Department Action: Partial corrective action taken.

The department states that it hopes its ongoing universal product number (UPN) project will resolve issues with keeping its codes and prices current. The department is continuing to collect data on UPN codes to determine the availability of these codes for DME. Additionally, the department states that its contract renegotiation process will serve as a mechanism for determining if reimbursements need to be adjusted thereby providing the department a process for reviewing and updating rates.

Additionally, with the passage of the 2003-04 budget trailer bill, the department was given the authority to establish maximum allowable reimbursement rates and utilization controls in provider manuals, and is no longer required to promulgate regulations to add, delete, or change a covered service or reimbursement rate.

Finding #4: The department has not fully considered the challenges and costs of implementing its cost-savings plans.

To combat the rising costs of DME and medical supply items, the department plans to implement the following two cost-savings measures in the near future:

- The department hopes to convert its medical supply codes from the current federally required billing code structure to the more detailed universal product number (UPN) codes to gain more relevant and timely information on the products it pays for.

- The department plans to implement negotiated contracts for some DME and medical supply items.

While both plans could potentially reduce the department's costs, both could also increase expenditures if the department fails to properly plan and support these actions—yet the department's plans remain vague, incomplete, and unfocused.

For example, the department has not discussed its contract negotiation plans with providers or manufacturers who may prove to be resistant to the department's efforts.

In order to realize future cost savings for Medi-Cal, the department should continue to develop and use a UPN structure for medical supplies and contract negotiations for its DME items. However, the department should ensure that it adequately plans and considers possible limitations of its efforts. Further, the department should bring manufacturers and providers into its planning sessions as soon as possible.

Department Action: Partial corrective action taken.

The department states that it is continuing its efforts to develop a UPN structure for medical supplies and DME, and plans to thoroughly study the benefits, possibilities, and limitations of using UPNs for billing. The department estimates that this project will take a minimum of two to three years to fully implement. The department further states that it is pursuing an exception from the national coding requirements for DME and medical supplies to allow it to demonstrate the feasibility and cost effectiveness of the UPN as a coding standard.

DEPARTMENT OF HEALTH SERVICES

Its Efforts to Further Reduce Prescription Drug Costs Have Been Hindered by Its Inability to Hire More Pharmacists and Its Lack of Aggressiveness in Pursuing Available Cost-Saving Measures

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) practices for containing Medical Assistance Program (Medi-Cal) pharmaceutical costs found the following:

- ☑ *Health Services may not fully achieve the roughly $104 million General Fund cost savings it predicted for fiscal years 2002–03 and 2003–04 because it has been unable to hire pharmacists, has not considered fully the consequences of some planned activities, and has presented questionable estimates.*
- ☑ *Although Health Services employs some cost-saving strategies, such as the List of Contract Drugs, it has been slow to consider or adopt others.*
- ☑ *Its efforts to educate physicians and pharmacists about inappropriate or medically unnecessary drug therapy are limited.*
- ☑ *Health Services has not sought funding for disease management pilot projects that could potentially benefit the Medi-Cal population.*

REPORT NUMBER 2002-118, APRIL 2003

Department of Health Services' response as of October 2003

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits examine current practices for containing Medicaid pharmaceutical and related expenditures and to assess the extent to which these practices can be or are applied to the Department of Health Services' (Health Services) Medi-Cal Fee-for-Service drug program. As part of the audit, the audit committee asked that we conduct a survey of selected states' Medicaid program practices aimed at containing costs. Further, the audit committee requested that the survey include, but not be limited to, other states' pharmacy reimbursement practices, policies to encourage the use of generic drugs, drug formulary practices, timely collection of rebates from manufacturers, establishment of disease management programs, and the net costs of drugs. Additionally, we were to compare Health Services' current practices with the cost containment practices of the California Public Employees' Retirement System (CalPERS). Using the data obtained from the surveyed states and CalPERS, we were asked to assess the applicability of the data to Medi-Cal and, if applicable, determine the extent to which Health Services uses such practices. Finally, we were asked to assess Health Services' staffing levels and contracting needs for carrying out its Medi-Cal pharmaceutical functions. Specifically, we found that:

Finding #1: Health Services has been unable to hire needed pharmacists.

Health Services has not been able to fill pharmacist positions approved during budget negotiations for fiscal years 2001–02 and 2002–03 to meet increases in its workload and to implement several budget reduction proposals. Additionally, although Health Services contracted with its fiscal intermediary, Electronic Data Systems Federal Corporation (EDS), for the services of five more

pharmacists, as of March 2003, it had also been unable to hire the pharmacists. Consequently, Health Services had not performed some of its ongoing duties as promptly as it could. Further, we question whether Health Services will fully achieve the cost savings that it estimated for fiscal years 2002–03 and 2003–04.

According to Health Services, it has failed to increase its pharmacist staff because its ability to recruit individuals with the appropriate knowledge and skills is hampered by the disparity between the salaries it can offer and those offered in the private sector, and there is a shortage of pharmacists in the State. However, Health Services' efforts to advertise open positions have consisted of sending more than 4,000 notices to licensed pharmacists in the counties surrounding Sacramento.

Health Services agreed that it should pursue other approaches to attempt to meet its staffing needs. For example, Health Services might be able to reassign general pharmacist duties to a nonpharmacist position that requires a lesser level of expertise and might be easier to fill. However, Health Services points out that the nonprofessional classifications have a federal reimbursement rate of 50 percent, 25 percent lower than the professional classifications, which may have a greater impact on the State's General Fund. Another option available to Health Services is to use interns from a pharmacy school, such as the University of the Pacific in Stockton, to assist its pharmacists in performing some of their duties.

To address its difficulties in attracting qualified pharmacists, we recommended that Health Services should do the following:

- Broaden its recruitment efforts beyond the counties of Sacramento and San Joaquin to all of California and advertise in pharmacy periodicals. If necessary, it should seek the appropriate approvals to expand its recruitment efforts beyond California.

- Perform an analysis to identify the number of staff it needs to meet its federal and state obligations. The analysis should include a reevaluation of the duties assigned to the pharmacist classifications to identify those that could be performed by nonpharmacist classifications. Further, it should quantify the effect that using nonpharmacist staff has on its federal reimbursement for personnel costs.

- Research its ability to use the services of interns.

Health Services' Action: Partial corrective action taken.

Health Services indicated that it sent flyers to every pharmacist in the State and placed advertisements in a number of pharmacy publications. After receiving the approval of the Department of Personal Administration for a recruitment and retention payment of $2,000 per month, Health Services stated that it recruited and hired four pharmacists in October 2003. However, Health Services does not believe seeking the appropriate approvals to expand its recruitment efforts beyond California would be fruitful, due to the State's more stringent licensing requirements.

Additionally, Health Services stated it has reclassified three unfilled pharmacist positions to analyst positions for database creation and analysis to assist the pharmacists. Finally, Health Services also indicated that it is continuing to seek interns from the University of the Pacific in Stockton, but has been unsuccessful in obtaining a proposal from the university.

Finding #2: Health Services does not complete many drug reviews promptly.

Between October 1999 and November 2002, it has taken Health Services as long as, and in a few instances longer than, one year to review new drugs before adding them to its drug list. Health Services has not established a deadline that addresses how long the entire new-drug process should take for drugs without a priority designation. It believes a reasonable time frame to conclude a new-drug review is roughly four to eight months.

As part of its review of new drugs, Health Services negotiates with drug manufacturers for state supplemental rebates. Delays in finalizing its negotiations for the supplemental rebates could result in Health Services paying higher prices for the new drugs than it otherwise would pay. Health Services attributes many of the delays in completing new-drug reviews to the drug manufacturers' lack of responsiveness and difficulties that arise during negotiations in addition to its inability to hire pharmacists to perform the new-drug reviews.

We recommended that Health Services revise its procedures for performing new-drug reviews to include a timeline for completing reviews and specific steps on how staff should address manufacturers' nonresponsiveness.

Health Services' Action: Pending.

Health Services indicated that it has increased the number of pharmacists who can negotiate contracts and is making changes so that it can complete new drug reviews more timely. For example, its staff are reviewing drafts of new or updated procedures for drug reviews, contract processes, and recordkeeping.

Finding #3: Health Services could further reduce costs by completing more reviews of entire drug categories.

Between 1998 and 2002, Health Services has only performed four therapeutic category reviews (TCRs) for the 113 classes of drugs on the drug list. A TCR entails reviewing all the drugs in one therapeutic or chemical drug category included in the drug list and negotiating supplemental rebate contracts for new or existing drugs on the drug list that are in that category. Health Services' procedures require it to develop a TCR schedule annually and make it available to the public on request. Yet, in 2002, Health Services did not develop a TCR schedule. In addition, Health Services reported in its November 2002 budget estimate that by performing TCRs of the drugs included in the categories of atypical antipsychotics and nonsteroidal anti-inflammatory drugs, it could achieve cost savings of almost $39 million in fiscal year 2002–03 and more than $46 million in fiscal year 2003–04. However, it has yet to perform any of these TCRs because under its current staffing situation, it is unable to do so.

We recommended that Health Services conduct the TCRs specified in its budget proposal for fiscal year 2002–03. Further, it should develop and adhere to annual schedules for future reviews.

Health Services' Action: Pending.

Health Services noted that the Legislature revised the law to require it to complete a TCR within 120 days instead of 150 days. Additionally, Health Services plans to complete four TCRs annually. Health Services also stated that it has hired and is training pharmacists to perform TCRs for cholesterol-lowering agents (statins) and anti-hypertensive (ace inhibitors) drugs.

Finding #4: The State is relying on other cost-saving strategies that may not be fully realized or may be delayed.

Health Services' original budget for fiscal year 2002–03 included certain cost savings totaling $127 million for pharmacy benefits provided to Medi-Cal beneficiaries. However, by November 2002, when it began the budget process for fiscal year 2003–04, Health Services had not implemented some activities related to these cost savings and had to reduce the estimated savings to about $80 million for fiscal year 2002–03. It estimated savings for fiscal year 2003–04 of $127 million. However, it may not fully achieve the added cost savings identified in the November 2002 estimate, or the savings may be delayed. Specifically, we found the following:

- Health Services has not routinely established supplemental rebate contracts with manufacturers of generic drugs, although it has clear authority to do so. Health Services told us that it has not aggressively pursued supplemental rebates for generic drugs because of its inability to hire pharmacists and the reluctance of generic drug manufacturers to negotiate lower prices. Yet, Health Services reported that it could achieve cost savings of roughly $40 million to the General Fund for fiscal years 2002–03 and 2003–04, by pursuing supplemental rebate contracts with generic drug manufacturers. However, because of the difficulties Health Services has experienced in filling vacant pharmacist positions, we question whether it will achieve this cost savings.

- Health Services may not be successful in achieving savings that result from a change it developed for one of its three predetermined pharmacy reimbursement rates. Specifically, a trailer bill to the budget act for fiscal year 2002–03, Assembly Bill 442 (AB 442), requires Health Services to base the maximum allowable ingredient cost (MAIC) on the mean of the wholesale selling price (WSP) of a generic drug from selected major wholesale distributors. The MAIC is the price set by Health Services for a generic drug. State law defines the WSP as the price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor for a drug. According to Health Services, it plans to ask selected wholesalers in California to report their WSPs for generic drugs and it intends to use the reported WSP plus an appropriate markup to reimburse pharmacies for each drug ingredient cost. Health Service reported that, once implemented, the new reimbursement method will provide cost savings of roughly $9 million to the General Fund

for fiscal years 2002–03 and 2003–04. However, we again question whether Health Services will achieve these cost savings for several reasons that include its difficulties in hiring pharmacists to implement this new reimbursement method and its lack of a plan to address what action it will take if wholesalers are unwilling to share their pricing data.

- Another cost-saving activity that AB 442 requires Health Services to perform is creating a subset of the existing drug list—a preferred prior-authorization drug list (sublist). Health Services' drug list is a list of preferred drugs that a physician can prescribe and for which a pharmacy can seek reimbursement without first obtaining approval from Health Services through its treatment authorization request (TAR) process. Although pharmacists will still have to submit TARs and provide justification for prescribing drugs not included on the drug list, it will require pharmacists to take even greater steps to justify and document reasons for selecting a drug that is not included on the sublist.

According to Health Services, the sublist will contain drugs that were deleted from the drug list or were not approved for addition to the drug list. It would add drugs to the sublist after evaluating the drug using certain criteria, including the cost of the drug, which is partially driven by the willingness of the manufacturer to negotiate a supplemental rebate contract. However, we question the necessity of a sublist given the additional workload this process would create. Specifically, Health Services' proposal might require it to re-review drugs it has already subjected to the new-drug review process. The increased workload to implement the sublist would further overburden a staff already unable to complete their required tasks. Health Services reported that implementing the sublist would result in cost savings to the General Fund totaling $9 million for fiscal years 2002–03 and 2003–04. However, according to Health Services, its cost-saving estimate was based on a cursory review of drug utilization by private third-party payers, yet, it could not provide us with the documents to support its review. Therefore, we cannot verify the accuracy of the estimate or determine whether the savings exceed the costs associated with the increase in Health Services' workload.

- Finally, AB 442 also added language that prohibits manufacturers from making retroactive adjustments to federal and state rebates owed as a result of revisions to their best prices or average manufacturer price (AMP)—the average

prices paid by wholesalers for drugs distributed to the retail class of trade, which is reported to the federal government by manufacturers. Currently, federal law requires drug manufacturers to pay rebates based on their AMP and best price data, but the federal rebate agreement allows manufacturers to make adjustments to their AMPs or best prices. For Medi-Cal, these adjustments can affect payments manufacturers made in prior quarters for not only the federal rebates but also state supplemental rebates, which are often based on AMPs. Health Services told us that this has resulted in California having to pay back rebates or provide manufacturers with credits toward future rebate payments. By prohibiting manufacturers from retroactively adjusting federal and state rebates owed, Health Services reported that it could achieve $13 million in savings to the General Fund for fiscal years 2002–03 and 2003–04.

However, before proposing this legislative change, Health Services should have obtained approval from the federal Centers for Medicare and Medicaid Services (center) to allow it to prohibit manufacturers from making retroactive adjustments to the federal rebates they owe based on revisions to their AMPs or best prices. According to Health Services, it anticipates that when it eventually refuses to make retroactive changes to the federal rebates, manufacturers will protest because their agreement with the federal government allow them to make adjustments. Therefore, Health Services indicated that ultimately it might need to seek a revision to state law to exclude federal rebates. Although state law will protect the State's supplemental rebate portion of the cost savings, if Health Services does not receive or further delays obtaining federal approval, it is unlikely the full savings related to protecting the federal rebates can be achieved.

To ensure that it fully achieves the added cost savings identified in the November 2002 estimate, we recommended that Health Services should do the following:

- Negotiate state supplemental rebate contracts with manufacturers of generic drugs, as the Legislature intended.

- Obtain written assurance from drug wholesalers that they will provide their wholesale selling prices so that it can compute the new MAIC for generic drugs. If the wholesalers are not willing to provide this information, Health Services should seek legislation to compel them to do so.

- Perform an analysis to support its proposal to create a preferred prior-authorization list. The analysis should include an evaluation of the impact this proposal has on its workload and adequate documentation to support its estimated savings.

- Seek federal approval from the center to prohibit manufacturers from making retroactive adjustments to federal rebates owed as a result of revisions to their AMPs or best prices.

Health Services' Action: Pending.

Health Services stated that it has solicited contract proposals from five manufacturers of generic drugs and, if the manufacturers respond, Health Services expects to execute contracts in February 2004.

Health Services stated that it met with wholesalers in October and November 2003 to obtain written agreements with wholesalers to supply their wholesale selling prices. It plans to hold one more meeting by the end of 2003.

Health Services indicated that it believes a preferred prior authorization list would be cost effective, but it did not provide an overall analysis to support this contention. Instead, Health Services stated that it plans to analyze the cost effectiveness of a preferred prior authorization list on a drug-by-drug or therapeutic drug category basis. Health Services noted that it analyzed the therapeutic class of drugs used in the treatment of multiple sclerosis. Although, it concluded that it should include the least costly product on its preferred prior authorization list, Health Services did not quantify the potential savings to the State.

Finally, Health Services indicated that the center has released a regulation for public comment that would allow manufacturers to make retroactive adjustments to their AMPs or best prices for a three-year period. However, this new regulation still conflicts with Health Services' legislation that permanently bars manufacturers from adjusting their AMPs or best prices retroactively. Health Services stated that it is seeking the centers' concurrence to allow California's existing law to supercede the new federal regulation.

Finding #5: Health Services just recently began working with manufacturers to reconcile federal and state rebates.

In a March 1996 audit, we reported that although Health Services prepared invoices specifically for supplemental rebates, the invoices did not specify the amount the manufacturers owed. Rather, the invoices instructed manufacturers to calculate and submit required supplemental rebates along with their federal rebate payments. We further reported that Health Service had failed to monitor and track supplemental rebate payments. We estimated that Health Services had not collected roughly $40 million in supplemental rebates owed to the State and the federal government. During the fiscal year 2002–03 budget process, Health Services received approval and hired four analysts as of February 2003 to help resolve these issues, although it had requested approval to increase its staff of analysts for almost the past five years. Between January 1991 and September 30, 2001, the amount of unresolved rebates grew to more than $216 million, or 6 percent of the $3.4 billion invoiced. State law requires that Health Services and manufacturers cooperate and make every effort to resolve rebate payment disputes within 90 days of the manufacturers notifying Health Services of a dispute in the calculation of the rebate payments. Health Services estimated that it could achieve a total of $10.5 million in savings to the General Fund for fiscal years 2002–03 and 2003–04 by resolving some of these rebate disputes.

To ensure that it has sufficient staff to work with manufacturers to resolve disputed rebates promptly and achieve cost savings, we recommended that Health Services evaluate periodically the number of staff needed to resolve disputed rebates within 90 days.

Health Services' Action: Pending.

Health Services expects to expand its staff by filling analyst positions and one manager by the end of December. Health Services anticipates resolving the backlog of disputes by the end of fiscal year 2004–05.

Finding #6: Health Services' AIDS Drug Assistance Program has not taken advantage of the new automated billing and tracking system.

Unlike Health Services' Medi-Cal drug program, the AIDS Drug Assistance Program (ADAP) does not have access to a unit rebate amount based on confidential pricing information that would enable it to calculate and bill correctly the federal rebate

payments owed by manufacturers. Instead, the ADAP relies on manufacturers to calculate and remit the correct amounts and thus cannot ensure that it has received the full rebate amounts. In 1998, the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, published a federal register notice that provided the ADAPs in all states with an option to receive the same federal rebates as the Medicaid program and to encourage ADAP's to emulate the Medicaid model.

However, because ADAP does not have access to the unit rebate amount information from the center, it bills manufacturers for its federal rebates using an estimated unit rebate amount that may be inaccurate. Additionally, the manufacturers send the rebates to the ADAP, usually including the actual unit rebate amounts they used to calculate the federal rebate owed; however, ADAP cannot verify whether the amounts are correct. In fact, our comparison of the federal rebates received by the ADAP with those received by Medi-Cal for nine of 67 drugs we reviewed found that the ADAP's federal rebates were lower, even though the amounts should have been the same. For example, for one drug, the ADAP received a rebate for one quarter that was nearly $125,000 less than the amount it would have received using Medi-Cal's unit rebate amount data for that drug for the same quarter.

The ADAP also does not use an automated system to track the billing and collection of manufacturers' federal rebates. Without an effective accounting system, the ADAP cannot ensure that it submits invoices to manufacturers and receive their federal rebate payments promptly. In fact, we found that the ADAP did not send 14 invoices totaling $2.9 million to manufacturers for the first quarter of 2001 until October 18, 2002, or more than six months after the completion of the quarter. Consequently, the State does not have the use of those funds for other commitments and is not maximizing the amount of interest it would otherwise collect by depositing the rebates earlier. Additionally, we suggest that it would be prudent for the ADAP to assess and collect interest from manufacturers that do not remit their rebates promptly as does the Medi-Cal program.

We believe that it would benefit the ADAP to take advantage of Health Services' Rebate Accounting and Information System (RAIS) to invoice drug manufacturers and, when the RAIS achieves its projected capability, to calculate interest on amounts owed by manufacturers when they delay in submitting federal rebate payments. In fact, in a letter dated January 2001, the

director of the center urged state Medicaid directors to work with the ADAPs in their state to assist in the submission of federal rebate claims to manufacturers within the requirement of the drug pricing confidentiality provisions.

We recommended that Health Services should follow the center's guidance and ensure that the ADAP and Medi-Cal staff coordinate their activities for obtaining federal rebates by using the RAIS for invoicing its manufacturers. Furthermore, it should ensure that its ADAP emulates the Medicaid model by seeking legislation to assess and collect interest from manufacturers when they delay submitting federal rebates.

Health Services' Action: Pending.

Health Services indicated it plans to ensure that the ADAP and Medi-Cal staff work together to improve the invoicing and collection of ADAP's rebates, either through the use of RAIS or other processes. However, Health Services stated that it does not plan to seek legislation to assess and collect interest from manufacturers when they delay submitting federal rebates. Specifically, Health Services stated that ADAP has not experienced delays in collecting rebates from manufacturers of brand name drugs, which generate the greatest amount of rebates. ADAP has experienced delays in collecting rebates from manufacturers of generic drugs and Health Services plans to remove their drugs from its drug list rather than continuing to use resources to pursue small rebates.

Finding #7: Health Services pays less for certain brand name drugs than it does for their generic counterparts, but it can improve its contracting process.

Although the supplemental rebates that Health Services negotiates with brand name drug manufacturers generally ensure that Medi-Cal incurs lower costs for drugs than do other state programs, Health Services does not have procedures to ensure that it accurately tracks the expiration dates of its supplemental rebate contracts and thus has ample time to renegotiate contracts. Our review of Health Services' drug prices found that it restricts its reimbursement to eight brand name drugs because it is generally able to obtain lower net costs for them than for their generic counterparts after applying the supplemental rebates it receives from the manufacturers. However, for the other two drugs we found that the net costs of the brand names were higher than those of the generics because Health Services failed either

to renegotiate the contracts or to secure critical contract terms from the manufacturer—errors that we estimated cost Medi-Cal roughly $57,000 in 2002.

Currently, Health Services maintains a database that lists each supplemental rebate contract's terms, effective date, and expiration date. However, Health Services does not have a review process in place to ensure staff have entered all contracts appropriately into this database or its RAIS used for invoicing purposes. Further, although Health Services can run ad hoc reports to determine when its contracts will expire, it does not have a process to ensure that it follows up on and renegotiates contracts before the expiration dates. Until Health Services establishes such processes, it cannot ensure that it invoices all manufacturers at the correct amount. Moreover, it cannot ensure that it renegotiates or renews contracts before the expiration dates and runs the risk of continuing to allow pharmacies to dispense more costly drugs.

To ensure it obtains the lowest net cost for drugs, we recommended that Health Services should do the following:

- Establish policies and procedures to ensure that it follows up on and renegotiates supplemental contracts before their expiration dates. Further, it should establish a review process to ensure supplemental rebate contracts are appropriately entered into its contract tracking database and RAIS.

- If it is unable to complete negotiations for state supplemental rebates before contracts expire, it should immediately instruct EDS to remove the restriction on brand name drugs to allow pharmacies to dispense less expensive generic drugs without requiring TAR approval.

- Ensure that it secures written assurance from the drug manufacturer for all agreements made during a negotiation and includes this information in the terms and conditions of the contract.

Health Services' Action: Partial corrective action taken.

Health Services stated that it has temporarily redirected pharmacists from other functions, in addition to hiring four pharmacists, to renew and complete new contracts. Health Services also indicated that it has established a review process to ensure that supplemental rebates are appropriately entered into its contract tracking database and RAIS.

Additionally, Health Services noted that if it is unable to complete negotiation for state supplemental rebates, it plans to remove the restriction to allow the use of generic drugs when there is a net cost savings to the State. Furthermore, it has begun evaluating the net cost impact of removing the restrictions to use brand name drugs on a case-by-case basis.

Finally, Health Services stated it will ensure that all terms and conditions are delineated in the supplemental rebate contracts with manufacturers.

Finding #8: Health Services could save $20 million annually by placing the responsibility on the pharmacists to recover copayments.

Federal law allows states to establish copayments; however, it does not allow states to assess charges for certain services, such as emergency services and services provided to any beneficiary under age 18. Additionally, it does not allow states to deny care to any beneficiary unable to afford the copayment. State law allows each participating pharmacy to retain the $1 copayment it collects from each Medi-Cal beneficiary filling a prescription. Further, the beneficiary remains liable to the pharmacy for any unpaid copayments. Health Services could not provide us with an analysis of the pharmacies' collection rates for copayments, but it believes their collection rates are low.

At least one state, however, has taken a more aggressive approach toward collecting copayments from beneficiaries. Montana instituted copayments so that beneficiaries could share in the cost of their medical care, thus allowing it to reduce the cost to the state. Montana deducts the copayments from the pharmacies' reimbursements, placing the responsibility of collecting copayments on the providers. Health Services estimates that if implemented, by deducting the copayment from the pharmacy reimbursement rate, it would save Medi-Cal more than $20 million annually, after adjusting for beneficiaries who are exempt.

We recommended that Health Services evaluate the pros and cons of deducting copayments from its reimbursement rate and having pharmacies collect these payments from beneficiaries. The evaluation should include, at a minimum, an analysis of costs, benefits, and pharmacies' collection rates.

Health Services' Action: None.

Health Services indicated that the 2003–04 Budget Act includes a 5 percent reimbursement reduction for pharmacies effective January 1, 2004. Health Services believes that this reduction will allow for greater annual savings than deducting copayments from its reimbursement rate and having pharmacists collect the payments from beneficiaries. Additionally, Health Services stated that an analysis of the costs, benefits, and pharmacy collection rates would likely require it to hire a contractor to conduct a survey of pharmacies, which would require a budget augmentation to pay for the contract.

Finding #9: Drug alerts requiring TAR approval may prove to be an effective cost control.

Two steps Health Services could take to possibly realize cost savings are adopting "duration of therapy' and "step therapy protocol" edits in its drug utilization review (DUR) program—a mechanism to ensure that prescriptions for covered outpatient drugs are appropriate, medically necessary, and not likely to have adverse medical effects. In 2000, the secretary of the Health and Human Services Agency established a task force to explore drug use and cost control strategies in the Medi-Cal program. One issue discussed by the task force was the possibility of having Health Services reestablish a hard edit for duration of therapy to control the use of certain drugs that become unnecessary or inappropriate after a specified period—for example, drugs prescribed for specific medical conditions, such as ulcers. In the past, Health Services used a hard edit for duration of therapy but decided to discontinue its use because of the substantial increase in the volume of TARs that its staff had to process as a result of the edit. However, Health Services could not provide us with data to support its claim that the volume of TARs that staff had to process increased substantially because of that particular hard edit. Additionally, task force participants supporting the reestablishment of the edit believed that it would prevent unnecessary prescription refills, reduce inappropriate therapies for certain medical conditions, and possibly reduce costs.

Another hard edit that might be useful in controlling drug costs would require a physician to prescribe a less expensive but therapeutically equivalent drug for a beneficiary who is in the early stages of a particular medical condition. This type of hard edit, called step therapy protocols or accepted treatment

guidelines, would recommend starting treatment of a condition with a less expensive drug that has a verified equivalent effect and moving on to a more expensive drug only if the patient is not responding to the first drug. Health Services told us that it had previously considered implementing step therapy protocols, however, it was unable to provide us with data or an analysis evaluating the costs and benefits of altering its process to include step therapy protocols. However, one state that responded to our survey reported that it has achieved cost savings totaling more than $3.1 million for 9,600 claims by implementing step therapy protocols.

To achieve additional savings in its Medi-Cal pharmacy program, we recommended that Health Services should do the following:

- Measure the effect that the use of the duration-of-therapy hard edit has on its workload. If feasible, consider reestablishing this edit for additional savings.

- Evaluate its ability to adapt its prospective DUR program by using other types of hard edits, including step therapy protocols for specific drugs or classes of drugs. The evaluation should include an analysis of the costs and benefits associated with these approaches.

Health Services' Action: Pending.

Health Services stated that it has experienced delays in implementing duration of therapy hard edits due to the loss of pharmacist staff at its fiscal intermediary. However, its fiscal intermediary has hired a pharmacist who is now training to perform this function. Finally, Health Services indicated it is evaluating a cost-containment proposal from its fiscal intermediary to install some additional hard edits in its claim payment system.

Finding #10: Health Services' educational methods related to DUR are indirect and project oriented.

Health Services' retrospective DUR process monitors drug use and cost trends to identify misuses and educational needs. Through this process, Health Services has identified and developed responses to costly Medi-Cal drug patterns. Currently, Health Services' educational program disseminates information only to general audiences periodically and comprises a small number of active and proposed projects that are heavily

dependent on the expertise and resources of its DUR board members. Consequently, efforts to educate providers about inappropriate or medically unnecessary drug therapies, and the potential to capture cost savings that may result from changes in drug prescribing and dispensing behavior, are limited.

Specifically, in contrast to Medicaid programs in some other states we surveyed, Health Services does not promote education that emerges from the retrospective DUR program by sending "Dear Dr." letters to physicians and pharmacists (providers). Instead, Health Services told us that the use of Dear Dr. letters to providers for DUR education would be very difficult to implement and administer in California because of the large number of Medi-Cal beneficiaries and providers. However, we question this assertion. Although it may not be feasible to send Dear Dr. letters to all Medi-Cal drug providers, Health Services can, as do Medicaid programs in other states, use profiling to identify providers whose practices indicate that are most in need of intervention and send letters only to them.

In addition, Health Services' DUR board is responsible for identifying drug therapy problems and recommending the types of interventions that will most effectively improve the quality of drug therapy. In this capacity, it has recommended a number of educational projects. Most of the projects will ultimately implement direct educational interaction with prescribers in specific subject areas. The advantage of Health Services' approach is that it can rely on the expertise and resources of its voluntary DUR board members. However, Health Services' heavy reliance on the DUR board can also prove to be a potential weakness of DUR education. Health Services devotes only minimal resources to the board and the projects selected for development. However, because it lacks a formal plan outlining the goals, anticipated outcomes, and resource needs of the DUR educational program, we could not assess the adequacy of the resources it devotes to the DUR education program or what its future needs may be.

As we previously discussed, Health Services is already having difficulty hiring the pharmacists it needs. If it needs to expand its involvement in the DUR educational program, one approach it might consider is outsourcing some of those functions to a pharmacy school, as is done in other states, such as Oregon and Idaho. Health Services told us that it has considered contracting out some of its retrospective DUR and educational activities to a school of pharmacy; however, it has not conducted an evaluation of the costs and benefits of outsourcing these functions.

To improve its efforts to educate providers about inappropriate or medically unnecessary drug therapies and potentially capture additional cost savings, we recommended that Health Services should do the following:

- Reevaluate the cost-effectiveness of using Dear Dr. letters in a focused educational program that targets physicians and pharmacists, whose prescribing or dispensing practices are inappropriate.

- Work with the DUR board to develop a formal plan for its educational activities that includes at a minimum, the goals, anticipated outcomes, and resource needs. Further, Health Services should update the plan annually.

- If, in the future, it determines that it lacks adequate resources for its retrospective DUR and educational activities, it should evaluate the cost-effectiveness of outsourcing some of these functions.

Health Services' Action: Pending.

Health Services indicated that it is in the process of filling two research analyst positions created to determine the cost effectiveness of Dear Dr. letters and any other prescribing education efforts it undertakes as part of its drug expenditure reduction initiatives. Additionally, Health Services stated that it will develop prescriber profiles to create general documents for all prescribers and to facilitate its plans for peer-to-peer interaction.

Finding #11: Despite working with other organizations on disease management, Health Services has not sought funding for the pilot projects.

Although many states have implemented disease management programs, which are designed to improve the quality of care for Medicaid populations and ultimately contain costs for both prescription drugs and Medicaid overall, Health Services' progress toward a comprehensive disease management program is minimal. Recently, Health Services has collaborated with the California Pharmacists Association (CPhA) to develop Medi-Cal-specific pilot projects for disease management. The Medi-Cal Pharmacist Care Project was initially proposed in 2000 by the University of Southern California (USC) School of Pharmacy, in cooperation with the CPhA and Health Services, as an effort

to establish a framework wherein qualified pharmacists would serve as coordinators of disease management for high-risk Medi-Cal beneficiaries suffering from asthma and diabetes. A second proposal focusing on pharmacist services for hypertension was developed in 2002. The objectives of the proposals are to determine whether a pharmacist-coordinated model of disease management, applied to the Medi-Cal population, can improve health outcomes for beneficiaries.

However, Health Services lacks the funding it needs to begin the proposed pilot projects because it has relied on its nonprofit partners to secure funds. Consequently, until Health Services seeks funding to move forward on these pilot projects, the potential benefits of disease management programs and their applicability to the Medi-Cal population will remain unrealized.

We recommended that Health Services consider seeking funds to continue its collaboration with the CPhA and USC for the proposed pharmacist-coordinated disease management pilot projects. Then evaluate the results of the pilot projects and, if feasible, implement the models on a more widespread basis.

Health Services' Action: Pending.

Health Services indicated that CPhA recently received significant monetary commitments to fund a pilot project. Thus, CPhA is moving forward on a pilot project in the San Diego area that focuses on diabetes and, according to Health Services, one of its pharmacists is providing feedback to CPhA on the pilot project's design. Health Services stated that, if results are positive, it would take the appropriate steps to incorporate the project in the Medi-Cal program.

Finding #12: Health Services may be able to achieve additional savings by reevaluating its policy regarding optional pharmacy benefits.

Under federal law, states are allowed to exclude several therapeutic classifications from reimbursement in their pharmacy benefit programs. Health Services made a policy decision to include five of these optional classes of drugs as part of its pharmacy benefit: anorexia, weight loss, or weight gain drugs; cough and cold drugs; smoking-cessation drugs; barbiturates; and benzodiazepines, which include antianxiety drugs. Health Services' data show that, had it excluded these classes of drugs from its pharmacy benefit, it might have saved the State nearly $80 million during 2001.

Health Services justifies its spending for these optional services with its belief that these drugs are keeping overall drug costs down. According to Health Services, if it did not cover these drug classes—in particular, the cough and cold drugs—its beneficiaries would demand prescription drugs from their physicians to relieve their symptoms, thereby creating a shift to higher-priced drugs that are not optional. Additionally, Health Services told us that other costs, such as Medi-Cal hospitalization costs, might increase because without the optional drugs, some beneficiaries might ultimately require hospitalization. However, Health Services could not provide us with an analysis to support the net effect that discontinuing to offer the optional drug class would have on increasing drug and hospitalization costs for certain beneficiaries. After conducting such an analysis, Health Service might be able to limit cough and cold drugs to beneficiaries who have asthma or are elderly, and similarly limit or eliminate other categories.

We recommended that Health Services conduct a study to identify the effect of discontinuing all or a portion of the optional drug therapeutic classifications from its benefits on Medi-Cal beneficiaries and Medi-Cal's drug costs. If it determines it is cost-effective to do so, Health Services should discontinue some or all of the optional drug classifications.

Health Services' Action: Pending.

Health Services stated that before discontinuing all or a portion of the optional drug therapeutic classifications, it must consider the health care consequences and costs in other parts of the Medi-Cal program that could occur with the removal of these drugs. Health Services indicated that it is currently reviewing all of its options.

FEDERAL FUNDS

The State of California Takes Advantage of Available Federal Grants, but Budget Constraints and Other Issues Keep It From Maximizing This Resource

REPORT NUMBER 2002-123.2, AUGUST 2003

Departments of Finance and Health Services responses as of October 2003

Audit Highlights . . .

Our review of federal grant funding received by California found that:

- ☑ *California's share of nationwide grant funding, at 11.8 percent, was only slightly below its 12 percent share of the U.S. population.*
- ☑ *Factors beyond the State's control, such as demographics, explain much of California's relatively low share of 10 large grants.*
- ☑ *Grant formulas using out-of-date statistics reduced California's award share for another six grants.*
- ☑ *In a few cases, California policies limit federal funding, but the effect on program participants may outweigh funding considerations.*
- ☑ *California could increase its federal funding in some cases, but would have to spend more state funds to do so.*

continued on next page

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits determine whether California is maximizing the amount of federal funds it is entitled to receive for appropriation through the Budget Act. Specifically, we were asked to examine the policies, procedures, and practices state agencies use to identify and apply for federal funds. We also were asked to determine if the State is applying for and receiving the federal program funds for which it is eligible, and to identify programmatic changes to state-administered programs that could result in the receipt of additional federal funds. Finally, the audit committee asked us to examine whether the State is collecting all applicable federal funds or is forgoing or forfeiting federal funds for which it is eligible. Specifically, we found:

Finding #1: California's share of federal grants falls short of its population share, due in part to the State's demographics and federal grant formulas.

California's share of total federal grants awarded during fiscal year 2001–02 was 11.8 percent, or $42.7 billion. This share is slightly below California's 12 percent share of the nation's population (population share). For 36 of 86 grants accounting for 90 percent of total nationwide federal grant awards in fiscal year 2001–02, California's share was $5.3 billion less than an allocation based on population share alone. Grants for which California's share falls below its population share include ones in which demographics work against California, and formula grants that provide minimum funding levels to states or use out-of-date statistics. With regard to state efforts to gain federal funding, we found that state

- ☑ *In some instances, California has lost federal funds because of its noncompliance with program guidelines or by not using funds while they are available.*
- ☑ *The statewide hiring freeze and a pending 10 percent cut in personnel costs may further limit federal funds for staff.*

departments appear to use reasonable processes to identify new or expanded funding from federal grants and do not miss grant opportunities because of a lack of awareness.

Of the 36 grants for which the State's share fell below its total population share, 10 are due to California's low share of a particular demographic group. For example, California received relatively little of the federal funds awarded to rural communities for water and waste disposal systems in fiscal year 2001–02 because its rural population is low in relation to the rest of the nation. In addition, California is the country's sixth youngest state, so it received less than its total population share of grants to serve the elderly.

Funding formulas that do not allocate funds based on populations in need result in a lower percentage of grant funding for populous states such as California. Some grants are awarded based on old statistical data that no longer reflect the distribution of populations in need. For example, much of a grant for maternal and child health services is distributed according to states' 1983 share for earlier programs, for which California's share was 5.8 percent. If the entire grant were based on more current statistics, California's award for fiscal year 2001–02 would be $23.6 million higher. Other grants provide minimum funding to states without regard to need; the State Homeland Security grant, for example, distributes more than 40 percent of its funds to states on an equal basis, with the rest matching population share. For this grant, the average per resident share for California will be $4.75, far less than the $7.14 average per U.S. resident.

We recommended that as federal grants are brought up for reauthorization, the Legislature, in conjunction with the California congressional delegation, may wish to petition Congress to revise grant formulas that use out-of-date statistics to determine the share of grants awarded to the states.

Legislative Action: Legislation passed.

In September 2003, the Legislature passed an Assembly Joint Resolution requesting that the California congressional delegation use the opportunities provided by this year's reauthorization of several federal formula grant programs to attempt to relieve the disparity between the amount of taxes California pays to the federal government and the amount the State receives in return in the form of federal formula grants and other federal expenditures.

Finding #2: State and local policies have limited California's share of federal funds in a few cases.

State and local policies limit California's share of federal funds for three programs. For the Special Education–Grants to States (Special Education) grant, California's share is less than would be expected based on its number of children because of the local approach to deeming children eligible for special education services. California's federal funding for the In-Home Supportive Services program is also low because of a state program that pays legally responsible relatives to be caregivers, a type of activity that is ineligible for federal reimbursement. Another agency has proposed changing the Access for Infants and Mothers and State Children's Health Insurance (Children's Insurance) programs to increase federal grant funding. These policies have affected the State's ability to maximize the receipt of federal funds. However, we did not review the effects on stakeholders that a change in government policies for these programs would entail, effects that may outweigh funding considerations.

The State's Residual In-Home Supportive Services program, funded solely from state and county sources, has likely reduced the participation of some eligible recipients in the federally supported Personal Care Services program. Both programs provide various services to eligible aged, blind, and disabled persons who are unable to remain safely at home without this type of assistance. The Residual In-Home Supportive Services program provides additional services and serves recipients who are not eligible for the federal program. In addition, the State's program allows legally responsible relatives to be caregivers to recipients. Legally responsible relatives include spouses and parents who have a legal obligation to meet the personal care needs of their family members. The federal program, in contrast, does not allow payments to such caregivers.

The Department of Health Services (Health Services), in conjunction with the Department of Social Services, may be able to apply for a waiver under the Medical Assistance program, called Medi-Cal in California. This recently developed waiver program, called Independence Plus, may allow states to claim federal reimbursement for a portion of the expenditures for caregiver services provided by family members. The departments estimate that the State may be able to save $133 million of costs currently borne by the State's Residual In-Home Supportive Services program if this waiver is pursued. They indicated that they are jointly exploring the feasibility of this waiver.

We recommended that Health Services continue to work with the Department of Social Services to determine the feasibility of pursuing an Independence Plus waiver that may allow the State to claim federal reimbursement for a portion of the expenditures for caregiver services provided by legally responsible family members to participants in the In-Home Supportive Services program.

➲ ***Health Services' Action: Pending.***

Health Services says that due to the state budget crisis and lack of available staff to develop the new Independence Plus waiver, it has suspended efforts in this area. When it obtains additional resources to work on the waiver, it says it will resume working with the Department of Social Services to obtain federal approval.

Finding #3: California is not obtaining the maximum funding available from some federal grants, but to do so generally would require more state spending.

The State has lost some federal dollars because departments were unable to obtain the matching state dollars required by federal programs. For example, a Health Services program to recognize high-quality skilled nursing facilities would have received more federal grant money had state matching funds been available. For fiscal years 2001–02 and 2002–03, the federal government agreed to provide as much as $16 million for the program. In fact, however, Health Services received only $4 million in state funding for this program during fiscal year 2001–02, and it received no state funding for the program in fiscal year 2002–03 because of cuts in General Fund spending. Consequently, the State received $12 million less in federal funding than it would have if it had spent the originally planned state match.

In addition, a reduction in state funding for several transportation-related funds may lead to the loss of federal funding for local projects. For example, the Los Angeles County Metropolitan Transportation Authority reported that if it could not replace traffic fund contributions, it risked losing $490 million in federal funds for one project. In April 2003, it requested that this project replace other projects already earmarked for funding by another state transportation fund in order to secure the federal funding. The use of state matching dollars to maximize federal funds must, however, be balanced against the State's other priorities.

We recommended that the Legislature may wish to ask departments to provide information related to the impact of federal program funding when it considers cuts in General Fund appropriations.

Legislative Action: Unknown.

Finding #4: The State has lost and may continue to lose some federal funds because of an inability to obligate funds, federal sanctions, and budget constraints.

Over the last three fiscal years, agencies sometimes lost federal funds by failing to obligate funds within the grants' period of availability. In addition, noncompliance with program guidelines in four instances resulted in funding losses of more than $758 million, mostly related to the lack of a statewide child support automation system. Finally, the statewide hiring freeze sometimes keeps agencies from spending available federal funding on grants staff, and a pending budget cut of 10 percent in personnel costs may further limit spending of federal funds.

Period of Availability

The most significant loss of federal funds resulting from a failure to obligate funds within a grant's period of availability relates to the Children's Insurance program grant, which is administered by the Managed Risk Medical Insurance Board (board). According to the board, over the last three years the State has forgone as much as $1.45 billion in available federal funding because of a slow start-up and limited state matching funds. As a state initiating a new program, California's need to enroll clients led to a slow start-up of the Children's Insurance program and a resulting loss of federal funds, which primarily match a state's spending on insurance coverage for enrollees. According to a report by San Diego State University, administrative start-up costs made up a high proportion of total costs for states with new Children's Insurance programs, but the federal Children's Insurance program limits federal funding for these costs to 10 percent of total program costs. Thus, states with new programs had to bear most of the costs for outreach and other administrative expenditures during this phase.

California has not had enough qualified program expenditures to use its total annual allocations each year, but expenditures have been rising steadily. According to estimates by the board, reimbursable program expenditures will approximate its annual

allocations in the next few years. Thus, the board estimates that unspent grant funds that carry over from year to year, though still large, will decline, and reversions to the federal government will stop after October 2003.

Program Noncompliance

Noncompliance with program guidelines in four instances resulted in funding losses of more than $758 million, mostly related to the lack of a statewide child support automation system. Since 1999, California has paid federal penalties for failing to implement a statewide child support automation system. Through July 2003, the total amount of federal penalties paid by the State amounted to nearly $562 million. The estimated penalty payment for fiscal year 2003–04 is $207 million.

As a step toward eliminating the penalties, the Legislature enacted Chapter 479, Statutes of 1999, providing guidelines for procuring, developing, implementing, and maintaining a single, statewide system to support all 58 counties and comply with all federal certification requirements. In June 2003, the Department of Child Support Services and the Franchise Tax Board, which is managing the project, submitted a proposal to the Legislature to enter into a contract with an information technology company to begin the first phase of project development in July 2003, with implementation in the 58 counties completed by September 2008. The total 10-year project cost is $1.3 billion, of which $801 million is for the contract. The federal government has conditionally approved the project, which is estimated to be eligible for 66 percent federal funding.

Hiring Freeze and Proposed 10 Percent Staff Reduction

In order to address the State's significant decline in revenues, Governor Gray Davis has undertaken several initiatives to reduce spending on personnel. These include a hiring freeze in effect since October 2001 and a 10 percent reduction in staffing proposed in April 2003. The hiring freeze already has had a negative effect on some federal programs, and the 10 percent reduction may affect them as well. After the October 2001 executive order, the Department of Finance (Finance) directed agencies, departments, and other state entities to enforce the hiring freeze. It also established a process for exempting some positions. The process includes explaining why a particular

position should be exempted and what the effect of not granting an exemption would be. Departments and their oversight agencies must approve the exemptions and then forward them to Finance for approval.

In response to our audit survey, staff at two departments said the hiring freeze and an inability to obtain exemptions had affected their federal programs negatively. In September 2002, the U.S. Centers for Disease Control and Prevention (CDC) wrote to Health Services noting vacant positions within the State's National Cancer Prevention and Control program and difficulties in filling vacancies due to the state-imposed hiring freeze as a major weakness. In a December 2002 letter of response to the CDC, Health Services indicated that it had filled some vacant positions, and in March 2003 Health Services sent exception requests for five federally funded positions to Finance, four of which Finance denied. As of June 2003, Health Services said that the CDC planned to reduce its grant for the 12 months ending June 30, 2004, to $8.4 million from the $10.6 million awarded for the nine months ending June 30, 2003. Health Services said an important element in the CDC's reduction was Health Services' inability to fill vacant federally funded positions.

Similarly, the U.S. Department of Agriculture (USDA) informed the Department of Education's (Education) Nutrition Services Division in September 2002 that through a management evaluation it had identified corrective actions in several areas where a lack or shortage of staff contributed to findings. It was concerned about staffing shortages in a unit responsible for conducting reviews and providing technical assistance to sponsoring institutions participating in the child nutrition programs. It warned that the USDA may withhold some or all of the federal funds allocated to Education if it determines that Education is seriously deficient in the administration of any program for which state administrative funds are provided. In May 2003, the State Superintendent of Public Instruction wrote to the Governor's Office asking for approval of a blanket freeze exemption allowing Education to fill all division vacancies, reestablish 12 division positions eliminated during the fiscal year 2002–03 reduction of positions, and exempt the division from a proposed 10 percent reduction in staff.

We recommended that Finance ensure that it considers the loss of federal funding before implementing personnel reductions related to departments' 10 percent reduction plans.

Finance Action: Partial corrective action taken.

Control Section 4.10 of the 2003 Budget Act, approved by Governor Gray Davis in August 2003, requires the Director of Finance to reduce departments' budgets by almost $1.1 billion and abolish 16,000 positions. Finance states that it specifically omitted any federal funds from its August 2003 notice to the Legislature identifying the appropriations to be reduced in accordance with this section. It did this so that departments would not be required to reduce federal fund appropriations without full consideration of the effects.

DEPARTMENT OF HEALTH SERVICES

It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) activities to identify and reduce provider fraud in the California Medical Assistance Program (Medi-Cal) revealed the following:

- ☑ *Because it has not yet assessed the level of improper payments occurring in the Medi-Cal program and systematically evaluated the effectiveness of its antifraud efforts, Health Services cannot know whether its antifraud efforts are at appropriate levels and focused in the right areas.*
- ☑ *Health Services has not clearly communicated roles and responsibilities and has not adequately coordinated antifraud activities both within Health Services and with other entities, which has contributed to some unnecessary work or ineffective antifraud efforts.*
- ☑ *An updated agreement with the California Department of Justice could help Health Services better coordinate investigative efforts related to provider fraud.*

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REPORT NUMBER 2003-112, DECEMBER 2003

Departments of Health Services' and Justice's responses as of December 2003

The Joint Legislative Audit Committee (audit committee) asked us to review the Department of Health Services' (Health Services) reimbursement practices and the systems in place for identifying potential cases of fraud in the Medi-Cal program, with the aim of identifying gaps in California's efforts to combat fraud. Many of the concerns we report point to the lack of certain components of a model fraud control strategy to guide the various antifraud efforts for the Medi-Cal program. Specifically, we found:

Finding #1: Health Services lacks some components of a model fraud control strategy.

Although Health Services has received many additional staff positions and has established a variety of antifraud activities to combat Medi-Cal provider fraud, it lacks some components of a comprehensive strategy to guide and coordinate these activities to ensure that they are effective and efficient. Specifically, it has not yet developed an estimate of the overall extent of fraud in the Medi-Cal program. Without such an assessment, Health Services cannot be sure it is targeting the right level of resources to the areas of greatest fraud risk. The Legislature approved Health Services' 2003 budget proposal for an error rate study to assess the extent of improper payments in the Medi-Cal program, and Health Services is just beginning this assessment.

In addition, Health Services has not clearly designated who is responsible for implementing the Medi-Cal fraud control program. A model antifraud strategy involves a clear designation of responsibility for fraud control, which in turn requires someone or a team with authority over the functional components that implement the antifraud program. Although Audits

- ☑ *Because it lacks an individual or team with the responsibility and authority to ensure fraud control issues and recommendations are promptly addressed and implemented, some well-known problems may go uncorrected.*
- ☑ *Health Services does not obtain sufficient information to identify and control the potential fraud unique to managed care.*

and Investigations (audits and investigations) is the central coordination point for antifraud activities within Health Services, some antifraud efforts are located in other divisions and bureaus of Health Services or in other state departments over which audits and investigations has no authority. Thus, audits and investigations' designation as the central coordination point within Health Services does not completely fill the need for an individual or team that crosses departmental lines and is charged with the overall responsibility and authority for detecting and preventing Medi-Cal fraud.

Rather than measuring the impact of its efforts by the amount of reduction in fraud, Health Services measures its success by reference to unreliable savings and cost avoidance estimates. A component of a model antifraud strategy requires evaluating the impact of antifraud efforts on fraud both before and after implementation of the effort. However, Health Services measures its efforts by the achievement of goals established during the development of its savings and cost avoidance estimates. Although antifraud efforts offer savings, they also need to be measured against their effect on the overall fraud problem to determine whether the control activities should be adjusted.

Finally, Health Services does not currently have processes to ensure that each claim faces some risk of fraud review. According to Health Services, although its current claims processing system subjects each claim to certain edits and audits, it does not subject each claim to the potential for random selection and in-depth evaluation for the detection of potential fraud. The 2003 budget proposal included establishing a systematic process to randomly select claims for in-depth evaluation and this is one of the components the Legislature approved.

We recommended that Health Services develop a complete strategy to address the Medi-Cal fraud problem and guide its antifraud efforts. This should include adding the currently missing components of a model fraud control strategy, such as an annual assessment of the extent of fraud in the Medi-Cal program, an outline of the roles and responsibilities of and the coordination between Health Services and other entities, and a description of how Health Services will measure the performance of its antifraud efforts and evaluate whether adjustments are needed.

Health Services' Action: Pending.

Health Services stated that it is in the process of implementing the model fraud control strategies. It has received federal funding for evaluating and measuring payment accuracy and will develop plans for annual payment accuracy studies that will aid in allocating resources and evaluating fraud deterrence and detection efforts. Health Services also stated that it will document the roles and responsibilities of the various programs participating in antifraud efforts and will work with the Health and Human Services Agency to improve the coordination of antifraud activities with other departments under its authority.

Finding #2: Health Services has not yet conducted routine and systematic measurements of the extent of fraud in the Medi-Cal program.

Health Services has not systematically assessed the amount or nature of improper payments in the Medi-Cal program. Improper payments include any payment to an ineligible beneficiary, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for applicable discounts. Without this information, Health Services does not know whether it is overinvesting or underinvesting in its payment control system, or whether it is allocating resources in the appropriate areas.

The Legislature approved portions of Health Services' May 2003 budget proposal including an error rate study and random sampling of claims. Building upon its authorization to conduct an error rate study, in August 2003 Health Services applied to the federal Centers for Medicare and Medicaid Services to participate in its Payment Accuracy Measurement (PAM) project for fiscal year 2003–04. In its PAM proposal, Health Services stated that it would develop an audit program to accomplish certain objectives, including identifying improper payments, and a questionnaire to confirm that a beneficiary actually received the services claimed by the provider. However, until Health Services completes its audit program and procedures, it is premature to conclude on the adequacy of its approach to verify services with beneficiaries to estimate the level of fraudulent payments.

We recommended that Health Services establish appropriate claim review steps, such as verifying with beneficiaries the actual services rendered, to allow it to estimate the amount of fraud in the Medi-Cal program as part of its PAM study. We also recommended that it ensure the payment accuracy benchmark developed by the PAM model is reassessed by annually monitoring and updating its methodologies for measuring the amount of improper payments in the Medi-Cal program.

Health Services' Action: Pending.

Health Services reported that it will ensure an appropriate claim review step is included to verify with the beneficiary that actual services were rendered. It also plans to reassess monitoring and measurement methodologies annually.

Finding #3: Health Services does not evaluate the effect on the extent of fraud of its antifraud activities and uses unreliable savings estimates.

Health Services does not perform a cost-benefit analysis for each of its antifraud activities, nor does it use reliable savings estimates to justify its requests for additional antifraud positions. According to Health Services, it uses a form of cost-benefit analysis, using estimated savings or cost avoidance as the benefit, to make decisions regarding resource allocations. Health Services indicated that it looks at the costs and savings of its antifraud activities in the aggregate and not by specific activity because not all the fraud positions it received are directly involved in savings and cost avoidance activities. Although it acknowledged that it does not use a formal cost-benefit analysis, Health Services asserts that it performs an intuitive type of assessment.

Health Services computes a savings and cost avoidance chart (savings chart) to estimate the savings it expects to achieve from its antifraud activities in the current and budget year. Health Services also uses the savings chart to quantify the achievements of each of its antifraud activities in the prior year and as a management tool to allocate resources. Health Services used the savings chart it created in November 2002 to support its request for 315 new positions for antifraud activities in its May 2003 budget proposal, of which the Legislature ultimately approved 161.5 positions.

However, Health Services' November 2002 savings chart potentially overstates its estimated savings because of a flaw in the methodology it uses to calculate the savings. Health Services

calculates its savings and cost avoidance estimates for some categories by using the average 12-month paid claims history of providers who have been placed on administrative sanctions. Health Services assumes that 100 percent of the claims it paid during the prior 12-month period to those providers sanctioned in the current year would be savings in the budget year. However, it does not perform any additional analysis to determine what proportion of the sanctioned providers' paid claims was actually improper. We questioned the soundness of Health Services' methodology because even though the improper portion of the claim history would be potential savings, any legitimate claims submitted by the sanctioned provider could continue as a program cost for beneficiaries who would presumably receive health care services from another provider who would bill the program.

We recommended that Health Services perform cost-benefit analyses that measure the effect its antifraud activities have on reducing fraud. Additionally, it should continuously monitor the performance of these activities to ensure that they remain cost-effective.

Health Services' Action: Pending.

Health Services stated that through the use of enhanced data analysis software and relationships with its various contractors, it will develop a standard cost-benefit analysis methodology for each antifraud proposal.

Finding #4: The provider enrollment process continues to need improvement.

Health Services' Provider Enrollment Branch (enrollment branch) screens applications to ensure that the providers it enrolls are eligible to participate in the Medi-Cal program. This includes ensuring that all Medi-Cal providers have completed applications, disclosure statements, and agreements on file, to help it determine whether providers have any related financial and ownership interests that may give them the incentive to commit fraud or were previously convicted of health care fraud. It also must suspend those Medi-Cal providers whose licenses and certifications are not current or active. Although these activities are important first lines of defense in preventing fraudulent providers from participating in the Medi-Cal program, the enrollment branch is not fully performing either of these activities.

In our May 2002 report, *Department of Health Services: It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process,* Report 2001-129, we made a number of recommendations to improve the provider enrollment process. However, the enrollment branch has not fully implemented many of these recommendations. For example, we recommended that the enrollment branch use its Provider Enrollment Tracking System to ensure that it sends notifications to applicants at proper intervals. However, the enrollment branch still does not track whether it sends the required notifications to applicants, nor does it notify a provider when an application is sent to audits and investigations for secondary review.

New legislation that took effect on January 1, 2004, increases the importance of sending these notifications. If the enrollment branch does not notify applicants within 180 days of receiving their applications that their application has been denied, is incomplete, or that a secondary review is being conducted, it must grant the applicant provisional provider status for up to 12 months. Moreover, this new legislation requires these notifications for applications be received before May 1, 2003. As of September 29, 2003, the enrollment branch had 1,058 applications still open that it received before May 1, 2003. If the enrollment branch did not notify these applicants of its decision on or before January 1, 2004, it must grant them provisional provider status regardless of any ongoing review.

It is noteworthy that when the enrollment branch refers applications to audits and investigations for secondary review, the processing time typically extends well beyond 180 days. Because audits and investigations currently has about a six-month backlog, the first thing an analyst does when performing a preliminary desk review is contact the applicant to verify the current address and continued interest in applying to the program. The analyst also redoes some of the screening previously performed by the enrollment branch, such as checking to confirm that the applicant's license is valid, resulting in inefficiencies and further extending the time applicants are left waiting.

Health Services is unable to ensure that all provider applications are processed consistently and in conformity with federal and state program requirements. The enrollment branch reviews applications for certain provider types, such as physicians, pharmacies, clinical labs, suppliers of durable medical equipment, and nonemergency medical transportation. The enrollment

branch checks a variety of sources to confirm licensure, verify the information provided on the application, confirm that the applicant has not been placed on the Medicare list of excluded providers, and refers many applications to audits and investigations for further review. However, other divisions within Health Services and other departments responsible for reviewing certain types of provider applications and recommending provider enrollment do not conduct a similar review. Since different units and departments screen providers against different criteria, Health Services may be allowing ineligible individuals to participate as providers in the Medi-Cal program.

Health Services' procedures are not always effective to ensure that enrolled providers remain eligible to participate in the Medi-Cal program. Our review of 30 enrolled Medi-Cal providers that Health Services paid in fiscal year 2002–03 disclosed two with canceled licenses. Even though state law requires providers whose license, certificate, or approval has been revoked or is pending revocation to be automatically suspended from the Medi-Cal program effective on the same date the license was revoked or lost, as of August 2003, the provider numbers for both of these providers were being used to continue billing and receiving payment from the Medi-Cal program every month since the cancellations occurred. Our review of the 30 selected providers also found that, despite the fraud prevention capabilities these required disclosures and agreements provide, the enrollment branch did not always have the agreements and disclosures required by state and federal regulations. Two of the 30 provider files we reviewed did not contain disclosure statements, and Health Services could not locate agreements for 24 of these providers. The disclosure statements provide relevant information to ensure that the provider has not been convicted of a crime related to health care fraud, and that the provider does not have an incentive to commit fraud based on the financial and ownership interests disclosed. The provider agreements give Health Services a certification that the provider will abide by federal and state laws and regulations, will disclose all financial and ownership interests and criminal background, will agree to a background check and unannounced visit, and will agree not to commit fraud or abuse.

Our May 2002 audit recommended that the enrollment branch consider reenrolling all provider types. Reenrollment would improve the enrollment branch's ability to ensure that all providers have current licenses, disclosure statements, and agreements on file. Although the enrollment branch has begun

reenrolling certain provider types it has identified as high risk, it has not developed a strategy to reenroll all providers and does not have a process to periodically check the licensure of existing providers with state professional boards. Additionally, it has not completed an analysis to determine what resources it would need to reenroll all providers.

To improve the processing of provider applications, we recommended that Health Services complete its plan and related policies and procedures to process all applications or send appropriate notifications within 180 days, complete the workload analysis we recommended in our May 2002 audit report to assess the staffing needed to accommodate its application processing workload, and improve its coordination of efforts between the enrollment branch and audits and investigations to ensure that applications, as well as any appropriate notices, are processed within the timelines specified in laws and regulations.

To ensure that all provider applications are processed consistently within its divisions and branches and within other state departments, we recommended that Health Services ensure that all individual providers are subjected to the same screening process, regardless of which division within Health Services is responsible for initially processing the application. In addition, we recommended that Health Services work through the California Health and Human Services Agency to reach similar agreements with the other state departments approving Medi-Cal providers for participation in the program.

To ensure that all providers enrolled in the Medi-Cal program continue to be eligible to participate, we recommended that Health Services develop a plan for reenrolling all providers on a continuing basis; enforce laws permitting the deactivation of providers with canceled licenses or incomplete disclosures; and enforce its legal responsibility to deactivate provider numbers, such as when there is a known change of ownership. Further, we recommended that Health Services establish agreements with state professional licensing boards so that any changes in license status can be communicated to the enrollment branch for prompt updating of the Provider Master File.

Health Services' Action: Pending.

Health Services stated it has taken some steps to improve the processing of provider applications and has created a workgroup to establish a complete work plan for processing applications as required by the new legislation. It will also evaluate the internal workload study on application processing and finalize the analysis. With the addition of new staff to enhance antifraud efforts, Health Services noted that provider enrollment and audits and investigations began to develop closer working relationships, and cited various actions taken to improve communication and coordination. In addition, its programs will participate and coordinate internally, as well as with other departments, programs, and entities that perform similar enrollment functions with the aim of using consistent enrollment processing procedures. Finally, Health Services indicates that it is developing a plan to reenroll all providers, will improve its procedures to ensure that provider numbers are properly deactivated, and is working with professional licensing boards to obtain provider permit and licensing information that is timely and readily useable.

Finding #5: The pre-checkwrite process could achieve more effective results.

Health Services has a review process it calls pre-checkwrite that identifies and selects certain suspicious provider claims for further review from the weekly batch of claims approved for payment. Although the pre-checkwrite process appears effective in identifying suspicious providers, Health Services does not review all of the providers flagged as suspicious. Moreover, Health Services does not delay the payments associated with suspect provider claims pending completion of the field office review.

We reviewed 10 weekly pre-checkwrites, which identified a total of 88 providers with suspicious claims from which Health Services selected 47 for further review. At the time of our audit, 42 provider reviews had been completed, and 31, or 74 percent, of these had resulted in an administrative sanction and referral to the Investigations Branch (investigations branch) or to law enforcement agencies. According to Health Services, limited staffing precludes it from reviewing all suspicious providers. Health Services states that it must perform additional analysis to develop sufficient evidence and a basis for placing sanctions, including withholding a payment or placing utilization controls on providers.

However, when Health Services does not promptly complete its reviews and suspend payment of suspicious provider claims until it completes its on-site review, its pre-checkwrite process loses its potential effectiveness as a preventive fraud control measure. Health Services could use existing laws to suspend payments for claims that its risk assessment process identifies as potentially fraudulent or abusive and release them once a pre-checkwrite review verifies the legitimacy of the claim. Although laws generally require prompt payment, they make an exception for claims suspected of fraud or abuse and for claims that require additional evidence to establish their validity.

We recommended that Health Services consider expanding the number of suspicious providers it subjects to this process, prioritize field office reviews to focus on those claims or providers with the highest risk of abuse and fraud, and use the clean claim laws to suspend payments for suspicious claims undergoing field office review until it determines the legitimacy of the claim.

Health Services' Action: Pending.

Health Services stated that it received additional staffing in fiscal year 2003–04 to expand the number and timeliness of pre-checkwrite reviews. It also indicated it will work with its legal office to maximize the pre-checkwrite activities and develop criteria to suspend specific claims and hold checks until the review is complete.

Finding #6: Health Services and the California Department of Justice have yet to fully coordinate their investigative efforts.

Although Health Services is responsible for performing a preliminary investigation and referring all cases of suspected provider fraud to the California Department of Justice (Justice) for full investigation and prosecution, it does not refer cases as required. Moreover, Health Services and Justice have been slow in updating their agreement even though the agreement is required by federal regulations and could be structured to clarify and coordinate their roles and responsibilities and, thus, help prevent many of the communication and coordination problems we noted with the current investigations and referral processes.

Our comparison of fiscal year 2002–03 referrals of suspected provider fraud cases from Health Services' case-tracking system database to similar records from Justice's case-tracking system

database revealed that 63 (41 percent) of the 152 Health Services case referrals to Justice were late, incomplete, or never received. According to Justice, it did not include 60 of the 63 referrals in its database because they were incomplete when Justice received them or it received them close to the date of indictment by an assistant U.S. Attorney for the Eastern District of California (U.S. Attorney). For the remaining three cases, although Health Services asserts that it referred them to Justice, Health Services could not provide documentation that clearly demonstrates its referral of them. Our review of 14 investigation cases corroborated that Health Services' investigations branch referred cases to Justice late; Health Services referred 12 an average of nearly five months after the date it had evidence of suspected fraud.

Although Health Services acknowledged that referring cases to Justice after indictment by the U.S. Attorney is no longer its practice, according to the investigations branch, it investigates and refers cases to the U.S. Attorney because the U.S. Attorney indicts suspected providers and settles cases quickly. Justice, on the other hand, typically focuses on developing cases for trial to pursue sentences that it believes reflect the seriousness of the defendant's conduct. Although both approaches have merit, depending on the particular case, Health Services and Justice have not come to an agreement on when each approach is appropriate and who should make that determination.

Additionally, according to Health Services' investigations branch chief, because neither federal nor state laws provide a clear definition of what constitutes suspected fraud, the investigations branch can refer cases to Justice at varying points in the process, including before, during, or after it has met the reliable evidence standard. Admittedly, the law does not clearly define what constitutes suspected fraud, but Health Services and Justice should reach an agreement on what standard must be met to assist both agencies in coordinating their respective provider fraud investigation and prosecution efforts.

The agreement between Health Services and Justice that is required by federal regulations could help alleviate many of the current problems about when Health Services should refer cases to Justice. Over the last several years, Health Services and Justice have intermittently discussed an update of the existing 1988 agreement. However, these two entities have yet to complete negotiations for an update of this agreement or to define and coordinate their respective roles and responsibilities for investigating and prosecuting suspected cases of Medi-Cal provider fraud.

We recommended that Health Services promptly refer all cases of suspected provider fraud to Justice as required by law and that both Health Services and Justice complete their negotiations for a current agreement. The agreement should clearly communicate each agency's respective roles and responsibilities to coordinate their efforts, provide definitions of what a preliminary investigation entails and when a case of suspected provider fraud would be considered ready for referral to Justice.

To ensure that Health Services and Justice promptly complete their negotiations for a current agreement, we recommended that the Legislature consider requiring both agencies to report the status of the required agreement during budget hearings.

Health Services' Action: Pending.

Health Services stated that a draft agreement would be finalized soon. It further indicated that it clarified the need to make timely referrals to Justice in its policy and procedures.

Justice Action: Pending.

Justice stated that both agencies are working quickly and in good faith to establish an agreement that will serve to strengthen the working partnership between the two agencies.

Legislative Action: Unknown.

We are unaware of any legislative action implementing this recommendation.

Finding #7: A more effective feedback process could strengthen Health Services' antifraud efforts.

Although audits and investigations is responsible for coordinating the various antifraud activities within Health Services, its line of authority does not extend beyond audits and investigations. What is lacking is an individual or team with the responsibility and corresponding authority to ensure that worthwhile antifraud recommendations are tracked, followed up, and implemented. Such an individual or team would provide Health Services' management with information about the status of the various projects and measures that are under way, to ensure that antifraud proposals, including those involving external entities, are addressed promptly.

Without an individual or team with the responsibility and corresponding authority to follow up and act on recommendations for strengthening its antifraud efforts, some antifraud coordination issues or detected fraud control vulnerabilities may continue to go uncorrected. For example, although Health Services' provider enrollment process is the first line of defense to prevent abusive providers from entering the Medi-Cal program, the provider enrollment process continues to need improvement. Similarly, another unresolved fraud control coordination issue is the lack of an updated agreement between Health Services and Justice related to the investigation and referral of suspected provider fraud cases. Although laws make each of these state agencies responsible for certain aspects of investigating and prosecuting cases of suspected provider fraud, the current case referral practices result in a fragmented rather than a cohesive and coordinated antifraud effort. Both agencies indicate that they have made some efforts to update their 1988 agreement, but they have yet to complete negotiations for a current agreement that spells out each agency's respective roles and responsibilities.

We recommended that Health Services consider working through the California Health and Human Services Agency to establish and maintain an antifraud clearinghouse with staff dedicated to documenting and tracking information about current statewide fraud issues, proposed solutions, and ongoing projects, including assigning an individual or team with the responsibility and corresponding authority to follow up and promptly act on recommendations to strengthen Medi-Cal fraud control weaknesses.

Health Services' Action: Pending.

Health Services recognizes the contribution a clearinghouse can potentially make and will work with the California Health and Human Services Agency to more fully explore this recommendation and different approaches for its implementation.

Finding #8: Health Services needs to give proper attention to potential fraud unique to managed care.

In addition to its fee-for-service program, Health Services also provides Medi-Cal services through a managed care system. Under this system, the State pays managed care plans monthly fees, called capitation payments, to provide beneficiaries with health care services. Although fraud perpetrated by providers and beneficiaries, similar to what occurs under the fee-for-service

system, can also occur, another type of fraud unique to managed care involves the unwarranted delay in, reduction in, or denial of care to beneficiaries by a managed care plan.

Because of incomplete survey results and its concerns about the reliability of encounter data, which are records of services provided, Health Services does not have sufficient information to identify managed care contractors that do not promptly provide needed health care. In addition, Health Services does not require its managed care plans to estimate the level of improper payments within their provider networks to assure they are appropriately controlling their fraud problems and not significantly affecting the calculation of future capitated rates.

We recommended that Health Services work with its external quality review organization to determine what additional measures are needed to obtain individual scores for managed care plans in the areas of getting needed care and getting that care promptly, complete its assessment on how it can use encounter data from the managed care plans to monitor plan performance and identify areas where it should conduct more focused studies to investigate potential plan deficiencies, and consider requiring each managed care plan to estimate the level of improper payments within its Medi-Cal expenditure data.

Health Services' Action: Pending.

Health Services stated that its new contracted vendor should be able to gather data to address the inadequacies found in the surveys. It is also assessing how it can use managed care plan data to help target areas for focused monitoring. Health Services will consult internally and with outside entities on the feasibility of implementing through appropriate contract language the requirement that managed care plans estimate the level of improper payments within their Medi-Cal expenditure data.

HEALTH AND HUMAN SERVICES AGENCY DATA CENTER

Investigations of Improper Activities by State Employees, August 2002 Through January 2003

ALLEGATION I2002-652 (REPORT I2003-1), APRIL 2003

Health and Human Services Agency Data Center's response as of July 2003

Investigative Highlights . . .

A former manager of the Health and Human Services Agency Data Center (data center) engaged in the following improper governmental activities:

- ☑ *Negotiated employment with a company while he was in a position to influence a $345,000 contract between the data center and that company.*
- ☑ *Drafted contract language that was incorporated into the contract between the data center and a company that he began working for one business day after ending his employment with the State.*

We investigated and substantiated an allegation that a manager of the Health and Human Services Agency Data Center (data center) violated conflict-of-interest laws. Our investigation showed that work the manager performed influenced the formation of a $345,000 contract between the data center and company 1, a private corporation that the manager negotiated for employment with while he was in a position to influence the contract.

Finding: A manager violated conflict-of-interest laws.

The manager was both directly and indirectly involved in the contract with company 1. Specifically, while he was employed at the data center, the manager drafted the statement of work that was incorporated as part of the contract between the data center and company 1, a private consulting firm the manager began to work for one business day after ending his state employment. The statement of work describes the State's and contractor's responsibilities, contract duration, tasks for the contractor to perform, payment methods, and other provisions.

The manager was also indirectly involved in creating the contract between the data center and company 1 because he prepared documents that data center staff ultimately relied on to establish the contract. We also substantiated that while he was employed at the data center, the manager negotiated for employment with company 1. State law prohibits employees from having a financial interest in any contract they make in their official capacity. Further, the cost to the State for the

manager's services as a consultant was more than three times the previous cost of his state salary and benefits, despite the fact that the manager's duties were essentially the same.

Data Center Action: Partial corrective action taken.

The data center has referred our findings to the Fair Political Practices Commission and the attorney general for evaluation of the alleged violations of conflict-of-interest laws. The data center also requested a review by the Department of Personnel Administration to determine whether it should take adverse action against employees who may have aided or assisted the manager. Further, the data center has provided mandatory in-service training to educate key employees involved in the procurement process and their responsibilities under state laws.

DEPARTMENT OF INDUSTRIAL RELATIONS

Its Process for Verifying the Status of Licenses Issued to Farm Labor Contractors Is Operational but Needs Some Improvement

REPORT NUMBER 2001-017, SEPTEMBER 2002

Department of Industrial Relations' response as of October 2003

Audit Highlights . . .

Our review of whether the Department of Industrial Relations (department) has established a process for verifying the status of state licenses issued to farm labor contractors revealed that:

- ☑ *The department's process for verifying the status of farm labor contractors' licenses has been operational since July 1, 2002.*
- ☑ *Agricultural growers, farm labor contractors, and others can request license verifications through the department's Web site or by electronic mail, telephone, or facsimile.*
- ☑ *More oversight is needed of the department's license verification process, especially in these early stages of implementation.*

Chapter 157, Statutes of 2001, amended Section 1695.7(e) of the Labor Code, and required the labor commissioner in the Department of Industrial Relations (department) to establish a unit for verifying the status of farm labor contractors' licenses by July 1, 2002. According to the amended code, agricultural growers and farm labor contractors that subcontract work must verify that a farm labor contractor is properly licensed. The Bureau of State Audits was required to certify that the department's unit responsible for these verifications is operational. Based on our review, we found the following:

Finding #1: Although the department's license verification process is operational, the unit manager should exercise more oversight.

The department's new verification process is sufficient to certify the status of a farm labor contractor's license within one business day of receiving a request, provided employees follow established procedures. The unit manager oversees the verification process and has significant review capability over requests received and responded to electronically—the most common submission and delivery method. However, the unit manager is less able to monitor requests and responses to requests that are not electronic, such as requests received over the telephone or fax, or responses sent by fax or mail. Although the five employees assigned to the verification function are required to maintain folders containing documentation of fax and telephone requests and evidence of the corresponding responses, the unit manager had not had a chance to review these files at the time of our testing. Consequently, the unit manager has less assurance that telephone and fax requests as well as mail and fax responses are processed appropriately.

In addition, the unit does not accurately compile statistics concerning the number and types of verification requests received. The unit needs to have accurate information concerning its workload so it can assign an appropriate amount of resources to this function.

To ensure that the department is complying with the requirement that it respond to requests for verification of farm labor contractor licenses within one business day, we recommended that the unit manager exercise more oversight. For example, the unit manager could develop a log for employees to record the date, time, and medium (online, fax, e-mail, or telephone) by which a request is received; the date and time that the employee transmits the verification; and the method by which he or she transmitted the verification (e-mail, fax, or mail). The unit manager could then review the logs to ensure that a response was recorded for every request. The unit manager could also compare the number of requests received to the number of unique verification numbers issued. The logs would also provide statistical information on the unit's workload.

Department Action: Partial corrective action taken.

The department reports that the unit manager reviews all incoming e-mail and fax requests daily to ensure that responses have been made. The department asserts that it has responded to all requests received in a timely manner. ➔ However, the department's response does not explain how it ensures that telephone requests are processed appropriately.

Finally, the department reports that it has kept statistics that reflect the number of requests and the method by which they are received. ➔ However, the department's response does not address our finding that these statistics are inaccurate.

Finding #2: The department has not established dedicated telephone and fax lines for license verification requests.

The department has not established a dedicated telephone line for license verification requests. Consequently, unit employees who are not trained to perform verifications of farm labor contractors' licenses occasionally answer incoming telephone calls and attempt to gather relevant information from the requestor. This practice increases the chance of

miscommunication between the requestor and the unit employee working on the verification. Similarly, the department does not have a fax machine dedicated to license verification requests. Rather, faxed requests are received in a general work area by a fax machine used by the entire unit. The lack of a dedicated fax machine increases the risk of misplacing a faxed license verification request.

To reduce the possibility that a request for verification is lost or incorrectly handled, we recommended that the department consider obtaining dedicated telephone and fax lines and a fax machine for this function.

Department Action: Corrective action taken.

The department reports that it received 369 requests for verification of licenses via fax in the first 12 months of operation. The department does not believe it is necessary to have a fax machine dedicated to license verification requests.

Additionally, the department reports that it received 568 license verification requests over the telephone in the first 12 months. The department does not believe that it is necessary to incur the costs of installing a telephone line dedicated to this function.

Finding #3: The department does not accept telephone requests on all state business days.

Although the license verification Web site indicates that requests can be submitted by calling the Fresno or San Francisco office, neither office accepts telephone requests on Thursdays, and the San Francisco office does not accept telephone requests on Tuesdays as well.

To be more responsive to its customers, we recommended that the department consider taking telephone requests for license verification on all state business days.

Department Action: Corrective action taken.

The department reports that it now accepts telephone requests for license verifications on all state business days.

DEPARTMENT OF INDUSTRIAL RELATIONS

Investigations of Improper Activities by State Employees, August 2002 Through January 2003

ALLEGATION I2002-605 (REPORT I2003-1), APRIL 2003

Department of Industrial Relations response as of April 2003

Investigative Highlight . . .

A Department of Industrial Relations official claimed reimbursement for more than $17,000 in travel expenses to which he was not entitled.

We investigated and substantiated allegations that an official with the Department of Industrial Relations (department) improperly claimed reimbursements for relocation and commute expenses for travel between his residence near San Diego and his headquarters in San Francisco. We also found that the official improperly claimed payment for lodging and meals incurred within a close proximity of his headquarters. At the time we received the allegation, the department was already investigating these issues, and we asked that it report its findings to our office. The department concluded that the official improperly claimed $5,726 in travel costs related to relocation and lodging expenses. After receiving the department's report, we performed some additional analysis and follow-up work and determined that the official had claimed an additional $11,803 in improper travel expenses.

Finding #1: The official claimed relocation expenses but did not relocate.

The State reimbursed the official for relocation expenses when he neither relocated nor obtained the necessary approval for the reimbursement. The department found that $4,939 of the official's $4,982 claim for relocation expenses was improper, and it recommended disallowing these costs. However, the department allowed the remaining $43, which represents a 9-cent-per-mile reimbursement for relocation travel between the official's home near San Diego and his headquarters in San Francisco. However, we determined that the State should not have paid the $43 because the official did not relocate.

Department Action: Corrective action taken.

The department agrees with our finding and required the official to reimburse the State for improper relocation expenses totaling $4,982.

Finding #2: The official submitted improper claims for lodging and meal expenses.

The official made improper claims for lodging and meals. The department reported that the official improperly received $787 in reimbursement for unallowable lodging expenses that he incurred within 50 miles of his headquarters location. Our analysis determined that the official also improperly received $1,082 in meal and incidental expenses incurred within 50 miles of his San Francisco headquarters.

Department Action: Corrective action taken.

The department agrees with our finding and required the official to reimburse the State a total of $1,869 for lodging, meal, and incidental expenses incurred within 50 miles of his headquarters.

Finding #3: The official claimed and the department approved other unallowable and unnecessary expenses.

Of the $47,790 in travel costs the official incurred between April 2000 and November 2001, the State paid $2,334 for 24 days of lodging in San Diego, which is within 35 miles of the official's home, $3,941 for flights between San Diego and his San Francisco headquarters, and $3,768 more than he was entitled to receive for costs associated with flights between San Diego and Sacramento.[1]

We also found that the official claimed unnecessary rental car expenses. A portion of the rental car expenses the official claimed was for weekend rentals for which he stated no business purpose. Although the department did not address the issue, we found that of the $3,417 in rental car expenses the official incurred during the 20-month period we reviewed, $635 related to vehicles he rented in San Diego on weekends.

[1] The $47,790 includes $31,831 in travel claims that the official submitted for reimbursement and $15,929 in travel expenses not included on a travel claim, but that the State paid directly to a vendor. This figure does not include any relocation expenses.

Finally, we found that even though a majority of the $31,831 in travel claims that the official submitted lacked sufficient explanations for his trips, as state regulations require, the department approved his claims. We spoke with two executives about the department's process for reviewing and approving travel claims, because they had approved a number of the official's claims. Both executives told us they do not or usually do not attempt to verify the purpose of each trip listed on the claims.

Department Action: Partial corrective action taken.

The department reported that it will require an executive-level civil service officer familiar with state reimbursement rules to authorize all exempt employee travel claims before submitting them to the accounting department for processing. The department also reported that it will require a senior level (or higher) accounting officer to audit all exempt employees' travel claims before making payment.

➲ After the department began its investigation of the official's travel expenses, and well after the official had incurred the expenses and received reimbursement, the department decided that, for the purpose of determining which costs were valid and in compliance with state requirements, it would consider the official's San Francisco headquarters to be his "primary residence." This determination was based on the California Code of Regulations, Title 2, Section 599.616.1(b), which states that a place of primary dwelling shall be designated for each state officer and employee and that the primary dwelling shall be defined as the actual dwelling place that bears the most logical relationship to the employee's headquarters and shall be determined without regard to any other legal or mailing address.

➲ The department's determination that the official's primary dwelling was one and the same as the San Francisco headquarters allowed the official to travel between San Francisco and San Diego at state expense, based on the assumption that all such travel is for a business purpose. Consequently, the department did not recommend that the official repay the State for $2,334 in lodging expenses and $635 in rental car expenses he incurred in San Diego, the $3,768 overpayment for trips the official took between San Diego and Sacramento, or the $3,941 in airfare for flights between San Diego and San Francisco. Since the department determined that for the purpose of calculating travel expenses, the official's residence is his headquarters in San Francisco and not where he resides (near San Diego),

these expenses became allowable; however, we question this determination and find no indication that the official's headquarters is an "actual dwelling place." Moreover, the department does not appear to have used the best interests of the State as its guiding principle when making this after-the-fact determination that contradicted statements on the travel claims.

CALIFORNIA'S WORKERS' COMPENSATION PROGRAM

The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care

Audit Highlights . . .

Our review of the workers' compensation medical payments system revealed that:

- ☑ *Rising medical costs are contributing to the increasing costs of the workers' compensation system—costs California's employers are required to pay.*
- ☑ *Despite numerous warnings from research experts, the Division of Workers' Compensation (division) has done little to respond to the problems in the workers' compensation medical payment system.*
- ☑ *Fee schedules intended to control the amounts paid for medical services and products are outdated or nonexistent. The medical payment system lacks enforceable treatment guidelines that can help contain medical costs and streamline the delivery of medical care to injured workers. Researchers point to inadequate control over treatment utilization as a primary cause of escalating costs in the workers' compensation system.*

continued on next page

REPORT NUMBER 2003-108.1, AUGUST 2003

Division of Workers' Compensation, Department of Industrial Relations' response as of January 2004

The Joint Legislative Audit Committee requested that we review the medical costs related to the workers' compensation insurance system and the extent to which the payment structure has resulted in unacceptably high reimbursement rates.

Finding #1: Workers' compensation medical costs are rising because the medical payment system has not been well maintained or fully developed.

The costs of the State's workers' compensation program to employers are spiraling upward, and numerous studies point to the rising medical costs of treating injured workers as a major contributor to the problem. The Workers' Compensation Insurance Rating Bureau (rating bureau) reported that the average total estimated medical cost per workers' compensation claim involving lost work time increased by 254 percent from 1992 to 2002. The insurance premiums charged to employers to provide workers' compensation coverage increased from $5.8 billion to $14.7 billion between 1995 and 2002.

The medical costs of the workers' compensation system are rising in part because the State has not taken the necessary steps to ensure that the costs of treating injured workers are within reasonable limits. The administrative director of the Department of Industrial Relations' (Industrial Relations) Division of Workers' Compensation (division) is responsible for administering and monitoring the workers' compensation

- ☑ *Although the division could adopt fee schedules developed by other entities, such as Medicare, it would first have to decide on how to adjust those fee schedules to best meet the needs of the workers' compensation system.*
- ☑ *The division lacks a data collection system that allows it to monitor medical costs and measure the effectiveness of reforms made to the system.*

system. However, the administrative director has not maintained or fully developed the medical payment system. Despite mandates to biennially update the medical fee schedules for professional services, inpatient hospital facilities, and for medical products—such as pharmaceuticals and durable medical equipment—other than for minor adjustments, these schedules have not been updated since 1999, and they are essentially a patchwork of prior fee schedules.

In addition, costs for services performed at facilities such as outpatient surgical centers and emergency rooms are not covered by fee schedules but are paid on the basis of what are known as usual, customary, and reasonable charges for such services. Health care experts consider this basis for payment to be inflationary, and thus these charges may be contributing to the escalating costs in the workers' compensation system.

Numerous studies have pointed to opportunities to improve cost control in the system; however, the division has not built upon those studies to implement corrective actions. The division's administrative director states that the division has not been able to dedicate more effort to improving the medical payment system due in part to staff reductions, indicating that he has lost almost 17 percent of his authorized positions and 19 percent of his filled positions since fiscal year 1999–2000. He added that when he was appointed in 1999, he was instructed to place a greater priority on improving the workers' compensation judicial process.

Further, the Legislature and administration have sometimes responded to the needs of the system with measures that impede improvement, such as requiring the use of data not currently being collected to develop a new fee schedule for outpatient surgical facility charges and reducing the funding for tasks critical to improving cost control.

Because rising medical costs in workers' compensation contribute to increased costs to California's employers, we recommended that greater importance should be placed on more closely managing the costs of providing medical care to injured workers. As such, the administrative director should take the steps necessary to identify the organization and level of resources needed to effectively administer the workers' compensation medical payment system and should work with the Department of Finance and the Legislature to obtain those resources. In addition, as part of an effort to more closely manage the

medical payment system, the administrative director should more aggressively pursue corrective action needed to address issues identified in research reports, such as those from the Commission on Health and Safety and Workers Compensation (commission), the Industrial Medical Council (medical council), the California Workers' Compensation Institute, and the Workers' Compensation Research Institute, as well as any issues raised by internal studies conducted by Industrial Relations.

We further recommended that to ensure future legislation does not contain any unintended impediments to the improvement of the workers' compensation system, the administrative director should be proactive in working with the Legislature to identify and amend any provisions that would adversely affect the administrative director's ability to effect changes.

Industrial Relations' Action: Partial corrective action taken.

Industrial Relations believes that the enactment of Senate Bill 228 (Chapter 639, Statutes of 2003) should reduce the resources needed to adopt fee schedules. It reports that the division is currently reviewing its resources and assessing what specific expertise is needed.

Although Industrial Relations responded that the governor's proposal to further reform the workers' compensation system will address concerns from stakeholder groups and research organizations, its response does not address how it will more aggressively respond to issues raised by researchers and experts in the field that we describe in our report.

Industrial Relations reports that the Labor and Workforce Development Agency (agency) and the division worked very closely with the Legislature and the Governor's Office on the proposals that were included in the 2003 reform and are currently assisting the Governor's Office in developing and reviewing legislative proposals to build on existing reforms.

Legislative Action: Legislation proposed.

Conference committee convened.

Finding #2: A lack of effective utilization controls leads to higher medical costs.

The workers' compensation payment system lacks a process that would allow doctors to use a uniform set of treatment guidelines as a standard for treating similar workplace injuries and illnesses.

Medical treatment guidelines that provide standards for the treatment reasonably required to relieve the effects of workers' injuries, and that are presumed correct unless medical opinion establishes the need for a departure from those guidelines, can serve to ensure that injured workers receive the care they need to return to work, control medical costs, and increase the efficiency of the delivery of those medical services. Researchers point to inadequate controls over treatment utilization as a primary cause of escalating costs in the workers' compensation system. Overall, they report that in the area of professional medical services, California's average payment amount per claim is typical of other states, but the number of treatments per claim provided to injured workers is far above the average.

Despite the research pointing out the absence of utilization controls, California's system is without an effective process that would make treatment utilization review standards consistent among insurers. As a result, according to a study conducted by the division, there is little consistency in the processes or criteria used by insurers and claims administrators to determine the necessity of treatments proposed by physicians. In fact, one-third of the claims administrators included in the study reported using more than one set of criteria but did not provide a methodology for selecting which one they used for a particular case.

The medical council has developed treatment guidelines and it recently voted to review the medical evidence on treatment and utilization and to update its guidelines. However, the law requires that the medical council be made up of members of the medical community that would be subject to the treatment guidelines and maintain liaisons with the medical, osteopathic, psychological, and podiatric professions. As such, we question whether the medical council is the entity that can most effectively develop treatment guidelines without giving the appearance that it could be influenced by the extent to which the guidelines might adversely affect the financial interests of the medical community.

We recommended that the administrative director, in coordination with the medical council, should adopt a standardized set of treatment utilization guidelines, based on clinical evidence, to deter over- or underutilization of physician services and other professional medical services and products. The administrative director should consider, to the extent possible, adopting treatment guidelines that are developed by independent entities and that are

updated with adequate frequency to reflect advancing technology and changes in professional practice. If the administrative director adopts treatment guidelines developed by the medical council, he should take the steps necessary to ensure that those guidelines are developed without the appearance of undue influence from any group that participates in the State's workers' compensation system.

Industrial Relations' Action: Partial corrective action taken.

Industrial Relations points out the reforms in Chapter 639, Statutes of 2003, effective January 1, 2004, requires the division to adopt a medical utilization schedule by December 1, 2004, but did not state when it would update such a schedule. It further states that the new reforms eliminated the medical council, thereby making moot the recommendation to consult with it on treatment utilization guidelines.

Industrial Relations states that the commission (an independent entity) will survey and evaluate existing medical treatment utilization standards and that it expects the commission's findings and recommendations by July 1, 2004. Industrial Relations states that until December 1, 2004, the most recent update of the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines are presumed to be correct in determining the extent and scope of medical treatment.

Finding #3: The current legal and regulatory structure for utilization control is ineffective.

A primary cause of the lack of effective utilization controls is that under the current law, utilization reviews are usually not admissible as evidence in judicial proceedings to resolve disputes between medical providers and claims administrators. To be admissible as evidence, a decision reached through a utilization review would need to be supported by a report from a physician performing an examination of the injured worker—a level of review not typically used by insurers and claims administrators when approving payment for treatment. Therefore, utilization reviews prepared by claims administrators have no weight in judicial proceedings.

In addition, the law requires that the administrative director adopt model utilization protocols in order to provide utilization review standards and requires insurers and claims administrators

to comply with those protocols. However, the regulations adopted by the former administrative director do not establish utilization review standards based on utilization protocols but instead allow insurers to establish their own unique utilization review plans as long as they meet certain administrative requirements. We believe that the regulations fail to achieve the objective of using utilization reviews to contain medical costs. However, the administrative director stated that he does not believe he has the statutory authority to make utilization reviews mandatory for insurers.

The absence of an effective utilization control process leads to disagreements between medical providers and claims administrators over proposed treatments for injured workers. However, the system does not have an effective process for resolving those disputes. Under the current dispute resolution structure, unresolved disagreements are finally settled by the Workers' Compensation Appeals Board after going through the judicial process within the workers' compensation system. Lacking a more efficient intermediary process, nearly 20 percent of the workers' compensation cases end up going through this judicial process. This lengthy process of resolving disputes can prolong the duration of workers' compensation cases.

To ensure that the treatment guidelines can serve as an authoritative standard for the treatment of workers' injuries, we recommended that the administrative director should seek the changes necessary in the Labor Code to ensure that all insurers and claims administrators are required to follow the standardized treatment guidelines and that treatment guidelines are accepted for use in judicial proceedings.

In addition, after obtaining any needed amendments to the law the administrative director should amend the division's regulations to reflect those changes to the law. Specifically, the division's regulations should require that insurers and claims administrators adhere to the standardized treatment guidelines and should clearly define the role of treatment guidelines in determining treatment and in judicial proceedings.

Industrial Relations' Action: Pending.

Industrial Relations stated that the new reforms provide that upon adoption by the administrative director of a medical utilization schedule, the schedule shall be presumptively correct on the issue of extent and scope of medical treatment. According to Industrial Relations, the new law will ensure that insurers and claims administrators follow the treatment guidelines in the schedule, and that the guidelines are accepted in judicial proceedings.

Industrial Relations also states that the division is in the process of drafting new utilization review regulations to implement the new reforms.

Legislative Action: Legislation proposed.

Conference committee convened.

Finding #4: Proposed changes to the medical payment system may control fees for medical services and products but do not ensure lower overall medical costs or access to quality care.

The administrative director and the commission have presented two different proposals for improving medical cost controls using variations of Medicare-based fee schedules. The Medicare payment system for physician services is founded on a valuation of the resources needed to provide each service. This system is known as the resource-based relative value scale (RBRVS) system.

Basing part or all of the workers' compensation system on the Medicare RBRVS system would have several advantages, among them the values on which payments are based would be derived from the amount of resources needed to perform services, rather than on customary charges. In addition, Medicare updates its schedules regularly, and so the values would remain current. Health policy experts believe resource-based systems to be less inflationary than charge-based ones. However, because the payments are resource based, it is projected that for some medical specialties, such as surgery and anesthesia, the payment amounts would be reduced from the traditional charge-based payments, and payments for evaluation and management services would be increased. This redistributive effect of the RBRVS system is a major point of controversy among providers of these affected medical specialties, in spite of the RBRVS system's ability to contain costs.

More work is needed to ensure that injured workers have access to quality care at reasonable costs to employers. If the State adopts a payment system that is based on indexed values, such as the RBRVS, it will need to determine how to adjust the RBRVS to arrive at payments that will meet this objective. There is no universal way to make these adjustments. Other states that have implemented a payment system based on the RBRVS have used a variety of approaches in adapting the system to fit their needs. Some considerations the State must weigh include the need to balance adequate access to care against overutilization and whether a transition strategy may be needed to mitigate the effects of the payment redistribution that would be caused by an RBRVS payment system.

We recommended that when determining the future structure of the workers' compensation medical payment system, the administrative director should consider the costs and practicalities of maintaining such a complex system and should give consideration to adopting a payment system that is based on models that are maintained by other entities, such as a variation of the RBRVS maintained by the federal Centers for Medicare and Medicaid Services, as he has done with his current proposal for modifying the physician fee schedule. If the administrative director decides to continue modifying the current workers' compensation payment system, he should consider pursuing a variety of activities, including the following:

- Continue his efforts to identify the adjustments needed to ensure that payments for services in the proposed modified physician fee schedule are high enough to encourage participation by physicians and other professionals in order to provide adequate access to care for injured workers.

- Seek the needed resources to develop and maintain fee schedules for the remaining medical services and products, such as outpatient surgical facilities, pharmaceuticals, emergency rooms, durable medical equipment, and home health care.

One proposal to improve California's workers' compensation payment system requires converting the entire system to a combination system that would use a variation of the Medicare payment system for medical services, facilities, and products, and the Medi-Cal payment system for pharmaceuticals. If this proposal is adopted, the administrative director should consider the following steps:

- Develop adjustments to the fee schedule for physician services and other professional services so as to mitigate any effects on access to care caused by adopting a resource-based relative value payment system that results in redistributing payment amounts away from medical specialties, such as surgery, and in increasing payments for evaluation and management services.

- Monitor the medical payment system to determine whether a reasonable standard of care can be achieved at the capped prices for services and products contained in the proposal.

- To fully benefit from adopting the Medi-Cal payment system for pharmaceuticals, in addition to adopting the Medi-Cal fee schedule, the administrative director should also study the feasibility of establishing a process to secure rebates from drug manufacturers like the supplemental rebates enjoyed by the Department of Health Services in its Medi-Cal pharmaceuticals purchase program.

Because there are no universally successful formulas for determining payments for medical services and products, we recommended that the administrative director should consult also with other states that have adopted Medicare-based payment systems and consider any measures they have employed to secure quality care at reasonable prices.

Industrial Relations' Action: Pending.

Industrial Relations reports it is taking the following steps to address the recommendations we made above:

- The reforms that took effect on January 1, 2004, revised the existing medical payment system by repealing the existing Official Medical Fee Schedule language and replacing it with provisions that require reimbursement of pharmaceuticals at 100 percent of the Medi-Cal rate; and that inpatient hospital services and outpatient surgeries that occur in either a hospital or ambulatory surgical center be reimbursed at no more than 120 percent of the relevant Medicare rate.

- To gauge access to care, the division's administrative director is preparing to contract with the University of California to conduct a study of injured workers' access to medical treatment. The initial study is to be conducted in 2004 using funding from existing resources.

- Industrial Relations believes that the legislative changes in Chapter 639, Statutes of 2003, should reduce the resources needed to adopt fee schedules. The division is currently reviewing its resources and assessing what specific expertise is needed. Since the hospital, outpatient, and pharmaceutical fee schedules are based on data already compiled by government entities outside the division, the resources required by the division for these fee schedules may be available within existing resources.
- The new reforms require that the existing Official Medical Fee Schedule for physician services be reduced by 5 percent and remain in effect until January 1, 2006, at which time the administrative director has the authority to adopt a new physician fee schedule.
- The reforms require the administrative director to contract for an independent annual study of access to medical treatment for injured workers. If it is found that access to quality health care or products is insufficient, the administrative director may make appropriate adjustments to medical and facilities' fee schedules.
- The division will study the feasibility of securing rebates from drug manufacturers for pharmaceuticals dispensed in workers' compensation cases. However, Industrial Relations notes that because workers' compensation in California is not designed as a single payer system, the division may be limited in its ability to negotiate lower pharmaceutical prices.
- Finally, Industrial Relations states that the division has been in contact with virtually all other states through the International Association of Industrial Accidents Boards and Commissions (IAIABC) and will consult with those states with Medicare-based payment systems.

Finding #5: The division lacks a data collection system that is adequate to monitor the workers' compensation system.

The division does not currently have a data collection system that will allow it to perform the necessary research to monitor the effect of policy decisions on the quality and availability of care to injured workers. Although legislation that took effect in 1993 mandated the development of a data collection system,

the Workers' Compensation Information System (WCIS) is still incomplete. According to the division, intense opposition to data collection from insurers, a shortage of knowledgeable and experienced staff, and technical difficulties in installing the proper hardware and software infrastructure have delayed the implementation of the WCIS. The division still has not identified a projected completion date for the system.

The WCIS consists of three components: two are used to collect information on the nature and duration of workplace injuries, and the third collects data on medical treatments and payments. The first two components are complete and operational, but the division is still working to identify the types of medical data it needs to collect to provide useful information for monitoring the performance of the medical payment system. However, the division has not provided us with any assurance that the medical data it collects will generate the information required to meet the statutory objectives for the system. According to the administrative director, identification of the needed medical data has been slow due in part to the effort required to work through the concerns the insurers have about the cost of reporting the data.

Further, the division stated that, if its funding is stabilized by passage of a state budget that includes employer user fees or sufficient General Fund moneys, and if the proposed funding augmentation for Assembly Bill 749 is made, it will identify a timeline for completing the medical data collection module of the WCIS expansion. The 2003–04 Budget Act includes both employer user fees and an augmentation to fund Assembly Bill 749 mandates.

Now that the division's budget contains employer user fees and a spending augmentation the administrative director asserts is needed to complete the division's WCIS, we recommended that the administrative director should place the WCIS implementation project on a timeline to facilitate its completion as quickly as possible. In addition, the administrative director should exercise the authority necessary to ensure that the data collected in the WCIS will provide the information needed to adequately monitor medical costs and services.

Industrial Relations' Action: Pending.

Industrial Relations states that division staff is working closely with staff from the Information Systems Unit to design, develop, and implement a prototype model for medical data collection. The division developed a proposed list of medical data elements to be collected, based on IAIABC guidelines. The division plans to reduce the number of data elements, based on an analysis of the ability to collect each data element and its anticipated usefulness.

The major remaining obstacle to the ability of the WCIS to collect medical data elements is the cooperation of claims administrators, who may not be capturing the data elements the division believes necessary to adequately analyze medical treatment. Initial data has been received from the State Compensation Insurance Fund.

DEPARTMENT OF MANAGED HEALTH CARE

Assessments for Specialized and Full-Service HMOs Do Not Reflect Its Workload and Have Disparate Financial Impacts

Audit Highlights . . .

Our review of the assessment structure of the Department of Managed Health Care found that:

- ☑ *The portion of assessments charged to specialized health maintenance organizations (HMOs), at 48 percent, exceeds the 22 percent of identifiable workload attributable to specialized HMOs.*
- ☑ *The current assessment structure results in disparate financial impacts with specialized HMOs charged about nine times more per dollar of premiums than full-service HMOs.*
- ☑ *Alternative methods could better align assessments with workload and reduce disparities in financial impact.*

In addition, our review of six core operating units found that:

- ☑ *Four units are meeting deadlines and/or have greatly expanded services.*
- ☑ *Two units, Financial Oversight and Licensing, are often late issuing financial examination reports and sending written notifications to HMOs regarding material changes in health care plans.*

REPORT NUMBER 2001-126, MAY 2002

Department of Managed Health Care's response as of May 2003

The Joint Legislative Audit Committee requested that we review the assessment mechanism used to generate funds for the Department of Managed Health Care (department) to determine whether the assessments paid by different classes of health maintenance organizations (HMOs) reflect the level of regulatory activity related to them. It also asked us to propose alternative assessment structures, if necessary, that would more closely reflect the level of regulatory costs and ensure adequate funding to meet the department's statutory responsibilities.

Finding #1: The annual assessments paid by two classes of HMOs—specialized and full-service—are not distributed equitably.

The percentage of the total assessment that the department charges to specialized and full-service HMOs does not match the level of effort the department devotes to these two classes of HMOs. Although assessments for specialized HMOs amount to 48 percent of total assessments, only 22 percent of the department's work that is identifiable by HMO class is attributable to them.

In addition, the financial impact of the assessment on HMOs, as represented by the percentage of their premiums that the HMOs are charged for assessments, varied widely between the different classes of HMOs. Specifically, the assessments the department billed to full-service HMOs amounted to about 0.04 percent of their premiums on average, while those for specialized HMOs amounted to about 0.37 percent on average, or about nine times more per premium dollar.

We developed four alternative assessment methodologies and found that two would both better reflect actual workload and reduce the disparity in financial impacts. Assessments under these two methods are based in whole or in part on the split in identifiable workload between specialized and full-service HMOs, and on total premiums received by individual HMOs.

We recommended that the Legislature consider changing the department's assessment structure to reflect the proportion of the documented workload that the department devotes to specialized and full-service HMOs and to reduce disparities in the financial effect on HMOs. We also recommended that the Legislature require the department to report to it triennially on the proportion of assessments charged to each class of HMO and the proportion of the documented workload related to each class of HMO.

Legislative Action: Legislation passed.

In May 2003, the governor approved legislation requiring full-service HMOs to pay for a larger share of the department's costs. Effective July 1, 2003, full-service HMOs will be required to pay 65 percent of the department's costs, not covered by other fees and reimbursements. Current law has no provision requiring the department to report triennially to the Legislature on the proportion of assessments charged to or the proportion of documented workload related to each class of HMO.

Finding #2: The department is generally effective in meeting deadlines, but it must improve the timeliness of financial examinations and its responses to requested plan changes.

The department has increased the output for some of its core functions, has introduced several new services for HMO enrollees, and is generally better at meeting deadlines when compared to the same functions previously carried out by the Department of Corporations (Corporations). For example, in the first half of fiscal year 2001–02, the department's Division of Plan Surveys completed 20 routine medical surveys (surveys) and ended calendar year 2001 with only four backlogged surveys. In contrast, Corporations had an output of seven surveys in the first half of fiscal year 1998–99 and 40 backlogged surveys at the end of calendar year 1998.

On the other hand, the department's Division of Financial Oversight is having difficulty completing financial examinations on time. Its backlog of 13 examinations at the end of calendar year 2001

compares unfavorably to the backlog of two examinations that Corporations experienced at the end of calendar year 1998. The Division of Financial Oversight has seen a large increase in its routine workload which, combined with staff vacancies and an increase in nonroutine work, contributed to the backlog. When the department does not complete financial examinations on time, the public is not fully informed of the financial status of HMOs.

In addition, the department's Division of Licensing has often failed to promptly notify HMOs of its decision regarding the HMO's requests to make significant changes, known as material modifications, to health plans. It was late in sending written notifications for 42 of the 122 material modification filings it received in 2001. According to department staff, workload issues may have been a factor contributing to late notifications. In addition, the Division of Licensing had no reliable means of tracking the status of its workload, and limitations in its manual processes made it difficult to ensure that statutory turnaround requirements were met. When the department does not notify HMOs of delays in approving their requests for changes, they are not able to respond to department concerns, resulting in delays in changes that the HMOs believe are necessary and significant.

We recommended that the department establish deadlines for the publishing of financial examination reports and closely monitor the success of its efforts to meet deadlines for these reports. In addition, we recommended that the department closely monitor the time elapsed between its receipt of requests for material modifications and the notifications it sends to HMOs, and make it a priority to send written notifications within the statutory deadline.

Department Action: Corrective action taken.

The department says it now includes target preliminary report and final report dates on its examination schedule and is making all reasonable efforts to remain compliant with statutory deadlines. It believes no examination reports are currently out of compliance with statutory deadlines. The department says that it has also taken steps to ensure that health plans are promptly notified of the status of their material modifications. Its attorneys are required to issue within the statutory 20-business-day period either (1) an order of approval, denial, or postponement or (2) a deficiency

letter, upon receipt of a written request from an HMO to extend the statutory period. The department says that through the third quarter of fiscal year 2002–03, with three exceptions, it issued orders of postponement or extensions for all material modifications it had not approved or denied within the statutory deadline.

VACANT POSITIONS

Departments Have Circumvented the Abolishment of Vacant Positions, and the State Needs to Continue Its Efforts to Control Vacancies

REPORT NUMBER 2001-110, MARCH 2002

Department of Finance's response as of May 2003, State Controller's Office response as of March 2003, and Department of Mental Health's response as of November 2002

Audit Highlights . . .

Our review of vacant positions in the State disclosed that:

- ☑ *Although the Legislature amended state law to shorten the period a position can be vacant before it is to be abolished, the law's effectiveness is hindered by departments' efforts to preserve positions.*
- ☑ *The five departments we visited misused certain personnel transactions to circumvent the abolishment of vacant positions.*
- ☑ *Changes in state law have not completely addressed the reasons departments have lengthy vacancy periods in some positions.*
- ☑ *The Department of Finance performed two reviews and plans to continue monitoring vacant positions during the next two years, but has not established an ongoing monitoring program.*
- ☑ *A method to provide the Legislature with an up-to-date yet reliable count of vacancies still does not exist.*

The Joint Legislative Audit Committee requested the Bureau of State Audits review vacant positions in the State and the uses of funding associated with the positions. Our review found that, although the Legislature amended state law to shorten the period a position can be vacant before it is abolished, the law's effectiveness is hindered by the efforts of state departments to preserve positions. Additionally, the departments we reviewed used the funding from vacant positions to carry out their programs, in part, because certain costs have not been fully funded. Finally, the Department of Finance (Finance) performed two reviews and plans to continue monitoring vacant positions during the next two years, but has not established an ongoing monitoring program. Specifically, we found that:

Finding #1: The five departments we visited misused certain personnel transactions to circumvent the abolishment of vacant positions.

The policies and procedures related to "120" transactions, which are intended to legitimately move existing employees between positions, allow flexibility, require little documentation substantiating the need for the transactions, and are not closely monitored. Although the State's policies do not specifically preclude departments from performing these transactions to avoid having positions abolished, circumventing state law is not a reasonable use of this form of transaction. Nevertheless, our review of transactions at the five departments for a two-year period revealed that they initiated at least 440 (89 percent) of 495 transactions to avoid the abolishment of vacant positions. However, our findings should not be interpreted to mean that departments throughout the State performed 89 percent

of "120" transactions to preserve vacant positions, as we selected some transactions to review because the patterns of use appeared questionable.

Our analysis of "607" transactions at these same five departments revealed that they are also sometimes being misused, though not nearly as often as "120" transactions. Properly used, "607" transactions propose new positions, delete positions, or reclassify positions. However, the departments performed, on average, at least 22 percent of the transactions we analyzed to preserve positions. More controls exist for "607" transactions than for "120" transactions, but the State requires little external accountability for "607" transactions. As we found with "120" transactions, state policies do not specifically preclude the use of "607" transactions to preserve existing positions. However, circumventing state law is not a reasonable use for the transactions.

We recommended that Finance issue an explicit policy to prohibit the use of "120" and "607" transactions to preserve vacant positions from abolishment. Additionally, we recommended that the State Controller's Office (SCO) issue guidance to departments on processing these transactions consistent with the policy issued by Finance. Further, the SCO should periodically provide to Finance reports of such transactions. Finance should analyze the reports to identify potential misuses of the transactions and follow up with departments as appropriate. Departments should discontinue their practice of using "120" and "607" transactions to circumvent the abolishment of vacant positions.

Legislative, Finance, and SCO Action: Legislation passed and corrective action taken.

In September 2002 the governor approved Chapter 1124, Statutes of 2002, which amended Government Code, Section 12439, to prohibit departments from performing personnel transactions to circumvent the abolishment of vacant positions. As a result, Finance did not issue an explicit policy to prohibit the use of "120" and "607" transactions to preserve vacant positions from abolishment. In December 2002 the SCO issued guidance to departments on processing the transactions consistent with the amended statute. Further, the SCO provided reports of "120" transactions to Finance in November 2002 and March 2003, respectively, for Finance's analysis and review. The SCO plans to provide reports of "607" transactions to Finance in fiscal year 2003–04.

Finally, the five departments we visited reported to us they have taken actions to discontinue or minimize the use of "120" and "607" transactions to circumvent state law and, thus, ensure that the transactions are used for appropriate reasons.

Finding #2: Despite changes, state law allows some positions to remain vacant almost a year.

After the Legislature became concerned about the number of vacant positions in state government, it amended Government Code, Section 12439, in July 2000 to reduce to six months the period of vacancy before the SCO abolishes vacant positions. However, the amended law stipulates that the six months must occur in the same fiscal year. This allows positions that become vacant after January 1 to stay vacant for almost a year before being abolished. Based on current law, the SCO's system tracks the vacancies until June 30 and then starts recounting the six consecutive monthly pay periods on July 1. Thus, some positions could be preserved from abolishment as long as the SCO issued a payment for only two days, January 2 and December 31. Finance reported in January 2002 it plans to examine the feasibility of amending state law to allow the vacancy period to cross fiscal years. However, as Finance also reported, the SCO's 30-year-old position control system requires significant changes to track vacancies without regard to fiscal year. Finance plans to evaluate the potential cost to modify the SCO's system. Finance stated that if the cost is feasible, it will address the funding in spring 2002.

We recommended that Finance, in conjunction with the SCO, continue with its current plans to examine the costs associated with modifying the SCO's position control system to track vacancies across fiscal years. If Finance determines that the necessary system changes are feasible, it should seek to amend Government Code, Section 12439, to require that the six consecutive monthly pay periods for which a position is vacant before abolishment be considered without regard to fiscal year.

Legislative and SCO Action: Legislation passed and corrective action taken.

Chapter 1124, Statutes of 2002, amended state law to allow the six consecutive monthly pay periods to occur within one fiscal year or between two consecutive fiscal years. As a result, the SCO has made the necessary changes to its position control system and planned to implement the changes no later than June 2003.

Finding #3: The amended law has not resolved some of the underlying causes of vacancies.

Changes in state law have not resolved some of the reasons departments have positions with lengthy periods of vacancy. The law currently provides departments with only one circumstance to retain vacant positions and two circumstances to reestablish vacant positions. In particular, the hard-to-fill designation has not entirely solved the problem of departments' inability to fill some vacant positions. Additionally, departments stated that lengthy examination and hiring processes hinder their ability to fill positions within six months. Further, departments may maintain some vacant positions to absorb other costs not fully funded.

We recommended that Finance continue to work with departments and other oversight agencies to fully identify and address the issues that lead to positions being vacant for lengthy periods. Finance should then consider seeking statutory changes that provide it with the authority to approve the reestablishment of vacant positions in additional circumstances, including when delays in hiring and examination processes extend the time it takes to fill positions.

Legislative Action: Legislation passed and corrective action taken.

Chapter 1124, Statutes of 2002, amended Government Code, Section 12439, to provide Finance with the authority to approve the reestablishment of vacant positions when certain conditions existed during all or part of the six consecutive monthly pay periods. The conditions include when a hiring freeze is in effect, when a department has been unable to fill positions despite its diligent attempts, and when positions are determined to be hard-to-fill. Additionally, the amended statute authorizes the SCO to reestablish vacant positions when department directors certify that specific circumstances existed in the six consecutive months.

Finding #4: The SCO's system for identifying positions to be abolished cannot track a position reclassified more than once during the fiscal year and does not have the capability to account for "120" transactions performed to circumvent abolishment.

The tracking system the SCO uses is supposed to follow a position through subsequent reclassifications. Thus, if the combined vacancy period before and after the reclassification

is more than six consecutive pay periods, the SCO flags the reclassified position for potential abolishment. However, the SCO's system for identifying positions to be abolished has two significant limitations. First, it cannot track a position that is reclassified more than once during the fiscal year. This causes the SCO to have to manually research transactions, which increases the risk that transactions may be missed. Second, the system does not have the capability to account for the use of "120" transactions performed to circumvent the abolishment of vacant positions. Our review found that departments use "120" transactions extensively to preserve vacant positions, thus increasing the likelihood of the tracking system missing vacant positions that should be abolished.

We recommended that the SCO consider the feasibility of modifying its system for identifying positions to be abolished so it can track them through more than one reclassification. Additionally, as we discussed in Finding #1, we recommended that the SCO periodically provide to Finance reports of "120" transactions so that Finance can identify potential misuses of the transactions and follow up with departments as appropriate.

SCO Action: Corrective action taken.

The SCO stated it has completed modifications to its system to track five different position changes. In addition, it has twice provided to Finance reports of "120" transactions for Finance's analysis of potential misuses of the transactions.

Finding #5: The Department of Mental Health did not adhere to the established controls requiring it to seek external approval for certain "607" transactions.

The Department of Mental Health (Mental Health) did not submit two transactions to Finance, even though they involved reclassifications to positions above the minimum salary level required for Finance's approval. Mental Health believed one of these transactions did not need Finance's approval because it downgraded a position and the related salary. Nonetheless, Finance staff stated that both transactions needed its approval.

We recommended that Mental Health ensure that it submits for Finance's required approval all "607" transactions that involve a reclassification to positions above the specified minimum salary level.

Mental Health Action: Corrective action taken.

Mental Health stated it has submitted for Finance's review and approval the reclassifications involving positions above the specified minimum salary level.

Finding #6: Despite Finance's recent scrutiny of vacant positions, ongoing monitoring is needed.

Finance performed two reviews to address the Legislature's concerns about the number of vacant positions. The reviews recommended that certain departments eliminate or redirect 4,236 positions beginning in fiscal year 2000–01. Additionally, Finance recommended in its first report that the funding from the positions be reallocated to the departments for other program uses. In its second report, Finance did not identify the total amount of funding to be eliminated or reallocated. In January 2002, Finance stated that it plans to conduct further reviews in 2002 and 2003. However, no ongoing monitoring program has been established. Without a regular process to monitor vacant positions, data may not be available to enable the State's decision makers, including the Legislature, to make informed decisions.

To ensure that the State continues to monitor vacant positions and the associated funding, we recommended that Finance direct departments to track and annually report the uses of such funding. Additionally, Finance should continue to analyze the departments' vacant positions and uses of funds, recommend to what extent departments should eliminate vacant positions, and either eliminate or redirect the funding for the positions. Further, it should periodically report its findings to the Legislature to ensure that the information is available for informed decision making.

Finance Action: Corrective action taken.

Finance stated that the Budget Act of 2002, Section 31.60, directed it to abolish at least 6,000 positions from all positions in state government that were vacant on June 30, 2002. The section also authorized Finance to eliminate at least $300 million related to the abolished positions. The section further required Finance to report to the Legislature on the specific positions abolished. Finance reported in November 2002 that it abolished 6,129 positions and $300.4 million. However, our review of Finance's report

revealed that it included 560 public safety positions, representing $23.5 million in cost savings, that Section 31.60 excluded from abolishment. Additionally, we found errors that understated the abolished positions by 39 and cost savings by $6.7 million. Moreover, we could not determine whether the positions Finance abolished included any that had been eliminated by other provisions of law. Chapter 1023, Statutes of 2002, also directs Finance to abolish at least 1,000 vacant positions by June 30, 2004, and to report to the Legislature on the specific positions abolished.

Finding #7: Actual funding needs may be obscured because departments use funding from excess vacant positions to carry out their programs, in part, because certain costs have not been fully funded.

Our review at five departments found that they spent the funds budgeted from excess vacant positions for the higher costs of their filled positions, overtime, personal services contracts, and operating expenses. For example, the five departments in total spent the majority of their funding from excess vacant positions on the higher cost of filled positions, in part because of their efforts to hire in hard-to-fill classifications included such expenses as hiring above the minimum salary level and pay differentials. The departments told us, and Finance acknowledges, that the State typically has not augmented department budgets for increases in the cost of filled positions. Because certain program costs have not been fully funded, departments sometimes use funding from excess vacant positions to bridge the gap between their actual costs and their present funding levels.

To ensure that budgets represent a true picture of how departments manage their programs, we recommended that Finance continue to assess if common uses of funds resulting from vacant positions represent unfunded costs that should be reevaluated and specifically funded.

Finance Action: Corrective action taken.

Finance stated that the Budget Act of 2002, Section 31.70, authorized it to reinstate up to one-half the funding reduced by Section 31.60 for fiscal year 2002–03 appropriations to ensure that departments have sufficient levels of funding. As of April 1, 2003, Finance approved the reinstatement of $37.4 million in funding.

Finding #8: A method to provide reliable, up-to-date information about the number of vacant positions does not exist.

Legislators have expressed concerns because current point-in-time information on vacant positions from the SCO appears to show a substantially higher number of vacancies than those presented by Finance. The vacancy number that Finance presented is derived from past year actual information from other SCO reports. However, this number is generally not available until about five to six months after the end of the fiscal year. The SCO and Finance worked together to calculate a reliable, up-to-date number of vacancies as of June 30, 2001. Their efforts were beneficial as they provided a better understanding of the differences in the various data used by the entities. However, the efforts resulted in an estimate of vacancies that proved to be inaccurate.

To ensure that the State's decision makers have an accurate picture of the number of vacancies during the fiscal year, we recommended that Finance and the SCO, in consultation with the Legislature, work together on a method to calculate an up-to-date and reliable number of vacant positions statewide.

➲ ***Finance Action: None.***

Finance stated that, because of the state hiring freeze and the reductions of positions over the next several months, it would not be possible for it and the SCO to develop a method to provide up-to-date and reliable calculations of vacant positions.

DEPARTMENT OF REHABILITATION

Its Delay in Correcting Known Weaknesses Has Limited the Success of the Business Enterprise Program for the Blind

Audit Highlights . . .

Our review of the Department of Rehabilitation's (department) administration of the Business Enterprise Program for the Blind (program) reveals that:

- ☑ *Program participants' (operators) average net income has increased, but 30 percent of them still earned less than the minimum wage in fiscal year 2000–01.*
- ☑ *In May 2002 the department completed its first strategic plan for the program; however, the plan lacks defined outcomes and performance measures.*
- ☑ *Although the department has been working for more than seven years to update its regulations, it has yet to do so.*
- ☑ *The department has not ensured that partnerships between operators and private food-service businesses are consistent with federal law and pay their fair share of program costs.*

continued on next page

REPORT NUMBER 2002-031, SEPTEMBER 2002

Department of Rehabilitation's response as of September 2003

The California Welfare and Institutions Code, Section 19640.5, requires the Bureau of State Audits to conduct a fiscal audit of the Business Enterprise Program for the Blind (program) every third fiscal year until January 2002 and a programmatic review every five years until January 2003. This programmatic review is the last of the series of reviews required by the statute. The program trains qualified blind persons to operate their own food-service businesses and provides them with food service facilities located in government buildings throughout the State. Specifically, we found:

Finding #1: The department only recently provided strategic direction to its staff and participants.

In May 2002, in conjunction with the California Vendor's Policy Committee, the Department of Rehabilitation (department) issued its first strategic plan for the program. The department's previous lack of action to establish strategic priorities for the program, identify expected outcomes, or offer methods to measure improvement hampered the program's ability to fulfill its mission and to address deficiencies in its operations that various audits identified as early as 1991. The plan does not reflect decisions regarding the prioritization of scarce resources, show which areas the department believes the program needs to improve the most, or provide any mechanism for the program to use to determine what level of resources to expend to attain planned objectives. Moreover, the current plan does not identify expected outcomes or offer performance measures or benchmarks. Consequently, the department might dedicate resources to an area but never be able to determine if the program has reached—or is moving toward—a stated goal.

- ☑ *Since August 1998 the program has not actively pursued the collection of past-due vending machine commissions from private companies.*
- ☑ *The program does not adequately monitor operators or provide them with all required consulting services.*

We recommended that the department, in consultation with the California Vendor's Policy Committee, should revise the program's strategic plan to include expected outcomes and performance measures so the department can evaluate the program's success and measure its progress in achieving strategic goals and improving noted deficiencies.

Department Action: Corrective action taken.

In its September 2003 response to our audit, the department reported that in consultation with the California Vendor's Policy Committee, it revised the program's strategic plan to include expected outcomes and performance measures.

Finding #2: The department has not updated its guidelines for administration of the program.

The department lacks guidance the program needs for sound administration. The program has neither updated its regulations nor provided updated policies for program administration to its staff. The lack of clear guidance may lead to disparate service delivery and compromise the program's success. State law and regulations require that every three years the department review and consider updating its regulations for the administration of the program. However, the department has been working for at least seven years to update the regulations. Because of this delay and the program's reliance on a 1994 policy and procedures manual that is outdated in some areas and provides insufficient guidance in others, the program has lacked clear guidelines on how it should operate. The program has not provided sufficient guidelines in its purchase of equipment and establishment of private partnerships. As a result, the department cannot ensure that the purchase of equipment is consistent among locations and that its private partnerships conform to federal law and its own mission statement. The department attributes its delay in updating its regulations on staff vacancies and on the magnitude and importance of the task; however, we found the department's reasons for not being able to establish guidelines to be unfounded. The department is currently developing a new draft of the proposed regulations, but it has not established timetables or deadlines to manage the process. The department intends to revise its policy and procedures manual to coincide with the new regulations once they are adopted.

We recommended that the department should aggressively and promptly pursue development of program regulations. If the current draft is too complex or lengthy, the program should consider breaking the draft regulations into segments, first identifying and addressing the highest priorities. The department should ensure that the guidelines include measures that will improve consistency in equipment purchase decisions, including a list of allowed and disallowed equipment and supplies, and statewide criteria for equipment purchase and replacement.

Department Action: Pending.

The department has not yet updated its regulations. However, it reported that it has drafted proposed regulations and plans to divide the proposed regulations into separate parts for submitting through the regulatory process based on program priorities. At the time of its September 2003 response, the department expected to finish dividing and prioritizing its proposed regulations in September 2003, and then to proceed with those regulatory changes it deemed are the highest priority. The department offered no expected timetable for completing the approval process of any of its proposed regulations.

➲ The department disagrees with our finding that it lacks sufficient guidelines to ensure that staff members use the same standards or information to decide whether equipment purchases are warranted. The department reported that it believes its current system provides consistency and flexibility.

Finding #3: By allowing operator partnerships with private businesses, the program has collected inequitable operator fees and may not have complied with federal law.

By encouraging private partnership agreements between blind operators and private food service businesses, the department recently has allowed the private businesses to obtain program benefits that federal law intended for blind operators. Under a private partnership agreement, a contract between a program participant and a private food service business, the private business pays the program participant a monthly amount and in exchange is allowed to prepare and sell food at a program site in a state or federal building and to receive other program benefits such as consulting services and equipment maintenance.

We found numerous problems with the program's administration of its private partnership agreements. Specifically, it has not adequately ensured that its actions conform to the intent of the federal Randolph-Sheppard Act under which the program was created. Moreover, because it has not developed guidelines on when or how to implement the partnerships, it cannot be sure that the partnerships are allowable, prudent, or consistent or that they protect the interests of the State or the program participants. Because of the terms of the partnerships, the department has lost its ability to monitor the investment of program funds in these locations in the same way that it can monitor the use of program funds at other locations, and it has not obtained enough information from the partnerships to determine if they are successful business ventures. Further, although the program generally provides the same services to private partnerships that it would to other program participants, it allows some partnerships to pay disproportionately lower fees than other program participants pay.

To improve its administration of private partnerships, we recommended that the department take the following steps:

- Establish and follow guidelines for partnerships, ensuring that they are in agreement with federal and state law, regulations, and guidance.

- Require program staff to further study the cost and benefit of each partnership to ensure that future agreements do not inequitably drain program resources.

- Establish a review process for proposed private partnerships that allow the department to adequately protect the interests of the State and program participants.

- Monitor partnerships to enable the department to compare the costs and benefits of partnerships and determine if they achieve program objectives.

- Ensure that program staff are able to monitor the success of all locations, including private partnerships.

Department Action: Pending.

The department reported that its proposed regulations address agreements between program participants and private entities and it reported that, in consultation with the California Vendors' Policy Committee, it will establish guidelines to ensure compliance with federal and state law, regulations, and guidance. However, the department did not provide us with an estimate of when these proposed regulations would be approved. At the time of its September 2003 response, the department had yet to determine what parts of its proposed regulations would be submitted for approval through the regulatory process.

The department stated that it already evaluates the costs and benefits of agreements between program participants and private entities, but will review its evaluation process to ensure that the review adequately protects program resources.

The department reported that it does not plan to establish a review process for proposed partnerships. It believes its current process adequately protects the interests of the State and program participants.

The department also reported that it would review its monitoring procedures to further its ability to compare the costs and benefits of agreements and determine if they achieve program objectives.

Further, the department reported that it will continue to monitor the success of all locations.

Finding #4: The department has not corrected flaws in its process for pursuing past-due commissions, some of which may now be uncollectible.

Since August 1998 the department has not actively collected past-due commissions owed to the program by private vending machine businesses operating on federal and state properties. The department's lack of pursuit of these past-due commissions may have rendered these commissions uncollectible. Moreover, the department's collection process is inadequate and its new database cannot track past-due commissions. This problem has been compounded because the department has not maintained all its contracts, conducted planned audits, and appropriately trained its collection staff.

We recommended that the department consider moving the commission-collection function to its accounting section, which already collects operator fees for the program and possesses the necessary collection knowledge and accounts receivable tracking system.

Department Action: Corrective action taken.

The department reported that it completed its evaluation of its resources and feasibility of moving the commission-collection function and has moved the commission-collection function to the department's specialized services division. It also reported that it has added an additional staff person to the commission-collection function and that it continues to refine its database.

Finding #5: The department has not consistently met all of its responsibilities to program participants as required by law and its own regulations.

By not fulfilling all its responsibilities to program participants in terms of training, feedback, and financial monitoring, the department may have hindered the ability of participants to succeed and engage in improved work opportunities. Specifically, the department has not complied with state law that requires it to provide the program's initial training in two locations, nor has it consistently provided upward mobility training as required by federal law. Further, the department has not always offered operators documented feedback that might enable them to increase the success of their facilities even though its own policies require that it give such feedback every three months. Finally, the department has not ensured that operators submit required financial reports and fees, and thus cannot readily identify operators who may be having operating difficulties and need assistance.

We recommended that the department offer program participants a second training location and ensure that it identifies and offers upward mobility training classes. Further, the department should track location reviews to ensure that business enterprise consultants complete the reviews at least quarterly. We also recommended that the department should ensure that consultants contact operators regarding missing monthly operating reports when they are a month or more delinquent as required by regulations, and

discontinue its practice of waiting 60 days before identifying delinquent monthly operating reports. Finally, the department should ensure that the program monitors operators adequately to prevent the accumulation of significant past due fees and lengthy delinquencies in reporting. When operators refuse to submit financial reports as required by regulations, the department should demonstrate it is willing to suspend and terminate operators' licenses to ensure compliance with program requirements.

Department Action: Partial corrective action taken.

The department reported that it completed an evaluation of the program's entire training program to ensure it meets the needs of program participants and the requirements of state and federal laws and regulations. As a result, the department has extended its annual licensing class for new participants, which it continues to provide in one location, from six months to eight months. It also reported that it will provide additional training at field office locations via teleconference or face-to-face for all its program participants at least annually. The department reported that it had provided training in four locations during 2003 and plans to provide training opportunities for participants and staff in the northern and southern part of the State at least once a year.

The department also reported that it has completed all required quarterly location reviews in the last two quarters of fiscal year 2002–03 and expects to complete all quarterly location reviews in fiscal year 2003–04. In addition, the department reported that it established a tracking system to ensure that required reviews are completed.

Further, the department reported that it reviewed its current process for entering operating report data and determined that it is the most cost-efficient method of entering the data. It also reported that it strengthened its use of its tracking system and emphasizes routine reporting and appropriate follow-up of operator status. Finally, the department reported that it will continue to pursue operators with delinquent reports and unpaid fees consistent with its available resources and priorities.

Finding #6: The department has not corrected weaknesses in its process for assigning interim locations.

In a previous report, issued in August 1997, we reported that the department's policy for classifying and circulating announcements for available locations was inequitable because it had not developed a fair process for assigning interim locations. To date, the department still has not corrected this weakness.

To ensure that its application and selection process for locations is equitable, we recommended that the department establish procedures to circulate announcements for all permanent and interim food service locations to eligible operators.

Department Action: Pending.

The department maintains that its established procedures to circulate announcements for all permanent locations and to select interim operators are appropriate and fair. However, the department reported that it has re-evaluated the procedures it uses to select interim operators and has included procedures in the proposed regulations to ensure all interested operators have equal opportunity to be considered for interim locations.

STATEWIDE FINGERPRINT IMAGING SYSTEM

The State Must Weigh Factors Other Than Need and Cost-Effectiveness When Determining Future Funding for the System

Audit Highlights . . .

Our review of the California Department of Social Services' (Social Services) Statewide Fingerprint Imaging System (SFIS) revealed:

- ☑ *Social Services implemented SFIS without determining the extent of duplicate-aid fraud throughout the State.*
- ☑ *It based its estimate of the savings that SFIS would produce on an evaluation of Los Angeles County's fingerprint imaging system, rather than conducting its own statewide study.*
- ☑ *Because Social Services did not collect key statewide data during its implementation of SFIS, we are not able to determine whether SFIS generates enough savings to cover the estimated $31 million the State has paid for SFIS or the estimated $11.4 million the State will likely pay each year to operate it.*
- ☑ *In deciding whether to continue SFIS, the Legislature should consider the benefits SFIS provides as well as what appears to be valid concerns regarding the system, such as the fear it may provoke in immigrant populations eligible for the Food Stamp program.*

REPORT NUMBER 2001-015, JANUARY 2003

Department of Social Services' response as of December 2003

Chapter 111, Statutes of 2001, directed the Bureau of State Audits (bureau) to conduct an audit of the Department of Social Services' (Social Services) Statewide Fingerprint Imaging System (SFIS). This system was designed to detect duplicate-aid fraud. The bureau was asked to report on the level of fraud detected through SFIS; the level of fraud deterrence resulting from SFIS; SFIS's deterrence of eligible applicants, especially the immigrant population, from applying for public benefits; and SFIS's cost-effectiveness.

Finding #1: Social Services did not know the extent of duplicate-aid fraud before implementing SFIS.

Before SFIS was in place, estimating how much duplicate-aid fraud actually existed in the State was difficult. Social Services was aware only of potential cases of duplicate-aid fraud that the counties brought to its attention. The methods the counties used to detect duplicate-aid fraud prior to SFIS met the federal requirement and were similar to those used in other states. According to our survey, the counties used computer matches as the primary method to detect possible duplicate-aid fraud, followed closely by tips from concerned citizens or other organizations. Data from the counties responding to our survey regarding the number of duplicate-aid fraud cases identified prior to the implementation of SFIS did not suggest to us that duplicate-aid fraud was a serious problem.

Social Services had a few options available for determining the known extent of duplicate-aid fraud in the State prior to implementing SFIS. For example, it could have surveyed the counties as we did or requested counties to analyze their Integrated Earnings Clearance/Fraud Detection System and

DPA 266 data to determine the extent of duplicate-aid fraud. The DPA 266 is a report that tracks, among other things, statewide statistics on duplicate-aid investigation requests.

We raised concerns regarding the accuracy and completeness of the DPA 266 in our March 1995 report, titled *Department of Social Services: Review and Assessment of the Cost Effectiveness of AFDC Fraud Detection Programs*. Social Services has not resolved fully its problems with the DPA 266. Our survey results indicate that the counties do not report information consistently on the DPA 266, and therefore it is an unreliable report.

According to the chief of its fraud bureau, Social Services no longer verifies the accuracy of the information the counties report, because it does not consider the DPA 266 to be a statistical or claiming document but merely an activity report. However, this statement is inconsistent with Social Services' instructions for completing the DPA 266, which state that information collected on the DPA 266 is used to prepare a federal program activity report and special reports for the Legislature. Specifically, federal regulations require state agencies to submit to the United States Department of Agriculture (USDA) an annual program activity statement that includes data on investigations of fraud. If Social Services had captured more detailed and reliable data using the DPA 266, it may have been able to present a clearer picture of the extent of duplicate-aid fraud identified by the counties.

To ensure that it reports accurate and complete information to the USDA, Social Services should require the fraud bureau to incorporate the review of DPA 266 data into its on-site visits to counties.

Social Services' Action: Pending.

Social Services stated that its fraud bureau is in the process of developing procedures to verify the accuracy of the DPA 266 data and will incorporate these procedures into its on-site visits to counties.

Finding #2: During implementation, Social Services missed its opportunity to determine SFIS's cost-effectiveness.

Social Services and the Health and Human Services Agency Data Center (data center) did not capture critical data during the implementation phase that would have allowed them to

quantify the savings attributable to SFIS. For example, each month two randomly selected groups of cases would be drawn from a subset of counties implementing SFIS over a six-month period to establish a control group and an experimental group of recipients. Individuals in the control group would not be fingerprinted, but individuals in the experimental group would be fingerprinted. Then the amount of benefits paid to each group in the first calendar month in which SFIS had its full effect on the experimental group would be used to calculate an initial savings amount. The recidivism rate—the rate at which individuals previously terminated from receiving aid return to aid—would be tracked for each county for one year and used to adjust the initial savings.

The deputy director of Social Services' Welfare-to-Work Division told us that in mandating SFIS, the Legislature did not provide any statutory authority or resources to require counties to collect data. Although we agree that state law mandating SFIS neither explicitly mandates the collection of data nor provides funding for these efforts, it does require Social Services and the data center to design, implement, and maintain the system. Moreover, other state laws and policies establish the State's expectations for implementing information technology (IT) projects. For example, state law holds the head of each agency responsible for the management of IT in the agency that he or she heads, including the justification of proposed projects in terms of cost and benefits. Further, state policy requires agencies to establish reporting and evaluation procedures for each approved IT project and to prepare a post implementation evaluation report that measures the benefits and costs of a newly implemented IT system against the project objectives. The State does not consider a project complete until the Department of Finance approves the post implementation evaluation report. Data collection is a key component in preparing this report. Therefore, the data center and Social Services were remiss in not bringing the lack of authority and resources to the Legislature's attention so they could effectively implement SFIS. Moreover, because counties did not begin to use SFIS until March 2000, roughly four years after the passage of the law, it is reasonable to conclude that the data center and Social Services had ample opportunity to do so.

To ensure that its implementation of future IT projects meets state expectations, Social Services and the data center should collect sufficient data to measure the benefits and costs against the project objectives. They also should identify promptly any obstacles that may prevent them from implementing effectively the project.

Social Services' Action: Pending.

Social Services and the data center stated that they will continue to adhere to all appropriate IT policies and processes, and identify obstacles that may prevent an appropriate analysis of impacts of the IT project.

Finding #3: Incomplete cost data and a flawed method for estimating savings renders Social Services' cost-benefit analysis for SFIS unreliable.

Social Services tracks some of the costs associated with SFIS, but it does not track county administrative costs. As a result, it does not know the full costs of operating SFIS. Further, because Social Services did not capture the data necessary to determine the savings attributable to SFIS during its implementation, Social Services developed an estimate based on the results of Los Angeles County's AFIRM demonstration project. However, the methodology it used to estimate the State's savings of roughly $150 million over five years for SFIS is flawed and therefore unreliable.

Although we were able to substantiate the data center's and Social Services' costs, we were not able to determine the counties' actual costs because Social Services did not require counties to track SFIS administrative costs separately. Social Services estimated that the total administrative costs that all counties except Los Angeles incurred for CalWORKs and the Food Stamp program for fiscal year 2000–01 would be roughly $1.8 million, yet Riverside County told us that its estimated costs for the same fiscal year were roughly $1.4 million; Riverside County alone estimated its costs as amounting to 78 percent of the costs Social Services estimated for 57 counties. Additionally, Social Services' estimate does not include the cost that counties incur for investigating possible fraudulent activity. Furthermore, Social Services chose not to include any administrative costs for Los Angeles County in its estimate because the county had not yet implemented SFIS. Therefore, Social Services may be understating the cost of implementing and operating SFIS substantially.

Social Services' November 2000 estimate also attempts to quantify benefits or savings that would accrue to the CalWORKs and Food Stamp programs. The estimate does not include savings attributable to the avoidance of duplicate-aid fraud in the Food Stamp program because the data was

not available. Further, Social Services did not include savings resulting from Los Angeles County's use of SFIS because the county was not yet using SFIS when Social Services built the estimate. Finally, Social Services used data from Los Angeles County's demonstration project to support key assumptions in its development of the SFIS savings estimate, which is inappropriate because it assumes that these conditions hold true in other counties. In fact, Social Services was unable to provide documentation to support some of its key assumptions.

To improve its management of SFIS, Social Services should identify the full costs of operating SFIS by requiring counties to track their administrative costs separately. To ensure that its estimates are representative of the entire state and its key assumptions are defensible, Social Services should study the conditions of a sample of counties instead of assuming that conditions in one county hold true in other counties and maintain adequate documentation, such as time studies or other empirical data to support its estimates.

Social Services' Action: Pending.

Social Services disagreed that it should separately track SFIS administrative costs, stating that these costs are included in general eligibility determination activities in the State's federally approved cost allocation plan. Social Services' failure to recognize the importance of these costs causes us concern. Until Social Services understands the total cost of operating SFIS, the State cannot properly evaluate the system in terms of costs and benefits.

Social Services agreed that maintaining adequate documentation to support its estimates is important and believes that in most instances sampling several counties is a better representation of the entire state. However, Social Services stated that, in the case of SFIS, it and the Legislature appropriately relied on data from Los Angeles County's demonstration project since it was specifically designed to test fingerprint imaging and because Los Angeles County represents 40 percent of the statewide public assistance caseload. Nonetheless, Social Services asserted that it has processes in place to assure that assumptions are appropriately documented.

Finding #4: The majority of matches SFIS identifies are administrative errors, and the actual level of fraud it detects is quite small.

Although Social Services does not know how many applicants SFIS deters from attempting to receive duplicate-aid, it can determine the number of applicants that SFIS detected who were attempting to receive duplicate aid. However, we found that the actual number of matches SFIS has identified as possible fraudulent activity is substantially fewer than the number of matches it identifies as administrative errors made by county staff. Between March 1, 2000, and September 30, 2002, SFIS detected a total of 25,202 matches, 7,045 which were still pending resolution as of September 30, 2002. Of the remaining 18,157 items with a final disposition, staff identified only 478 of the items, or roughly 3 percent, as possible fraud situations. Further, investigators found fraud in only 45 of the 478 possible fraud items, just 0.2 percent of the 18,157 items resolved, according to SFIS reports. In order to determine how long items had been pending resolution, we asked for an aging report as of October 21, 2002. We found that roughly 3,000 of the 4,920 matches shown as pending resolution in SFIS were more than 99 days old, and 1,100 had been pending for a year or more. Social Services told us that it generates monthly reports from SFIS that allow it to see whether counties are investigating and resolving discrepancies but that it reviews these reports in detail only twice a year. Moreover, although Social Services provides training and instructs counties to promptly resolve any matches that SFIS identifies, it does not have a regulation, policy, or set of procedures requiring counties to do so. Additionally, Social Services has yet to develop written procedures for its own staff to follow when reviewing reports that SFIS generates. Without policies and procedures, Social Services cannot ensure that SFIS information remains current, which can diminish its usefulness.

To improve its management of SFIS, Social Services should establish policies and procedures that require counties to resolve pending items in the resolution queue promptly. Additionally, the fraud bureau should develop written procedures for its staff to follow up on items pending in the resolution queue. The procedures should include fraud bureau staff requesting a monthly aging report to use as a tool to determine whether items pending in the resolution queue are current and, if necessary, contacting the appropriate counties. Furthermore, Social Services should ensure that counties investigate and record the outcomes of their investigations in SFIS.

Social Services' Action: Corrective action taken.

Social Services stated that it has developed an aging report for use as a tool to monitor pending items in the resolution queue. Further, it told us that written procedures to guide its staff in following up with counties to resolve pending cases have been developed.

Finding #5: Social Services does not collect the data it needs to determine if it is successful in reaching its Food Stamp program target populations.

California's Legislature voiced its concern over low participation rates by requiring Social Services to develop a community outreach and education campaign to help families learn about and apply for the Food Stamp program. In an annual report to the Legislature dated April 1, 2002, Social Services stated that it believes its outreach efforts have had an effect on increasing the number of applications received and the caseload of the Food Stamp program. However, the Legislature specifically instructed Social Services to identify target populations and report on the results of its outreach efforts. Social Services identified two target populations: families terminating from CalWORKs and legal noncitizens. Although Social Services recognizes that the ultimate measurement of its outreach efforts' success depends on its ability to reach the target population, it did not collect data to evaluate the participation rates of these two populations. Instead, it chose to rely on the USDA's report of estimated state Food Stamp program participation rates, which presents information that is up to three years old. Furthermore, the USDA's report does not have information specific to Social Services' target populations. Therefore, Social Services does not know if its efforts to reach legal noncitizens have been successful.

To report accurately the results of its community outreach and education efforts to the Legislature, Social Services should establish a mechanism to track the participation rates of the target populations.

Social Services' Action: Corrective action taken.

Social Services stated that it has contracted with the University of California, Los Angeles, to collect data necessary to track non-citizens' participation in the Food Stamp program. Social Services believes that this data, in combination with data from the federal census, will allow it to track non-citizen participation over the years.

Finding #6: Decision makers should consider the benefits and drawbacks of SFIS when deciding future funding for the system.

The primary benefits that the State derives from continuing to use SFIS are the proven effectiveness of fingerprint imaging technology to identify duplicate fingerprints and its ability to identify applicants who may travel from county to county seeking duplicate aid. However, several factors could also support discontinuing the use of SFIS. For one, the State is spending $11.4 million or more annually to operate SFIS without knowing the actual savings that it may be producing. Additionally, although we were not able to verify some of the concerns that opponents of SFIS raised, other concerns appear valid. For example, the fingerprint imaging requirement may add an element of fear to the welfare application process and thus may keep some eligible people from applying for needed benefits. The State must weigh these factors in deciding whether to continue to fund SFIS.

The Legislature should consider the pros and cons of repealing state law requiring fingerprint imaging, including whether SFIS is consistent with the State's community outreach and education campaign efforts for the Food Stamp program. To assist the Legislature in its consideration of the pros and cons of repealing state law requiring fingerprint imaging, Social Services and the data center should report on the full costs associated with discontinuing SFIS.

Legislative Action: Legislation proposed.

The Legislature is currently considering Assembly Bill 1057 (Lieber), which proposes to repeal the requirement for Social Services to use SFIS. This bill is currently in the Assembly Committee on Human Services.

Social Services' Action: Pending.

Social Services agreed, but stated that it has previously provided this information to the Legislature. Social Services did not state clearly the actions it will take to address our recommendation.

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DEPARTMENT OF SOCIAL SERVICES

Continuing Weaknesses in the Department's Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk

REPORT NUMBER 2002-114, AUGUST 2003

Department of Social Services' response as of October 2003

Audit Highlights . . .

As the State's agency for licensing and monitoring community care facilities, the Department of Social Services:

- ☑ *Has been less prompt in communicating exemption decisions.*
- ☑ *Has not adequately managed or investigated subsequent criminal history reports.*
- ☑ *Did not always follow its complaint procedures or make certain that facilities fully corrected identified deficiencies.*
- ☑ *Has adequately reviewed the counties it contracts with to license foster family homes, but has not always corrected identified deficiencies.*
- ☑ *Was not always timely, consistent, and thorough in its enforcement of legal decisions.*

The Joint Legislative Audit Committee requested that we assess the Department of Social Services' (department) policies and practices for licensing and monitoring community care facilities. Since our last review in August 2000 (child care report), the department has more selectively granted criminal history exemptions and has prioritized and quickly processed legal actions against facility licensees. However, the department could improve in other areas.

Finding #1: The caregiver background check bureau granted exemptions without considering all available information.

The caregiver background check bureau (CBCB) did not sufficiently consider information other than convictions when reviewing five of the 45 approvals we examined. The department's evaluator manual instructs the CBCB staff to consider factors such as the age of a crime, a pattern of activity potentially harmful to clients, and compelling evidence to demonstrate rehabilitation. However, the CBCB did not always consider all these factors. For example, the CBCB ignored self-disclosed crimes not appearing on individuals' criminal history records (rap sheets) and accepted without question character references that appeared inadequate.

To ensure that criminal history exemptions are not granted to individuals who may pose a threat to the health and safety of clients in community care facilities, the department should:

- Make certain it has clear policies and procedures for granting criminal history exemptions.

- Ensure staff are trained on the types of information they should obtain and review when considering a criminal history exemption, such as clarifying self-disclosed crimes and vague character references.

Department Action: Partial corrective action taken.

The department reported that it agrees with these recommendations. It has drafted procedures related to exemption processing, trained its staff on these procedures in September 2003, and will release an updated procedures manual in November 2003. The department reported that rap sheet screening procedures, among others, have been finalized and it is training staff on this material.

Finding #2: The CBCB often did not perform criminal history checks within established time frames.

The CBCB's performance in promptly communicating to facilities and individuals the ultimate decisions on exemption requests worsened since we issued the child care report, despite the CBCB extending its time frames for decisions from 45 days to 60 days. In 20 of the 45 (44 percent) criminal history exemption approvals we examined, the CBCB did not meet its timeline in effect when the exemption decisions were made, even though there was nothing unusually complex about most of the cases. In July 2003, emergency regulations became effective that prohibit an individual from being in a licensed facility until the CBCB completes a criminal history review. This regulatory change addresses the concern that individuals with dangerous criminal backgrounds may begin work before the department has evaluated their criminal history. However, the CBCB's delays will also prevent individuals with less serious criminal histories from working until the CBCB completes its criminal history reviews. Thus, the CBCB's delays may impede a person's ability to work.

To process criminal history reviews as quickly as possible so that delays do not impede individuals' right to work or its licensed facilities' ability to operate efficiently, the department should work to make certain that staff meet established time frames for making exemption decisions as requested.

Department Action: Partial corrective action taken.

The department said that it was placing a higher priority on individuals with lesser crimes or infractions because this group represents the largest majority of workload and allows these individuals to be in a facility as quickly as possible. The department stated that individuals needing a standard exemption will take longer to process.

Finding #3: The CBCB's quality control review of exemption decisions was not always effective.

Although the CBCB performed quality control reviews of exemption analysts' processing of exemption requests, we had one or more concerns with six of 17 cases that were subject to the CBCB's quality control process, indicating further improvement is necessary. The CBCB's quality control process is designed to help ensure that the exemption analysts reached the proper decisions based on the available information, including, but not limited to, rap sheets. In addition, the CBCB requires the quality assurance reviewer to verify that exemption analysts properly complete departmental forms and correctly draft letters communicating the exemption decision to the appropriate people and entities. However, we found that the CBCB's quality assurance reviewers sometimes failed to question cases for which exemption analysts had recommended approval despite missing documents or vague disclosures.

The department should assess its quality control review process and ensure that these policies and procedures encompass a review of the key elements of the exemption decision process.

Department Action: Partial corrective action taken.

The department stated that it is modifying its quality control procedures and expects final procedures to be in place by the end of 2003.

Finding #4: The department could better track and assess arrest-only information and better review criminal history information before issuing clearances.

If the CBCB receives arrest-only information, which discloses arrests for crimes without convictions, the CBCB may refer the information to the department's Background Information Review Section (BIRS). The BIRS determines whether an investigation of the circumstances leading to the arrest is necessary.

We expected the BIRS to have a process in place that did the following:

- Recorded when a case was referred to the field for investigation.

- Tracked a case to ensure that an investigation took place.

However, when the BIRS initiated an investigation, it failed to effectively track cases to their conclusion and has no systematic follow-up on cases it referred to the field to ensure an investigation is completed. As a result, necessary investigations may not have been completed, potentially exposing clients in community care facilities to unfit caregivers.

In addition, the department's policies and procedures for processing and tracking arrest-only investigations are not always clear. For example, confusion exists about how field investigators are to report their recommendations on cases involving behavior that is considered "conduct inimical"—behavior so harmful or injurious, either in or out of a facility, that there may be a statutory basis to ban an individual from a licensed community care facility. It is clear that both the BIRS and licensing offices should be informed of the recommendation, but it is not clear if the field investigators are to inform the licensing offices directly, or indirectly, through the BIRS. Without clear communication to track the status of a case, it is possible that after determining that an individual is unfit to be a caregiver, the department would fail to take action to remove the individual.

If the arrest-only information reflects a crime the CBCB considers inconsequential, such as a vehicle code infraction, or if a field investigation initiated by the BIRS cannot develop sufficient information to legally exclude the individual, either unit will issue a criminal history clearance. In three of 25 cases

with arrest-only information we examined, the CBCB (two cases) and the BIRS (one case) inappropriately issued criminal history clearances to individuals who were actively involved in court-mandated diversion programs. In these three cases—two cases involving welfare fraud and perjury and one case involving possession of a controlled substance—the CBCB and the BIRS failed to follow department policy of seeking additional information to determine whether the individuals were satisfactorily meeting the court's requirements. By clearing individuals currently participating in diversion programs, we believe that the CBCB and the BIRS risk ignoring important information that could be used to better protect clients in community care facilities.

So that investigations of arrest-only information are properly tracked and communicated, we recommended that the department:

- Develop a process for the BIRS to record when it refers a case for investigation and track a case to make certain that an investigation takes place.

- Make certain that policies and procedures are consistent and clear on where the responsibility lies for ensuring that the necessary action occurs upon an investigation's completion.

We also recommended that the department review and enforce its arrest-only policies and procedures to ensure that it is issuing criminal history clearances only when appropriate to do so and properly train staff on these policies and procedures.

Department Action: Corrective action taken.

The department stated that it implemented a system that generates a listing of cases and the dates these cases are referred to the field for investigation. The department said the list will prompt its analysts to inquire about the status of case investigations. In addition, the department reported that it implemented procedures that clearly define the responsibilities for ensuring that an investigation has been completed and appropriate action taken. Finally, the department stated that it had implemented procedures that address clearance criteria for arrests and that all appropriate staff have been trained.

Finding #5: The CBCB's handling of subsequent criminal history information was weak.

The Department of Justice (Justice) sends the CBCB subsequent rap sheets (subraps) to notify the CBCB of crimes for which caregivers or others at a facility have been arrested or convicted after the CBCB conducts its initial criminal history review. However, significant problems exist in the way the CBCB processes subrap information it receives from Justice. For example, the CBCB did not have adequate procedures for tracking its handling of subraps and sometimes did not record when it had received them. By not tracking its process, the CBCB was unable to effectively monitor whether it promptly considered subraps to protect clients in community care facilities. Furthermore, the CBCB was slow to notify facilities when exemptions were needed based on conviction information in subraps and did not notify its licensing offices when individuals could no longer be present in facilities because they failed to respond to these notices. Because of these delays, the CBCB sometimes allowed individuals unfit to be caregivers to remain in that role.

To ensure the department can account for all subraps it receives and that it processes this information promptly, we recommended that the department develop and implement a policy for recording a subrap's receipt and train staff on this policy. In addition, upon receiving a subrap, the department should ensure that staff meet established timeframes for notifying individuals that they need an exemption.

So that the department's licensing staff have accurate information about who should or should not be in a facility, thereby helping to protect clients, the department should meet its established time frame for notifying licensing staff and facility owners/operators that an individual has not submitted a criminal history exemption request as necessary and may no longer be present in a facility.

Department Action: Partial corrective action taken.

The department said that it has modified its computer system to allow for better subrap tracking. In addition, the department reported that all policies, procedures, and training plans will be in place by January 2004. Moreover, the department stated that it has placed a higher priority on cases where individuals have received approval to work in a facility and are later arrested for certain crimes or are

convicted of a crime. Finally, the department reported that it is reassessing its work priorities in order to establish more realistic timeframes regarding exemption needed notices.

Finding #6: Under the CBCB's current criminal history review procedures, certain out-of-state crimes may go undetected.

If an individual leaves a community care facility and returns to work within two years, the CBCB may not be aware of that individual's complete criminal record for the two-year period. To meet the Health and Safety Code requirement that it maintain criminal record clearances for two years after a caregiver or adult nonclient resident is no longer in a facility, the CBCB receives subraps from Justice disclosing any in-state criminal activity over the two-year period. Department policy is to rely on these ongoing disclosures and not require a full criminal background check when these individuals return to work in a licensed facility. As a result, a caregiver or nonclient resident could leave a facility, be arrested or convicted of a crime outside of the State, which would not appear in Justice's subraps, and then return to a facility within two years without the CBCB knowing about the criminal activity. Unlike Justice, according to the operations branch chief of the Community Care Licensing Division, the Federal Bureau of Investigation does not offer a subrap service. However, he acknowledged that the problem we outlined exists, and stated that the department would continue to look at the issue.

We recommended that the department assess its Federal Bureau of Investigation background check practices to ensure that it is fully aware of an individual's criminal record should that individual have a two-year or less gap in employment in community care.

Department Action: Pending.

➲ The department assessed its practices as we recommended, but reported that limited resources will prohibit it from requiring additional Federal Bureau of Investigation background checks for individuals who become disassociated from a facility and then return to work within two years.

Finding #7: The department did not always follow required complaint procedures.

The department asserts that most of the corrective actions it undertakes are identified through its complaint process rather than other facility evaluations. However, we found when licensing analysts (analysts) identified facilities' deficiencies during complaint investigations, they did not always ensure that caregivers complied with the corrective action plans. For 11 of the 33 substantiated complaints we reviewed, the department could not demonstrate that the facilities completely corrected the problems that prompted the complaints. By not following through to see that corrections are made, the department negates its efforts in investigating and substantiating complaints.

To protect clients' welfare, laws and procedures mandate certain time frames within which the department must initiate and follow through on complaint investigations, but the department did not always meet these timeframes. For example, our review of 75 complaints the department received in calendar years 2001 and 2002 identified 19 complaints for which the department made its initial facility visits beyond the 10-day requirement set by law. The visits ranged from two to 175 days late. Whenever the department delays an initial facility visit following receipt of a complaint, the department runs the risk of perpetuating a client's exposure to the alleged harmful conditions.

Finally, the department's policies specify that abuse complaints are a top priority and require analysts and supervisors to handle these complaints differently from routine complaint investigations because these complaints represent a serious threat to the clients' well-being. However, the department did not consistently follow these special procedures for the top-priority allegations among the 75 complaints we reviewed. For instance, the department did not refer two of 22 abuse complaints to the field investigators as required and did not send another three within the required time frame of eight working hours after receiving the complaint. When analysts do not refer or are slow to refer serious complaints to the field investigators, the analysts risk jeopardizing the expeditious handling of complaints and may affect the immediate safety of vulnerable clients.

To address the department's weaknesses in following required complaint procedures, we recommended that the department:

- Continue to emphasize complaint investigations over other duties and require supervisors to review evidence that facilities took corrective action before signing off on a complaint.

- Require analysts to begin investigating complaints within 10 days of receiving complaints.

- Ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt.

Department Action: Partial corrective action taken.

In August 2003, the department reminded its licensing staff of the importance of conducting and completing complaint investigations in a timely manner through a Workload Prioritization memorandum. The department reported that it will require all supervisors to wait to sign off on complaints until all plans of correction are complete. The department cited its increasing emphasis on complaints and the concern that all corrections be completed for making this change. The department indicated it plans to change its evaluator manual to reflect the requirement that licensing field staff issue a citation within 10 days of receipt of the investigative findings.

Finding #8: Certified family homes may have avoided correcting their deficiencies by changing certification from one foster family agency to another.

The department is responsible for licensing foster family agencies—private nonprofit corporations that in turn certify adults (certified parents) to operate foster family homes (certified family homes). However, because the department does not require foster family agencies to request information about applicants' compliance histories, the opportunity exists for certified parents to avoid correcting identified deficiencies.

We recommended that the department require foster family agencies to ask each applicant whether he or she had uncorrected, substantiated complaints at any other foster family agency and to verify the accuracy of an applicant's statements with the applicant's immediate prior foster family agency.

Department Action: Partial corrective action taken.

The department reported that it is developing a self-assessment Technical Assistance Guide for foster family agencies and plans to finalize it by February 2004. In addition, the department stated that this guide will serve as the foundation for regulations that it will develop within a year.

Finding #9: The department sometimes granted facility licenses based on incomplete applications and did not always perform required post-licensing visits.

When making its decision to license a new facility, the department did not always demonstrate that it collects and considers all required information and documents that help ensure the safety of vulnerable clients, such as evidence that the applicant obtained the necessary health screening and client care training. For example, of the 54 licenses we reviewed that the department granted during 2001 and 2002, the department granted 12 licenses before the applicants met one or more of the necessary requirements. In addition, the department did not consistently conduct all necessary post-licensing evaluations or ensure that the visits it did perform were made within statutory timelines. Specifically, of the 54 licenses we reviewed, 44 required post-licensing visits. For 13 of these facilities, the department could not provide documentation that it had conducted the necessary post-licensing visits. Moreover, the department conducted post-licensing visits late for an additional 21 facilities.

To ensure that it issues licenses only to qualified individuals, we recommended that the department ensure that analysts follow the department's checklist in collecting and considering all required licensing information, including, but not limited to, health screening reports, administrator's certification, and necessary background checks.

We also recommended that the department conduct the necessary post-licensing evaluations within the required time frame to make certain that newly licensed caregivers are operating according to regulations.

Department Action: Partial corrective action taken.

The department reported that it completed reviews of its licensing processes for its four program areas and is developing plans to better assure that all information necessary to approve licenses is received and reviewed. In September 2003, the department issued a memo outlining its program focus in response to the fiscal year 2003–04 budget. The memo lists post-licensing evaluations as an important activity and introduces annual and sample visit protocols that will provide additional time for post-licensing visits.

Finding #10: The department did not always evaluate staff performance or provide required staff training.

To periodically monitor the quality of the most important aspects of an analyst's work, the department created its quality enhancement process (QEP) reviews. Although supervisors in the foster care program prepared and documented the necessary QEPs for the analysts we selected to review, supervisors in the adult and senior care programs at the licensing offices we visited did not. In fact, adult and senior care program supervisors did not complete nine of the 11 QEP reviews of analysts we selected for examination. Although the supervisor recalls preparing QEPs for the remaining two analysts, she could not provide documentation to support her assertion. We believe ongoing assessment of the analysts' performance is essential to ensure the analysts are effectively applying program policies.

The Health and Safety code sets out staff development and training requirements for all analysts so they have the skills necessary to properly carry out their duties. Although these requirements are designed to provide information analysts need to stay current with the demands of their jobs, of the 22 analysts we selected who required this level of training during fiscal year 2001–02, 20 had training hours that fell short of statutory requirements. Without the necessary ongoing training, we question whether analysts are prepared to effectively perform their duties.

We recommended that the department make certain that all licensing office supervisors conduct QEP reviews of their assigned analysts. In addition, we recommended that the department make available to analysts the necessary training and develop a method to track whether analysts are meeting statutory training requirements.

Department Action: Partial corrective action taken.

➲ The department reported that it suspended its QEP evaluations in offices with severe staffing shortages and that it plans to reimplement these evaluations when staffing levels improve.

The department also stated that it had developed a new training database and instructed staff on its use. In addition, the department said it is developing a training need assessment tool to assist it in determining the specific needs of each licensing program.

Finding #11: The department has adequately monitored county licensing functions, but did not always ensure counties promptly corrected deficiencies.

As the department's agents for licensing and monitoring foster family homes within their geographical boundaries, contracted counties must follow related state law and department guidelines for implementing and enforcing rules and regulations pertaining to foster family homes. Although the department reviews the counties' licensing programs, it provides limited guidance regarding time frames to department staff performing the reviews, for preparing their reports, notifying counties about deficiencies, and to provide counties to correct deficiencies. Our analysis revealed that liaisons sometimes allowed a long time to elapse between the end of their reviews and the due date for the counties to submit their corrective action plans. Four counties we reviewed originally had between 120 days and 329 days after the end of the review to submit their plans, and the liaison granted extensions to the due dates for three of these. By not obtaining the counties' evidence of prompt corrective action, the department has limited the effectiveness of its county reviews and potentially allows counties to continue to operate improperly.

To help ensure that counties contracting with the department to license and monitor foster family homes adequately and promptly respond to complaints and enforce corrective actions, we recommended that the department establish reasonable time frames for liaisons to prepare reports resulting from reviews of the counties and to notify counties of the results of those reviews and for counties to submit and complete their corrective action plans.

Department Action: Corrective action taken.

The department said that it developed a formal policy with timeframes for liaisons to prepare reports and send notification of the review results to the affected county. In addition, the department developed standard timeframes for staff to utilize in developing corrective action plans. This policy went into effect October 1, 2003.

Finding #12: Despite recent efforts to improve, the department could do more to oversee county criminal history exemptions.

There are 42 counties that contract with the department to license foster family homes, and these counties perform background checks on potential caregivers and nonclient residents to ensure that people with serious criminal histories are not providing foster care or living in foster family homes. Contracted counties must submit exemption reports each quarter, but the department did not fully utilize the reports. The department has not provided its staff guidance on when to review the reports, what to look for when they perform their reviews, and when to follow up. We believe collecting and reviewing the exemption reports on a continuous basis allows the department to track criminal record information from all 42 counties and make certain it is aware of all their exemption processing.

We recommended that the department develop procedures to ensure that it promptly and consistently reviews quarterly reports on exemptions granted by each contracted county to help ensure that counties contracting with the department to license foster family homes are making reasonable decisions regarding criminal history exemptions.

Department Action: None.

In its response, the department stated that it has continually reviewed its quarterly county exemption reporting process with the counties and licensing supervisors. However, the department has not addressed the need for it to establish internal procedures to ensure the information the counties submit is promptly and consistently reviewed.

Finding #13: By conducting follow-up visits, the department could have improved its enforcement of legal actions.

Once the department signs a decision revoking a caregiver's license, excluding a caregiver or adult nonclient resident, or putting a caregiver on probation, the legal division is responsible for sending a copy of the decision to the applicable licensing office. The licensing office is then responsible for enforcing the legal actions. We reviewed 26 legal actions which resulted in a caregiver's probation, exclusion, or license revocation. In 11 instances the department either did not adhere to its follow-up procedures to ensure the caregivers complied with the terms of the probation, revocation, or exclusion, or did not document its actions. Specifically, in five cases, the department failed to follow up with the caregiver promptly and in two cases did not visit the caregiver at all. In the remaining four cases, the department did not document the actions it took to follow up on the legal decision that was made.

To improve its enforcement of legal actions, we recommended that the department conduct follow-up visits to ensure that enforcement actions against facilities are carried out and that it document its follow-up for enforcement of revocation and exclusion cases.

Department Action: Corrective action taken.

The department stated that in August and September 2003 it issued memos reemphasizing the importance of conducting required visits to facilities to enforce legal actions.

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

Investigations of Improper Activities by State Employees, February 2003 Through June 2003

ALLEGATION I2002-661 (REPORT I2003-2), SEPTEMBER 2003

California Unemployment Insurance Appeals Board's response as of September 2003

Investigative Highlights . . .

The California Unemployment Insurance Appeals Board engaged in the following improper governmental activities:

- ☑ *Improperly granted leave valued at an estimated $170,314 to 314 of its nonexempt employees who it already compensated for their overtime.*
- ☑ *Failed to maintain accurate time and attendance records for each employee.*

We investigated and substantiated an allegation involving the California Unemployment Insurance Appeals Board (Appeals Board) improperly granting unofficial time off to employees even though it had already compensated them for the overtime they worked.

Finding: The Appeals Board improperly granted leave that resulted in economic waste.

The Appeals Board improperly granted four days of leave to most of its employees. The Appeals Board employs 517 employees, consisting of both exempt and nonexempt employees. Exempt employees who work time in excess of the minimum average workweek shall not be compensated in overtime or compensatory leave. In contrast, the Appeals Board can either pay or award leave to nonexempt employees for overtime worked. In October 2001, the Appeals Board and the bargaining unit representing the Appeals Board's administrative law judges (who are exempt employees) entered into an agreement to grant these employees one day off each quarter in 2002 in exchange for an increased workload.

The Appeals Board has some flexibility in granting informal leave to exempt employees who work substantial overtime, but the same flexibility may not extend to granting leave to nonexempt employees. Nevertheless, the Appeals Board decided to also grant four days of informal administrative leave to its 314 nonexempt employees, even though it had already compensated those employees for overtime worked, resulting in an economic loss to the State. We could not determine the exact loss to the State since

the Appeals Board does not use the State Controller's Office's leave accounting system nor does it have a formal method to track the leave it grants to its employees. However, the leave improperly granted to 314 nonexempt employees totaled an estimated $170,314. The Appeals Board also violated state regulations when it failed to keep complete and accurate time and attendance for each employee.

Agency Action: Partial corrective action taken.

➲ The California Labor and Workforce Development Agency (agency), to whom the Appeals Board reports, disagreed with our conclusion that the Appeals Board improperly granted leave. The agency argued that Government Code, Section 19991.10, provides departments broad discretion to grant administrative time off as part of the appointing power's basic authority to manage its departments and that the statute sets forth no standards or criteria and provides no limitations upon the granting of such leave, except that no paid leave shall exceed five working days without prior approval of the Department of Personnel Administration (Personnel Administration). The agency also pointed out that the State Personnel Board (SPB) defined administrative time off as paid time granted by an appointing power to employees for the good of the service, to promote morale, and for other good reasons. However, the agency failed to note that the SPB also provided examples of the specific types of situations where administrative time off has been granted, such as when the appointing power determines that the safety of the employees is better served by their remaining at home or when work facilities have been destroyed or rendered uninhabitable because of lack of heat or electricity. Current state regulations related to Government Code, Section 19991.10, support the SPB's interpretation in that the regulations allow appointing powers to grant such employees administrative time off in emergency situations, but do not provide additional guidance on how the discretion provided by Section 19991.10 of the Government Code may be exercised. Thus, the Appeals Board's use of administrative leave in this case does not appear to be consistent with the intent of state law and regulations. We also believe that the Appeals Board's decision to grant administrative leave to those employees who it already compensated for overtime is wasteful and duplicative.

Notwithstanding, the agency said that it has asked Personnel Administration to review and provide written clarification on the matter and that it would instruct the Appeals Board to abide by any instructions Personnel Administration provides. With regard to our conclusion that the Appeals Board failed to track its employees' use of the administrative leave, the agency reported that it believed there was an internal misunderstanding surrounding the recording of administrative leave granted because the Appeals Board did not provide its employees with clear directions on how to record such leave. As a result, the agency directed the Appeals Board to develop a formal policy for the reporting of such absences.

CALIFORNIA VETERANS BOARD

Without a Clear Understanding of the Extent of Its Authority, the Board Has Not Created Sufficient Policies Nor Provided Effective Oversight to the Department of Veterans Affairs

Audit Highlights . . .

Our review of the California Veterans Board (board) revealed that:

- ☑ *The board has not established itself as an effective policy-maker for the Department of Veterans Affairs (department).*
- ☑ *The board lacks the independent counsel to minimize the legal risks of its policy-making and appeals actions.*
- ☑ *The board's appeal process needs to ensure that veterans' appeals are handled consistently and appropriately.*
- ☑ *The board's effectiveness is hindered by its reduced membership and lack of training on its responsibilities.*

Although the department has implemented eight of the 14 recommendations that were reviewed from our previous audits, it has not given sufficient attention to a key recommendation regarding the long-term viability of the Cal-Vet program.

REPORT NUMBER 2002-120, JUNE 2003

California Veterans Board's response as of January 2004 and the Department of Veterans Affairs' response as of February 2004

The Joint Legislative Audit Committee (audit committee) requested that we review the California Veterans Board's (board) oversight of the Department of Veterans Affairs (department). Specifically, the audit committee was concerned that the board may not always exercise independent oversight and guidance of the department in a manner that would further the department's mission and goals. Additionally, the audit committee wanted to know the effectiveness of corrective actions the department has taken on our recommendations from previous audits.

Finding #1: The board is not an effective policy-maker for the department.

Although state law gives the board considerable policy-making authority over the department, the board of seven volunteers has established itself as an ineffective policy-maker, unable to strengthen weaknesses in the department's administration of veterans' programs that the Bureau of State Audits (bureau) has reported over the past three years. As an example of the board's inability to effect strong policy, only half of its 32 policies provide direction for departmental operations. Further, although the bureau and other oversight agencies have identified a number of problems within the department, the board has no clearly defined policies to guide and monitor the department's corrective actions. The board has also not used the services of the inspector general for veterans affairs (inspector general) to review the department's operations in areas where board policy could improve the department's delivery of services to veterans.

We recommended that the board assert its policy-making authority by actively identifying areas of the department's operations that it feels need guidance or direction and developing meaningful policies that provide the department with the guiding principles necessary to complete its mission. Using the issues raised in our previous audits and by the inspector general would be a good start for the development of specific policies.

We also recommended that the board monitor the department's corrective actions on external audits by establishing a policy requiring the department to regularly report its progress in implementing corrective actions and when needed, create policies to guide the department's corrective actions.

Board Action: Partial corrective action taken.

The board states that it is currently developing a board training manual and researching training programs that will encompass policy-making guidelines. The board believes that these training efforts, along with the assistance of independent counsel, will allow it to develop meaningful policies to provide the department with guiding principles. In addition, the board realizes that the corrective actions from external audits will provide direction for the department's goals and objectives. The board has been working with the department to obtain funding for independent counsel. However, on February 2, 2004, the interim secretary for veterans' affairs declined the board's request for independent counsel, indicating to the board that balanced against the difficult fiscal challenges that all Californians now face, it is his position that the department's attorneys are providing legal advice, counsel on appeals, and aid to the board in a legally acceptable manner consistent with the law and free of conflicts.

➲

Finding #2: The board has no independent counsel to provide legal advice on its responsibilities.

Despite the board's important responsibilities for making policy and ruling on veterans' appeals of services that the department has denied, the board does not have an independent counsel it requires to minimize the legal risks of its actions. Instead, the board relies on the department's legal staff for advice. Although they are probably knowledgeable on these laws, the department's legal staff are not the appropriate advisors for the board on policies

under consideration because the board's policies govern the department. Further, the board's rulings on veterans' appeals should have an independent and fair consideration of the department's actions and the veterans' rights to services. Currently, the board must rely on the department's legal staff for advice on appeals, a practice that introduces questions of fairness and impartiality on appeal decisions.

We recommended that to improve the board's ability to independently make decisions on policies and appeals, and to reduce the legal risk created by its present practices, the board should establish a policy to obtain the services of an independent counsel to assist with its policy-making and appeal responsibilities.

Board Action: Partial corrective action taken.

The board indicates that it passed a policy citing the need for independent counsel on July 18, 2003, and that as of January 2004 a retired attorney sits on its select committee on policies and procedures. However, as noted previously, on February 2, 2004, the interim secretary for veterans' affairs declined the board's request for independent counsel.

Finding #3: The board lacks formal written procedures for conducting appeals in a fair and consistent manner.

Despite the board's existence since 1946, it has no formal written procedures outlining or detailing instructions for processing appeals at an operational level. Further, the board does not have a clear understanding of the type of appeal procedures it should follow, which could result in the board conducting a more formal hearing on an appeal than is warranted or not giving veterans an adequate degree of protection. Without a set of formalized procedures, the board cannot ensure that its members have the same understanding of how to conduct appeals, nor can it be certain that members' actions are consistent. However, to give veterans the fair treatment they deserve and expect, and to avoid legal risks, the board must be able to process all veterans' appeals consistently and professionally. In addition, the board relies upon the department's chief counsel to preside over formal hearings on appeals. However, as a member of the department's management team and potentially a participant in the decisions to deny services, the chief counsel is not in a position to act in an unbiased manner.

To ensure that the board consistently and fairly reviews veterans' appeals of services that the department has denied, we recommended that the board should create a policy establishing formal written procedures for conducting appeals. In addition, to ensure that every veteran's appeal is heard in the proper forum, the board should acquire the expertise to determine the appropriate type of hearing for each appeal. In addition, to avoid the appearance of bias in its appeal decisions, the board should discontinue having the department's chief counsel preside over formal hearings.

Board Action: Partial corrective action taken.

The board states that it is currently developing a training manual that will include specific steps for reviewing and conducting appeals. Further, to avoid the appearance of partiality in the appeal process, the board was working with the department to obtain the services of independent counsel. However, as noted previously, on February 2, 2004, the interim secretary for veterans' affairs declined the board's request for independent counsel.

➲

Finding #4: With a reduced membership, the board may lack the expertise the Legislature intended and may be unable to hold meetings.

The board's effectiveness has been hindered over the past few years because is has rarely comprised the seven members authorized by the Military and Veterans Code. The governor appoints board members and five board members must have expertise in a particular area required by law. Without these expert members, the board might be limited in its understanding of departmental issues and veterans' appeals. Additionally, its reduced membership could prevent it from meeting the quorum of four required by board policy to conduct business.

To assist the governor in promptly appointing members to fill both the current and future vacancies, we recommended that the board proactively identify possible board members when vacancies occur.

Board Action: Pending.

The board states that there are three vacancies on the board as of January 15, 2004 and it is waiting for the Governor to appoint new members. It currently receives calls from veterans interested in joining the board, and redirects those veterans to the Governor's appointment office.

Finding #5: To be an effective oversight and policy-making body, the board needs to adequately train its members.

Contributing to the board's deficiencies as a policy-making and oversight body is the fact that members receive no formal training regarding the laws and regulations controlling veterans' affairs; board policies, duties, and authority, including how to conduct appeals; departmental operations; state laws regarding open meetings; and state laws regarding the privacy of medical information. Insufficient training may have caused the board to violate state open-meeting laws and possibly resulted in two instances of the board discussing veterans' confidential medical records in public board sessions.

To enable board members to perform their oversight functions effectively, we recommended that the board provide ongoing training to its members in topics related to their responsibilities.

Board Action: Partial corrective action taken.

The board states that it is currently developing a training manual that will include areas on policy making, duties and authority, the appeal process, department operations, state laws regarding open meetings, and state laws regarding the privacy of medical information. However, at this time the board can only send board members to ethics training due to budget constraints.

Finding #6: Despite implementing many recommendations we made in previous audits, the department has not sufficiently addressed an important issue for the Cal-Vet program.

The board's weak policy-making deprives a problem-prone department of needed assistance in improving on weaknesses documented in reviews by the bureau and other oversight agencies.

Our follow-up on recommendations we made to the department in two previous audits revealed that the department has implemented eight of the 14 recommendations we could reasonably expect the board to address. However, the department has not given sufficient attention to a key recommendation regarding the long-term viability of the Cal-Vet program, the department's loan program that helps veterans purchase farms or homes. As mentioned in our previous audits, unless there is a change in federal tax laws, fewer and fewer veterans will benefit from the Cal-Vet program because federal tax restrictions have limited eligibility for loans backed by the bonds that supply the majority of the program's funding. Despite two previous unsuccessful efforts, the department is attempting to change federal tax laws to make more veterans eligible for the Cal-Vet program. However, the department has not performed sufficient contingency planning for the potential reduction in the Cal-Vet program's funding should its efforts fail again.

To ensure effective and efficient operations, the department should continue to address the recommendation of our prior audits, especially the recommendations regarding the long-term viability of the Cal-Vet program.

Department Action: Pending.

Although we anticipated that the department would respond to this finding, the board submitted a response to us. The board indicates that it will continue to address the bureau's concerns regarding the Cal-Vet program once it obtains independent counsel.

VETERANS HOME OF CALIFORNIA, YOUNTVILLE

Investigations of Improper Activities by State Employees, March 2002 Through July 2002

ALLEGATION I2000-876 (REPORT I2002-2), NOVEMBER 2002

Department of Veterans Affairs' response as of August 2002[1]

Investigative Highlight . . .

The Veterans Home of California, Yountville, improperly billed Medicare $55,000 for visits that the staff physician did not make.

We investigated and substantiated that the information system used by the hospital at the Veterans Home of California, Yountville (home), for processing charges for services provided to the home's residents contains charges attributed to one doctor for services that the doctor could not have provided.

Finding: The home processed charges for services the doctor could not have provided.

The information system the home uses to bill Medicare, Medi-Cal, and other insurers showed that one doctor saw patients 2,614 times from July 1, 1999, through July 17, 2001, but we concluded that the doctor did not see a patient in 1,792 (69 percent) of those visits. Some of these excess visits in the system were for patients who were not on the doctor's clinic schedule for that day. In 400 other cases, the doctor was not working on the day in question, including weekends, holidays, and days that she was on vacation or sick leave. Furthermore, 148 incorrectly recorded visits were on 50 days on which the doctor worked from home. As further evidence of the information system's lack of credibility, it indicated that the doctor saw patients on every day of 35 consecutive days spanning August and September 1999, 34 consecutive days spanning June and July 2000, and 26 consecutive days spanning May and June 2001. In fact, the billing system indicated that the doctor saw patients on all but three of the 70 days from July 15

[1] Since we report the results of our investigative audits only twice a year, we may receive the status of an auditee's corrective action prior to a report being issued. However, the auditee should report to us monthly until its corrective action has been implemented. As of January 2003, this is the date of the auditee's latest response.

through September 22, 1999. As of January 22, 2002, the home had billed Medicare $131,000 for 1,488 of these 2,614 patient visits. However, $55,000 was for 887 visits that we concluded the doctor did not make.

Department Action: Pending.

The Department of Veterans Affairs (department) reports that it is actively working to upgrade its billing system and is working with its billing agent to resolve any charges billed and reimbursed incorrectly. Further, the department states that it will ensure that it obtains the signature of the attending physician/technician to maintain proper practices and Medicare compliance.