Implementation of State Auditor's Recommendations

Audits Released in January 2003 Through December 2004

Special Report to

Assembly Budget Subcommittee #4—State Administration

February 2005
Report No. 2005-406 A4

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CALIFORNIA STATE AUDITOR

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February 23, 2005 2005-406 A4

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 Assembly Budget Subcommittee No. 4—State Administration. 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/subcom2005-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 2003 through December 2004, that relate to agencies and departments under the purview of the Assembly Budget Subcommittee No. 4—State Administration. 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 7, 2005.

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STATE MANDATES

The High Level of Questionable Costs Claimed Highlights the Need for Structural Reforms of the Process

Audit Highlights . . .

Our review of the Peace Officers Procedural Bill of Rights (peace officer rights) and the animal adoption mandates found that:

- ☑ *The costs for both mandates are significantly higher than what the Legislature expected.*
- ☑ *The local entities we reviewed claimed costs under the peace officer rights mandate for activities that far exceed the Commission on State Mandates' (Commission) intent.*
- ☑ *The local entities we reviewed lacked adequate supporting documentation for most of the costs claimed under the peace officer rights mandate and some of the costs claimed under the animal adoption mandate.*
- ☑ *Structural reforms are needed to afford the State Controller's Office an opportunity to perform a field review of initial claims for new mandates early enough to identify potential problems.*
- ☑ *Commission staff have indicated that the Commission will not be able to meet the statutory deadlines related to the mandate process for the foreseeable future due to an increase in caseload and a decrease in staffing.*

REPORT NUMBER 2003-106, OCTOBER 2003

Commission on State Mandates' and State Controller's Office's responses as of October 2004[1]

The Joint Legislative Audit Committee asked the Bureau of State Audits to review California's state mandate process and local entity claims submitted under the Peace Officers Procedural Bill of Rights (peace officer rights) and animal adoption mandates. Our review found that the costs for both mandates are significantly higher than what the Legislature initially expected. In addition, we found that the local entities we reviewed claimed costs under the peace officer rights mandate for activities that far exceeded the Commission on State Mandates' (Commission) intent. Further, claimants under both mandates lacked adequate supporting documentation and made errors in calculating costs claimed.

The problems we identified highlight the need for some structural reforms of the mandate process. Specifically, the mandate process does not afford the State Controller's Office (Controller) the opportunity to perform a field review of the first set of claims for new mandates early enough to identify potential claiming problems. In addition, the Commission could improve its reporting of statewide cost estimates to the Legislature by disclosing limitations and assumptions related to the claims data it uses to develop the estimates. Finally, Commission staff have indicated that the Commission will not be able to meet the statutory deadlines related to the mandate process for the foreseeable future due to an increase in caseload and cutbacks in staffing. Specifically, we found:

Finding #1: Local entities claimed reimbursement for questionable activities under the peace officer rights mandate.

We question a large portion of the costs claimed by four local entities that received $31 million of the $50 million paid under the peace officer rights mandate, and we are concerned that

[1] San Jose and San Diego County responses as of January 2004; city of Los Angeles, San Francisco, Stockton, and Los Angeles County responses as of October 2004.

the State already may have paid more than some local entities are entitled to receive. In particular, we question $16.2 million of the $19.1 million in direct costs that four local entities claimed under the peace officer rights mandate for fiscal year 2001–02 because they included activities that far exceed the Commission's intent. Although we noted limited circumstances in which the Commission's guidance could have been enhanced, the primary factor contributing to this condition was that local entities and their consultants broadly interpreted the Commission's guidance to claim reimbursement for large portions of their disciplinary processes, which the Commission clearly did not intend. We also noted that the local entities we reviewed did not appear to look at the statement of decision or the formal administrative record surrounding the adoption of the statement of decision for guidance when they developed their claims.

We recommended that, to ensure local entities have prepared reimbursement claims for the peace officer rights mandate that are consistent with the Commission's intent, the Controller audit the claims already paid, paying particular attention to the types of problems described in our report. If deemed appropriate based on the results of its audit, the Controller should request that the Commission amend the parameters and guidelines to address any concerns identified, amend its claiming instructions, and require local entities to adjust claims already filed. The Controller should seek any statutory changes needed to accomplish the identified amendments and to ensure that such amendments can be applied retroactively.

We also recommended that, to assist local entities in preparing mandate reimbursement claims, the Commission include language in its parameters and guidelines to notify claimants and the relevant state entities that the statement of decision is legally binding on all parties and provides the legal and factual basis for the parameters and guidelines; it also should point out that the support for such legal and factual findings is found in the administrative record of the test claim.

Further, we recommended that all local entities that have filed, or plan to file, claims for reimbursement under the peace officer rights mandate consider carefully the issues raised in our report to ensure that they submit claims that are for reimbursable activities. Additionally, they should refile claims when appropriate. Finally, if local entities identify activities

they believe are reimbursable but are not in the parameters and guidelines, they should request that the Commission consider amending the parameters and guidelines to include them.

Controller Action: Partial corrective action taken.

The Controller reports that it has developed an audit program and initiated audits of the peace officer rights claims. As of its October 2004 response, the Controller planned to complete the audits by December 2004. In addition, it expected to submit to the Commission suggested amendments to the parameters and guidelines by November 2004 to clarify that costs for activities guaranteed by the due process clauses of the U.S. and California Constitutions are not reimbursable.

Commission Action: Corrective action taken.

Commission staff report that they have developed language to implement our recommendation for inclusion in all new parameters and guidelines adopted after early December 2003.

Local Entities Action: Partial corrective action taken.

The city of Los Angeles reports that, subsequent to our audit, the Controller audited its fiscal year 2001–02 peace officer rights claim and disallowed the entire claim because the city did not substantiate the time study data that was the basis for the claim. To address the Controller's concern, the city of Los Angeles reports that it performed a comprehensive time study and provided all of the data to the Controller in September 2004. However, as of October 2004, it had not submitted any revised peace officer rights claims. Los Angeles County reports that it conducted a time study of its peace officer rights activities from May to October 2004 and asserts that the Controller indicated this data can be used to support its claims related to fiscal years 2001–02 through 2004–05. However, its one-year response did not indicate whether the county had submitted any revised claims and suggested that more clarification regarding the scope of reimbursable services is needed. In addition, Los Angeles County continues to believe that a broad scope of its investigation activities are reimbursable and asserts that the parameters and guidelines provide no limitation on claimants' costs in conducting prompt, thorough, and fair investigations. The city and County of San Francisco (San Francisco) reports that it has examined its peace officer rights process carefully as a result of our audit and a subsequent Controller field audit. As part of this process, San Francisco indicated that it conducted a time study in May 2004 and submitted the results to the

Controller in June 2004. Further, San Francisco believes that its time study substantially supports the costs it initially claimed and, as of October 2004, gave no indication that it intended to revise its previously submitted claims. The city of Stockton (Stockton) indicated that, in January 2004, it filed an amended peace officer rights claim for fiscal year 2001–02 that was approximately $522,000 less than its original claim. In addition, Stockton reported that the Controller was in the process of auditing all of its claims back to fiscal year 1994–95, but had not issued a report as of Stockton's October 2004 response.

Finding #2: In varying degrees, claimants under the peace officer rights and animal adoption mandates lacked adequate support for their costs and inaccurately calculated claimed costs.

We question $18.5 million of the $19.1 million in direct costs that four local entities claimed under the peace officer rights mandate because of inadequate supporting documentation. The local entities based the amount of time they claimed on interviews and informal estimates developed after the related activities were performed instead of recording the actual staff time spent on reimbursable activities or developing an estimate based on an acceptable time study.

Additionally, we noted several errors in calculations of costs claimed under the peace officer rights mandate. Although we generally focused on fiscal year 2001–02 claims, the largest error we noted was in the fiscal year 2000–01 claim of one local entity. It overstated indirect costs by about $3.7 million because it used an inflated rate and applied the rate to the wrong set of costs in determining the amount it claimed. We noted two other errors related to fiscal year 2001–02 claims involving employee salary calculations and claiming costs for processing cases that included those of civilian employees, resulting in a total overstatement of $377,000.

We also found problems with the animal adoption claims. The four local entities we reviewed could not adequately support $979,000 of the $5.4 million they claimed for fiscal year 2001–02. In some instances, this lack of support related to the amount of staff time spent on activities. In another instance, a local entity could not adequately separate the reimbursable and nonreimbursable costs it incurred under a contract with a nonprofit organization that provided shelter and medical services for the city's animals.

In addition, we noted numerous errors in calculations the four local entities performed to determine the costs they claimed under the animal adoption mandate for fiscal year 2001–02. Although these errors caused both understatements and overstatements, the four claims were overstated by a net total of about $675,000. Several errors resulted from using the wrong numbers in various calculations involving animal census data.

We recommended that the Controller issue guidance on what constitutes an acceptable time study for estimating the amount of time employees spend on reimbursable activities and under what circumstances local entities can use time studies.

We also recommended that all local entities that have filed, or plan to file, claims for reimbursement under the peace officer rights or animal adoption mandate consider carefully the issues raised in our report to ensure that they submit claims that are supported properly. Additionally, they should refile claims when appropriate.

Controller Action: Partial corrective action taken.

The Controller indicates that it developed draft time study guidelines in consultation with representatives of local governments and their consultants and provided them to interested state agencies for comment in March 2004. As of October 2004, the Controller expected to make final guidelines available to claimants in January 2005.

Local Entities Action: Partial corrective action taken.

All six local entities we reviewed provided us responses generally indicating that they had taken some action to correct errors and develop better documentation to support their claims. In particular, the cities of Los Angeles, San Jose, and Stockton and San Diego County indicated that they have submitted revised animal adoption claims for fiscal year 2001–02. In addition, Stockton reports that it filed an amended peace officer rights claim for fiscal year 2001–02 that was approximately $522,000 less than its original claim. Finally, although the city of Los Angeles, Los Angeles County, and San Francisco report that they have conducted time studies and have been working with the Controller to resolve issues related to their peace officer rights claims, their one-year responses to our audit did not indicate that any of them have submitted revised claims.

Finding #3: The Commission's animal adoption guidance does not adequately require claimants to isolate reimbursable costs for acquiring space and its definition of average daily census could be clearer.

Although the guidance related to the animal adoption mandate generally is adequate, the Commission's formula for determining the reimbursable amount of the costs of new facilities does not isolate how much of a claimant's construction costs relate to holding animals for a longer period of time. The two local entities we audited that claimed costs for acquiring space in fiscal year 2001–02 used the current formula appropriately to prorate their construction costs. However, one of them needed space beyond that created by the mandate; as a result, the costs it claimed probably are higher than needed to comply with the mandate.

In addition, we found that one local entity understated its annual census of dogs and cats by including only strays in the figure, instead of including *all* dogs and cats. The entity made this mistake because it used a definition from an earlier section of the parameters and guidelines that limited the census number to strays. Although the parameters and guidelines could have been clearer by including a separate definition in the care of dogs and cats section of the guidance, we believe the context makes it clear that the total costs for *all* dogs and cats must be divided by a census figure including *all* dogs and cats to compute an accurate daily cost per dog or cat.

We recommended that the Legislature direct the Commission to amend the parameters and guidelines of the animal adoption mandate to correct the formula for determining the reimbursable portion of acquiring additional shelter space. If the Commission amends these parameters and guidelines, the Controller should amend its claiming instructions accordingly and require local entities to amend claims already filed.

In addition, we recommended that the Controller amend the claiming instructions or seek an amendment to the parameters and guidelines to emphasize that average daily census must be based on all animals housed to calculate reimbursable costs properly under the care and maintenance section of the parameters and guidelines.

Legislative Action: Legislation passed.

Chapter 313, Statutes of 2004, added Section 17572 to the Government Code to require the Commission to amend the parameters and guidelines for the animal adoption mandate. In particular, the legislation requires the Commission to amend the formula for determining the reimbursable portion of acquiring or building additional shelter space that is larger than needed to comply with the increased holding period to specify that costs incurred to address preexisting shelter overcrowding or animal population growth are not reimbursable. In addition, the legislation requires the Commission to clarify how the costs for care and maintenance shall be calculated. As of October 2004, Commission staff indicated that this matter is tentatively set for a March 2005 hearing.

Controller Action: Corrective action taken.

The Controller reports that it submitted to the Commission suggested parameters and guidelines amendments to clarify calculation of the average daily census and the documentation requirements for new animal shelters.

Finding #4: Structural reforms are needed to identify mandate costs more accurately and to ensure that claims reimbursement guidance is consistent with legislative and commission intent.

The problems we identified related to claims filed under the peace officer rights and animal adoption mandates highlight the need for some structural reforms of the mandate process. For example, it is difficult to gauge the clarity of the Commission's guidance and the accuracy of costs claimed for new mandates until claims are subjected to some level of field review. However, the mandate process does not afford the Controller an opportunity to perform a field review of the claims for new mandates early enough to identify potential claiming problems.

Also, inherent limitations in the process the Commission uses to develop statewide cost estimates for new mandates result in underestimates of mandate costs. Even though Commission staff base statewide cost estimates for mandates on the initial claims local entities submit to the Controller, these entities are allowed to submit late or amended claims long after the Commission adopts its estimate. The Commission could disclose this limitation in the statewide cost estimates it reports to the Legislature by stating what assumptions were made regarding

the claims data. In addition, Commission staff did not adjust for some anomalies in the claims data they used to develop the cost estimate for the animal adoption mandate that resulted in an even lower estimate.

We recommended that the Controller perform a field review of initial reimbursement claims for selected new mandates to identify potential claiming errors and to ensure that costs claimed are consistent with legislative and Commission intent. In addition, the Commission should work with the Controller, other affected state agencies, and interested parties to implement appropriate changes to the regulations governing the mandate process, allowing the Controller sufficient time to perform these field reviews and identify any inappropriate claiming as well as to suggest any needed changes to the parameters and guidelines before the development of the statewide cost estimate and the payment of claims. If the Commission and the Controller find they cannot accomplish these changes through the regulatory process, they should seek appropriate statutory changes.

We also recommended that Commission staff analyze more carefully the completeness of the initial claims data used to develop statewide cost estimates and adjust the estimates accordingly. Additionally, the Commission should disclose the incomplete nature of the initial claims data when reporting to the Legislature.

Controller Action: Corrective action taken.

The Controller reports that it, along with representatives from the Department of Finance, the Legislative Analyst's Office, the Commission, and local governments testified on mandate reform issues before the Assembly Special Committee on State Mandates. This committee subsequently authored Chapter 890, Statutes of 2004, that implemented certain reforms to the mandate process. In particular, the Controller indicates that the legislation requires the Commission, when adopting parameters and guidelines, to adopt a reasonable reimbursement methodology that balances accuracy and simplicity; specifies the content of a test claim filing with the Commission to include a statewide cost estimate; and codifies the period of reimbursement and procedures for amendment. As indicated in the following paragraph regarding Commission action, we note that the legislation also provides the Controller with an opportunity to review mandate claims and suggest any needed changes to the related parameters and guidelines before claims are paid.

Commission Action: Corrective action taken.

Commission staff indicate that the Commission and the Controller sponsored legislation clarifying that, after an audit is conducted, the parameters and guidelines for a mandated program could be amended so that claiming errors can be corrected prior to adoption of the statewide cost estimate and payment of claims. Further, Commission staff indicate that they have developed additional assumptions and revised the method for projecting future-year costs and for reporting statewide cost estimates to the Legislature.

Finding #5: Commission staff assert that lack of staffing will continue to affect the Commission's ability to meet statutory deadlines related to the mandate process.

Commission staff indicated that the Commission has developed a significant caseload and has experienced cutbacks in staffing because of the State's fiscal problems. As a result, staff state that the Commission will not be able to meet the statutory deadlines related to the mandate process for the foreseeable future. This will cause further delays in the mandate process in general, including determination of the potential cost of new mandates.

We recommended that the Commission continue to assess its caseload and work with the Department of Finance and the Legislature to obtain sufficient staffing to ensure that it is able to meet its statutory deadlines in the future.

Commission Action: Corrective action taken.

Commission staff report that, on an ongoing basis, they will submit budget change proposals to the Department of Finance for additional resources that support the Commission's caseload. In addition, staff will report caseload status to the Commission at each hearing and will continue to update relevant legislative committees on caseload issues. Finally, staff will continue to report pending statewide cost estimates to the Legislature to notify it of potential future costs to the state budget.

CALIFORNIA DEPARTMENT OF CORRECTIONS

Although Addressing Deficiencies in Its Employee Disciplinary Practices, the Department Can Improve Its Efforts

REPORT NUMBER 2004-105, OCTOBER 2004

California Department of Corrections' response as of December 2004

Audit Highlights . . .

Our review of the California Department of Corrections' (department) process of handling employee disciplinary matters revealed that the department:

- ☑ *Spends an average of 285 days to serve an adverse action or close a case.*
- ☑ *Can improve its disciplinary process by simplifying its investigative process for straightforward, uncontested cases, by eliminating the headquarters review of most adverse actions, and by taking steps to bring more standardization of penalties. Further, many disciplinary case files were disorganized and had key pieces of information missing.*
- ☑ *Has disciplinary policies and procedures that are incomplete, out of date, and in need of revision.*
- ☑ *Uses several redundant databases to track disciplinary matters and each system is incomplete and inaccurate.*

continued on next page . . .

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the California Department of Corrections' (department) process of handling employee disciplinary matters. Specifically, the audit committee requested that we determine the extent to which the department has established uniform policies and procedures for the use of legal services in employment matters and whether the institutions are following those policies and procedures.

Finding #1: The department averages 285 days to deliver an adverse action or close a case.

On average, the department takes 285 days to deliver a notice of adverse action against an employee or to close a case, and the process occasionally surpasses the one-year deadline for taking action against peace officers—leaving the department unable to correct or punish the employee. We found that the department often does not meet the guidelines from its operations manual and a procedural bulletin for completing the various steps involved in the disciplinary process. To assist in meeting the overall deadlines, the department should include similar steps in its new procedures and then monitor the procedures to ensure that staff are following them. Unnecessarily lengthy time frames between the date an offense is alleged and the date action is taken can undermine the process—potentially lessening the effectiveness of any corrective action taken.

We recommended that the department identify, benchmark, and monitor for improvement the adverse action timelines for each step in the process.

- ☑ *Recently began requiring job-specific training for a key position involved in its disciplinary process; however, it can do more to require training for other key positions.*
- ☑ *Has yet to implement several audit recommendations related to disciplinary matters from audits conducted in 2000 and 2001.*

Department Action: Partial corrective action taken.

The department stated that it is in the process of designing and implementing database systems in which it will identify and benchmark adverse action timelines for each step in the process. The department estimates that the databases will be operational by March 1, 2005. Until that time, the department is tracking each type of case using its existing databases. The department also reported that the office of civil rights is now closing investigations in an average of 147 days—an improvement since our audit—but still above its goal of 90 days.

Finding #2: The department lacks a formal streamlined process for straightforward cases and wastes time on unneeded information requests.

The department can reduce the time it spends on certain disciplinary matters by simplifying its investigations of uncontested, straightforward cases and eliminating unnecessary requests for information, and the transcriptions of interviews. Additionally, when it implements the disciplinary matrix, which will prescribe standard penalties within a range for specific employee offenses, we believe that the need for a review by headquarters will be limited to those cases that do not fit within the disciplinary matrix parameters. More efficient use of their time allows staff involved in the disciplinary process to focus their efforts on necessary work.

We recommended that the department implement procedures to allow for expedited investigations and actions for uncontested, straightforward cases such as driving under the influence; eliminate headquarters and regional reviews before serving disciplinary actions that meet the parameters of the disciplinary matrix; and discontinue the practice of transcribing all interviews and transcribe only those that are necessary.

Department Action: Partial corrective action taken.

The department reported that its office of civil rights implemented policy and procedures allowing for expedited investigations and that it expects to update its operations manual with the procedures by July 1, 2005. For other cases, the department is considering a centralized intake process and other procedural changes, which will facilitate implementation of our recommendation to expedite straightforward cases. The department expects to incorporate the new procedures by

August 16, 2005. Moreover, the department reported that it will implement the disciplinary matrix by March 1, 2005, and it plans to eliminate most, if not all, headquarters and regional office reviews at that time. Finally, the department stated that its office of civil rights determined that staff were transcribing fewer interviews related to its cases in response to its policy requiring staff to only transcribe those interviews that are necessary. For all other cases, an attorney will determine the necessity for transcription of interviews once the department implements its vertical advocacy model.

Finding #3: The State Personnel Board often modifies or revokes the department's adverse actions.

Annually, the State Personnel Board (board), which reviews roughly 14 percent of the department's adverse actions, revokes or modifies approximately 62 percent of those it reviews. Currently, the department does not analyze its individual and overall performance statistics concerning cases that go before the board, nor has it established any benchmarks. We believe it would be useful to the department to continually monitor these statistics to measure any improvements and to assist in identifying training needs. Improving this performance is important to ensure employee confidence in the process and in management.

We recommended that the department benchmark its individual program and overall performance statistics for cases that go before the board and continually monitor these statistics.

Department Action: Pending.

The department reported that it will benchmark and monitor cases going before the State Personnel Board once it implements its two new database systems. The department plans to include the status and timing of these efforts in its six-month response to our audit.

Finding #4: The process for handling employee misconduct allegations and discipline are not significantly different, but consistency can be improved.

Although we did not find significant issues with regard to varying processes used by institutions and regions, the department could improve its disciplinary process by eliminating some of the minor differences in its disciplinary practices and by standardizing

penalties at various institutions. For example, each institution we tested uses a combination of full-time investigators and other employees at the rank of sergeant or above who do not work solely for the Investigative Services Unit (investigative services). These "field investigators" have other duties and are called upon to handle investigations as needed. The department may want to consider conducting a workload study to determine the number of full-time investigators each institution may need and whether existing resources can be allocated for this purpose.

We also found instances in which the institutions took different adverse actions for similar offenses. However, the occurrence of assessing inconsistent penalties may be decreased when the department implements its discipline matrix, which is designed to ensure a consistent foundation and common approach regarding whether and what type of penalty to impose. However, for the matrix to be fully effective, the department will need to ensure the wardens are held accountable for their penalty decisions by requiring them to document their reasons for any deviations from the prescribed penalty range.

Moreover, although the department's operations manual requires that the regional Office of Investigative Services (OIS) track and audit certain of its cases, we found no evidence that the auditing or review of the investigation authorization forms or completed investigative reports occurs at one OIS regional office. Finally, we found that many disciplinary case files were disorganized and had key pieces of information missing.

To ensure it completes investigations in a timely manner, the department should consider conducting a workload study to determine the number of full-time investigators each institution may need and whether existing resources can be allocated for this purpose.

We also recommended that the department should:

- Standardize, as much as possible, adverse-action and investigative processes, forms, reports, and file checklists for all types of cases.

- Continue its efforts to implement a disciplinary matrix and ensure the wardens are held accountable for their penalty decisions by requiring them to document their reasons for any deviations from the prescribed penalty range.

To allow it to provide feedback and training to investigative services, the department should ensure that it monitors and enforces its requirement for its OIS to audit certain investigations.

Department Action: Partial corrective action taken.

The department stated that a team is reviewing the workload of certain investigations to determine the number of full-time investigators each institution may need and whether it can allocate existing resources for that purpose. The team will develop recommendations by January 2005 and implement them by July 2005—contingent on funding. Additionally, the department indicated that in November 2004, its office of investigative services issued the first of a series of revised manuals to standardize forms, reports, and file checklists for investigative staff. The department plans to issue additional manuals by the end of 2004 and to revise and standardize its reporting format by March 2005. The office of civil rights is also taking actions to standardize its forms and case file maintenance and expects to begin implementation in January 2005. Moreover, the department reported that it plans to implement its statewide disciplinary matrix in March 2005 and to develop management and oversight reports, by November 2005, to monitor the use of the disciplinary matrix. Finally, the department stated that its office of investigative services is developing a plan to review certain investigations.

Finding #5: Investigative and other department offices that handle employee misconduct allegations and discipline can improve their coordination and communication.

The department has had difficulty coordinating efforts and fostering effective communication among its various offices and institutions involved in employee misconduct allegations and discipline. The overall lack of interaction among the major investigative bodies is unfortunate: if communication and coordination improved, the three could coordinate policy development, learning opportunities, and related investigative work.

For example, the Office of Civil Rights has not always communicated or reported to the affected institutions when it discovers departmental policy violations or supervisory issues during its investigations. As a result, the department may have missed opportunities to take corrective or punitive action against the guilty employee.

To ensure supervisory issues or policy violations contained in reports on civil rights investigations are not missed, we recommended that the Office of Civil Rights consider sending all unsustained cases to the warden for review.

Department Action: Corrective action taken.

The department reports that its office of civil rights is currently providing written summaries of all investigations to the hiring authorities and it plans to continue to assess this process for adequacy.

Finding #6: The department is implementing a process requiring its attorneys to become more involved in employee misconduct allegations.

The department is moving forward with a plan to improve communication between legal affairs and the institutions to have its attorneys more involved with employee misconduct allegations. It will implement a "vertical advocacy" model, which it believes will ensure competent legal representation during the employee disciplinary process. Currently, legal affairs' communication with the institutions seems to be limited. The vertical advocacy model will involve an attorney early in the investigative process and should provide additional legal guidance to the employee relations officers (EROs), as well as improve the integrity, quality, and timeliness of investigations.

We recommended that the department continue its efforts to implement a department-wide vertical advocacy model to allow for greater attorney involvement in adverse action cases, including equal employment opportunity cases.

Department Action: Pending.

The department stated that it plans to hire staff, train them, and implement its vertical advocacy model by March 1, 2005. Once implemented, the department also plans to conduct a time study to determine the appropriate staffing levels.

Finding #7: The department needs to update and follow its policies on employee misconduct allegations and discipline and consolidate its policy and process development for all types of investigations.

The department's policies and procedures for employment-related matters are outdated and in need of revision and may contribute to inconsistencies because they do not require common practices or forms. The operations manual gives no clear guidance on how any of the processes should work.

Furthermore, to better standardize institutional and regional investigation procedures, the department should centralize the oversight of its various investigatory bodies. Currently, the three investigative units of the department—the investigative services, the OIS, and the Office of Civil Rights—rarely work together and all have different processes. Centralizing policy and process development for the three types of investigations would allow the department to create and introduce more standardization into the processes, the investigative report formats, and the case files and would foster communication and coordination among investigators.

We recommended that the department consolidate policy and procedure development and monitoring for all types of adverse action investigations under one branch and continue its efforts to update its employment-related policies and procedures.

Department Action: Pending.

The department reported that its final action related to this recommendation is dependent upon a proposed reorganization. The department will share the reorganization plan once it is approved by the governor. Moreover, as previously discussed in finding numbers 2 and 4, the department is in the process of developing new employment-related policies and procedures.

Finding #8: The department can do more to resolve employee problems short of litigation and adverse actions.

The department can improve its efforts to resolve employment related disputes without litigation. For example, better communication regarding the availability and use of a mediation program could help to resolve disputes before they escalate into litigation or adverse actions that are heard by the board. These steps should help the department avoid potentially time-consuming and costly litigation.

We recommended that the department implement its own or use an outside mediation program such as the one offered by board, and make the program known and available to all programs and institutions.

Department Action: Pending.

The department told us that it has initiated contact with the board to discuss the board's mediation program and that it will be making that program known and available to all programs and institutions. Further, the department also indicated that its office of civil rights is currently developing a mediation process to assist with early resolution of complaints. The department plans to provide us a summary of its progress with its six-month response to our audit.

Finding #9: The lack of documentation and monitoring prevent the department from ensuring appropriate adverse action settlements.

An administrative bulletin discussing department policies for settling appealed adverse actions exists, and the department recently implemented training on factors to consider during settlement negotiations. Unfortunately, the policies are not completely followed, and the department does not monitor settlements. As a result, the department cannot ensure it is settling as effectively or as often as it could.

The department should follow its existing policy or design and implement a comprehensive new settlement policy, ensure all pertinent employees are aware of the policy, and monitor compliance at the headquarters level.

Department Action: Pending.

The department reported that it will include its settlement policy in the employee relations officer advocacy training in January 2005. Further, it plans to also provide training to the new vertical advocates and the hiring authorities by March 2005.

Finding #10: The department's electronic databases do not allow it to adequately monitor employee misconduct allegations and discipline.

Gaining an overall understanding of the department's current or past employee disciplinary actions is severely hindered by a lack of cohesive or integrated electronic data systems. One must currently obtain data from six different computer databases—all of which track combinations of similar and entirely different information—to try to piece together a complete picture of the department's actions. Further exacerbating this problem, the four primary systems we tested are incomplete and include erroneous data because the department does not keep the databases current. We found that a primary database used to track compliance with statutory deadlines is missing important data, including the entire case for 24 of the 127 cases we tested at six institutions.

Partially as a result of its poor tracking systems and management's inaction in using the data it does have, the department does very little to monitor the disciplinary actions it pursues. In response to these problems, it is implementing two new integrated computer databases for disciplinary and legal matters to replace the six outmoded systems currently in place. Although the new systems, which include deadline reminders and management reporting capabilities, appear promising, the department will need to ensure that it updates and maintains the systems to realize the benefits.

To ensure that it can appropriately and accurately monitor and track employment-related actions and outcomes, we recommended that the department should do the following:

- Complete its implementation of the new computer databases, eliminate the redundant systems, and consolidate monitoring of these systems within the information systems division.

- Ensure that staff involved in maintaining the new computer databases receive proper training, enter data accurately and consistently, and appropriately update the systems in a timely manner.

Department Action: Partial corrective action taken.

The department is continuing its implementation of both the case management system (CMS) and its ProLaw system. The department expects CMS to be fully operational in its institutions, the office of civil rights, the employment law unit, and the office of personnel management by August 30, 2005. The department also expects the ProLaw system to be operational in the employment law unit by March 1, 2005. Finally, the department reported that by March 15, 2005, it will train staff charged with inputting information into CMS and ProLaw and that it will finalize a plan for monitoring the accuracy of data entered into these systems.

Finding #11: The department can still do more to train employees who deal with misconduct allegations and discipline.

It is important to ensure that the employees who administer the discipline process have the necessary training to do so. Training is even more important for the employees in five of these positions—the EROs, the Office of Civil Rights investigators, the equal employment opportunity coordinators, the investigative services staff, and the litigation coordinators—because the positions do not have specific state classifications, which means these employees did not need to meet minimum qualification requirements specific to these five positions. The department appears to be moving in the right direction by appropriately developing, implementing, and requiring a job-specific training course for three positions, but it should consider establishing mandatory job-specific training requirements for the other positions as well. In recognition of the need to have training requirements, the Office of Civil Rights completed a proposal in September 2004 that would make training mandatory for all new investigators and require annual training for all investigators.

To ensure that it provides adequate training for key positions involved in the disciplinary process, we recommended that the department consider establishing job-specific mandatory training requirements for its litigation and equal employment opportunity coordinators. Further, the Office of Civil Rights should continue its efforts to implement mandatory training for its investigators and ensure its policy is followed, as it already did for its EROs, investigative services staff, and special agents.

Department Action: Pending.

According to the department, the office of civil rights plans to develop and require new investigative staff to participate in a two week investigative course along with ongoing on-the-job training. The office of civil rights also plans to require semi-annual training for all investigative staff. Moreover, the department will evaluate the need for job-specific mandatory training for litigation and equal employment opportunity coordinators as the vertical advocacy model is implemented and the roles of those entities in the disciplinary process are more specifically defined.

Finding #12: The department could save the State money by filling the employee relations officer positions with employees who are not peace officers.

The department has taken steps recently that should help to improve the competency and tenure for those staff filling the ERO position; however, it should consider the success rates of the varying levels of staff in this position to determine if one level is better than others. Using staff other than peace officers could reduce salary, overtime, and retirement costs and help relieve the possible shortage of correctional officers to work in areas for which they are specifically trained.

To determine the most cost-effective level to fill its ERO position, we recommended that the department track the success rates of all its EROs, including staff other than peace officers.

Department Action: Pending.

The department reported that once it has completed implementing CMS in March 2005, it plans to explore whether it can design special reports from CMS that provide information as to the success rates for cases with representation by an attorney, an employee relations officer, and other classifications.

Finding #13: The department has been slow to implement some changes to improve its employee misconduct allegation and discipline process.

Despite several prior audits that identified weaknesses in the department's employee disciplinary practices and that made recommendations for improvements, the department has at times been slow in taking action or has not taken any action at all. This likely contributed to the ongoing problems we described throughout our audit report. One reason for implementation delays is that until May 2004, the department did not have a centralized division or unit with responsibility for ensuring that the department addresses external audit recommendations. Instead, each individual office and division maintained responsibility for responding to audit recommendations and tracking their corrective action status.

We recommended that the department ensure that its newly created division charged with tracking audit recommendations and corrective action is proactive in doing so.

Department Action: Pending.

The department reported that its final action related to this recommendation is dependent upon a proposed reorganization. The department will share the reorganization plan once it is approved by the governor.

CALIFORNIA DEPARTMENT OF CORRECTIONS

More Expensive Hospital Services and Greater Use of Hospital Facilities Have Driven the Rapid Rise in Contract Payments for Inpatient and Outpatient Care

Audit Highlights . . .

Our review of the California Department of Corrections' (Corrections) contracts for medical services revealed the following:

- ☑ *Corrections' hospital payments have risen $59.4 million from fiscal years 1998–99 through 2002–03, growing at an average rate of 21 percent per fiscal year.*
- ☑ *Inpatient hospital payments increased by $38.5 million from fiscal years 1998–99 through 2002–03, primarily driven by increased payments per hospital admittance.*
- ☑ *Outpatient hospital payments increased by $12.7 million from fiscal years 1998–99 through 2002–03, driven by both increased payments per hospital visit and increased numbers of hospital visits.*
- ☑ *Two institutions attributed their inpatient hospital payment increases, among other reasons, to changes in contract terms resulting in hospital payments that were three times as much as they would have paid previously for the same inpatient stay.*

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REPORT NUMBER 2003-125, JULY 2004

California Department of Corrections' response as of February 2005

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the California Department of Corrections' (Corrections) contracts for medical services, including contracts with Tenet Healthcare Corporation (Tenet). Specifically, the audit committee asked the bureau to identify any trends and, to the extent possible, reasons for the trends in the costs Corrections is paying for contracted inpatient and outpatient health care services and costs for similar services among hospitals as well as hospital systems. Further, the audit committee asked the bureau to compare the costs Corrections is paying Tenet for inpatient and outpatient health care services to the costs paid for similar services at other hospitals and, to the extent possible and permissible, publicly report the results and reasons for an differences. Our review revealed the following:

Finding #1: Corrections did not have detailed analysis to explain the reasons behind the overall increase in its hospital payments.

We found that, overall, Corrections' payments for hospital services have risen an average of 21 percent annually since fiscal year 1998–99. The reasons for the growth can primarily be attributed to a combination of more expensive health care and Corrections' increased use of contracted hospital facilities. Although Corrections agreed that the growth in hospital payments occurred, it did not explain with supporting analysis the reasons behind the dramatic overall increase in its payments to hospitals.

To understand the reasons behind the rising trend in its inpatient and outpatient hospital payments, Corrections should do the following:

- ☑ *Corrections paid some hospitals amounts that were from two to eight times the amounts Medicare would have paid the same hospitals for the same inpatient services, including a hospital operated by Tenet Healthcare Corporation, which was paid eight times the amount Medicare would have paid.*
- ☑ *One institution's outpatient hospital payments increased by $821,000 primarily because its average payment per emergency room visit, which are paid at a percentage of the hospital bill without a maximum limit, increased from less than $950 per visit to more that $3,300 per visit.*
- ☑ *Corrections' outpatient payment amounts averaged two and one-half times the amount Medicare would have paid for the same services.*
- ☑ *A lack of key data being entered into Corrections' database limits analyses behind causes of increased payments and utilization, such as the extent to which case severity is a cause.*

- Enter complete and accurate hospital-billing and medical procedures data in its health care cost and utilization program (HCCUP) database for subsequent comparison and analysis by the Health Care Services Division (HCSD) and correctional institutions of the medical procedures that hospitals are performing and their associated costs.
- Perform regular analysis of its health care cost and utilization data, monitor its hospital payment trends, and investigate fully the reasons why its costs are rising for the purpose of implementing cost containment measures.
- Investigate the significant and sudden increase in its inpatient hospital payments, beginning in fiscal year 2000–01, for the purpose of determining whether renegotiating contract payment rates, reducing the length of stay in contract hospital beds, or other cost containment measures can most effectively reduce its contract hospital costs.
- Complete its analysis of high-cost cases to determine why the number of high-cost inpatient cases and more-expensive outpatient visits are rising so that it can identify cost-effective solutions to its increasing health care costs. For example, Corrections should fully investigate the extent to which each of the potential cost drivers it has identified as part of its analysis of high-cost impatient cases is increasing its hospital inpatient costs.
- Follow up with all institutions using new hospital contracts to determine if renegotiated contract payment terms are resulting in significantly higher costs, as they did for the two institutions that informed us of the significant effect on their inpatient hospital costs for high-cost cases.

➲

Corrections Action: Pending.

Corrections stated that it continues to enter data from medical invoices and has established validation reports to ensure data is entered appropriately and will perform audits to ensure all available procedure data is entered. It also reported that it would establish a peer review program and develop training plans to improve data integrity. Additionally, Corrections stated that it hired analysts that are responsible for analyzing health care cost and utilization data and established a workgroup to identify reasons for rising costs and to implement cost containment measures. Further, Corrections indicated that it revised its utilization management database

to connect this data to its cost and utilization database, as well as add health care guidelines for reviewing patient treatment and placement, and would transmit reports from these data to each institution for review and action by appropriate staff. Corrections indicated it expects to begin reporting on its cost containment in July 2005.

Corrections also reported that it was gathering contract data and information on the impact of utilization and contract provisions. Further, it indicated that it would not investigate the significant increase in inpatient hospital payments beginning in fiscal year 2000–01 for the purpose of determining cost containment measures. Instead, due to limited resources, it stated it would prospectively analyze current hospital payments. Additionally, although it analyzed fiscal year 2002–03 high-cost inpatient cases and cited the impact of patient age on hospital costs as the most striking finding, its analysis did not first eliminate the effect of contracts renegotiated in 2001 that became disadvantageous to Corrections. Further, Corrections reported its analysis of cost and utilization data for three hospitals and noted increasing costs. However, it did not indicate whether it had each institution analyze their payments to hospitals, similar to the two that reported to us, to determine if renegotiated contract payment terms are resulting in the higher costs. Instead, Corrections indicated that due to limited resources, it would prospectively analyze current or existing hospital payments.

Finding #2: Certain contract provisions resulted in Corrections paying higher amounts for inpatient and outpatient health care.

Our review of inpatient hospital payments for selected hospitals revealed that the terms of some contracts resulted in payments that were significantly higher than those made by Medicare for similar hospital services. This effect appeared most pronounced for hospitals whose contracts include stop-loss provisions, which sets a dollar threshold for hospital charges per admittance. Typically, if the charges per admittance exceed the threshold, Corrections pays a percentage of the total charge, rather than a per diem or other rate. However, should hospital administrators inflate charges to take advantage of stop-loss provision, Corrections could unknowingly pay higher amounts to hospitals than expected unless Corrections takes additional steps to monitor and investigate potentially inflated hospital charges. Similarly, Corrections' outpatient contract provisions base payments on a percentage of

the hospitals' billed charges rather than costs and generally resulted in Corrections paying on average two to four times the amounts Medicare would have paid for the same outpatient services.

To control increases in inpatient and outpatient hospital payments caused by contract payment provisions, Corrections should do the following:

- Revisit hospital contract provisions that pay a discount on the hospital-billed charges and consider renegotiating these contract terms based on hospital costs rather than hospital charges. Corrections should also reassess hospital contract provisions that require it to pay a percentage of hospitals' billed charges for outpatient visits, including emergency room outpatient visits. To renegotiate contract rates, Corrections should use either existing cost-based benchmarks, such as Medicare or Medi-Cal rates, or hospital cost-to-charge ratios to estimate hospital costs. Further, should Corrections renegotiate hospital contract payment terms, it should perform subsequent analysis to quantify and track the realized savings or increased costs resulting from each renegotiated contract.

- Obtain and maintain updated cost-to-charge ratios for each contracted hospital, using data from the Centers for Medicare and Medicaid Services, the Department of Health Services, or the Office of Statewide Health Planning and Development. It should use these ratios to calculate estimated hospital costs for use as a tool in contract negotiations with hospitals and for monitoring the reasonableness of payments to hospitals.

- Require hospitals to include diagnosis related group (DRG) codes on invoices they submit for inpatient services to help provide a standard, along with hospital charges, by which Corrections can measure its payments to hospital as well as case complexity.

- Detect abuses of contractual stop-loss provisions by monitoring the volume and total amounts of hospital payments made under stop-loss provisions, which are intended to protect hospitals from financial loss in exceptional cases, not to become a common method of payment.

Corrections Action: Pending.

Corrections reported that as hospital contracts are renegotiated, it is requesting the charge description master. Additionally, it stated that as staff negotiate contracts, they are requesting that

rates be tied to a reimbursement benchmark such as Medicare. In cases where hospitals refuse, Corrections indicated it is pursuing per diem benchmarked by Medicare rates, as well as lower maximum caps on outpatient rates that are a percent of billed charges. Hospitals that insist on a percent of billed charges rate structure are asked to accept billed charges in line with their cost-to-charge ratio. If a hospital refuses all its rate proposals, Corrections indicated it would not contract with that hospital. According to Corrections, no hospital has agreed to its proposals. Corrections stated it would report on its progress in its one-year status report. Further, it reported obtaining hospital cost-to-charge ratios for use in contract negotiations and assessing the reasonableness of payments to hospitals.

Corrections further reported that it amended its hospital contract language to require hospitals to submit DRG codes on the hospital invoices for all inpatient admissions and would modify its database to capture these codes. It indicated that it is using the DRG code to determine what Medicare would have paid and assessing its payments to hospitals. Additionally, it stated that it identified those hospitals that have stop-loss provisions in their contracts and will renegotiate to tie rates to a reimbursement benchmark such as Medicare. Corrections indicated that if a hospital refuses all its rate proposals, it would not contract with that hospital. For hospitals that provide emergency services, yet will not negotiate reasonable rates, Corrections pays Medicare rates per state law.

Finding #3: Increases in hospital admissions and visits contributed to Corrections' increased inpatient and outpatient hospital payments.

An increase in the number of hospital admissions contributed to 28.9 percent of the increase in inpatient hospital payments, while 45.7 percent of the increase in outpatient hospital payments was attributed to an increase in the number of hospital visits. More striking is the fact that outpatient hospital visits nearly doubled from 7,547 visits in fiscal year 1998–99 to 14,923 visits in fiscal year 2002–03, even though Corrections' inmate population remained relatively constant during this period.

To control rising inpatient and outpatient hospital payments caused by increases in the numbers of hospital admissions or visits, Corrections should do the following:

- Include in its utilization management quality control process, a review of how utilization management medical staff assess and determine medical necessity, appropriateness of treatment, and need for continued hospital stays.

- Investigate the reasons why the number of outpatient visits by inmates has nearly doubled even though the inmate population has remained relatively constant, and implement plans to correct the significant increase in outpatient hospital visits.

- Continue with its plan to analyze how mentally ill inmates are affecting inpatient costs and utilization at its institutions.

Corrections Action: Pending.

➲ Corrections indicated that it plans to increase the number of utilization management staff. Further, Corrections stated that it has taken additional proactive measures to improve quality of services. It acquired recognized inpatient care guidelines to ensure standardized and consistent services. Using these guidelines, it will focus on conditions associated with unscheduled admissions, emergency department use, and high-cost/high-volume procedures. However, Corrections did not specifically indicate how it would review utilization management medical staff's assessments and determinations of medical necessity, appropriateness of treatment, and need for continued hospital stays to identify staff that are ineffective at containing costs while providing necessary medical services. Further, Corrections indicated that it formed a subcommittee to identify annual objectives for quality improvement and costs containment. According to Corrections, it believes program standardization and more oversight have increased the denial rate for outpatient services by 13 percent. However, due to limited resources, it indicated that it would not investigate why the number of outpatient visits nearly doubled, but instead would analyze current outpatient hospital visits. Corrections also reported that it would refine its utilization management system to identify the impact of mental health crisis patients and their effect on cost and use of hospital beds. It stated that this analysis would be available by July 2005.

CALIFORNIA DEPARTMENT OF CORRECTIONS

It Needs to Ensure That All Medical Service Contracts It Enters Are in the State's Best Interest and All Medical Claims It Pays Are Valid

Audit Highlights . . .

Our review of the California Department of Corrections' (Corrections) processes to contract for health care services not currently available within its own facilities concludes that:

- ☑ *Corrections staff who negotiate contracts tend to rely on a 30-year-old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids.*
- ☑ *Corrections' negotiation practices are flawed. For example, some of the Health Care Services Division's and prisons' hospital contracts leave out information vital to ensuring that the State receives discounts those contracts specify.*
- ☑ *Corrections is unable to justify awarding contracts for rates above its standards, violating this requirement of Corrections' contract manual.*
- ☑ *Corrections sometimes exceeds the authorized contract amount and fails to obtain proper approvals before receiving nonemergency services.*

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REPORT NUMBER 2003-117, APRIL 2004

California Departments of General Services' and Corrections' responses as of October 2004

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits (bureau) to examine the process that the California Department of Corrections (Corrections) uses to contract for health care services not currently available within its own facilities. Specifically, the audit committee directed the bureau to examine the process Corrections uses to negotiate contracts for outside health care services, including the different types of agreements it enters, its fees schedules, the roles of headquarters and prisons, and the qualifications of its negotiation staff. Further, the audit committee instructed the bureau to select a sample of contracts for outside health care services, including hospitals in both rural and urban areas, to determine whether Corrections negotiated the best value for the services, whether rates in rural and urban areas are comparable for similar services, whether rates for similar services are comparable to those under the State's Medicaid Assistance program (Medi-Cal), and whether Corrections employs data on trends of volume and average use of contracted medical services to obtain price breaks or quantity discounts. The audit committee also asked the bureau to review Corrections' policies and procedures for processing and monitoring claims for contracted health care services to determine if Corrections verifies the validity of the claims. Finally, the audit committee requested the bureau to evaluate Corrections' implementation of certain recommendations outlined in the bureau's report titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care,* issued in January 2000.

☑ *Corrections' prisons are not adhering to its utilization management program, established to ensure inmates receive quality care at contained costs. Consequently, prisons are overpaying for some services, incurring unnecessary costs for the State.*

Finding #1: Corrections' reliance on a long-standing policy exemption to competitive bidding for medical services may not be in the State's best interest.

Corrections staff who negotiate contracts tend to rely on a 30-year old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids.

We recommended that the California Department of General Services (General Services) consider removing its long-standing policy exemption that allows Corrections to award, without advertising or competitive bidding, medical service contracts with physicians, medical groups, local community hospitals, 911 emergency ambulance service providers, and an ambulance service provider serving a single geographical area.

If General Services decides that it is not in the State's best interest to remove the long-standing policy exemption, it should prescribe the methods and criteria for Corrections to use in determining the reasonableness of contract costs as follows:

- Require Corrections to undertake procedures similar to those required in the noncompetitively bid (NCB) process. Specifically, it should require Corrections to conduct a market survey and prepare a price analysis to demonstrate that the contract is in the State's best interest.

- Require Corrections to obtain approval of its market survey and price analysis from its director before submitting this information along with its contract to General Services for approval.

Department Action: Corrective action taken.

General Services completed its analysis of information obtained through a survey and meetings with various state departments that have historically used the medical services bidding exemption to award certain contracts. General Services has concluded that it is not in the best interest of the State to retain its long-standing policy exemption. Specifically, on January 26, 2005, General Services issued Management Memo number 05-04, which establishes a new statewide policy and requirements regarding medical services contracts. The Management Memo directs departments to employ the competitive bidding process to the maximum extent possible and requires that the director of General Services (or his/her designee) determine whether to grant

bidding exemptions. The Management Memo does not require competitive bidding for the following: (1) contracts for ambulance services (including but not limited to 911) when there is no competition because contractors are designated by a local jurisdiction for the specific geographic region, and (2) contracts for emergency room hospitals, and medical groups, physicians, and ancillary staff providing services at emergency room hospitals, when a patient is transported to a designated emergency room hospital for the immediate preservation of life and limb and there is no competition because the emergency room hospital is designated by a local emergency medical services agency and medical staffing is designated by the hospital. This exemption covers only those services provided in response to the emergency room transport.

Finding #2: Corrections has negotiated and awarded many hospital contracts that omit schedules to verify hospital charges are appropriate.

The compensation terms of some hospital contracts we reviewed do not include the information needed to evaluate potential costs and determine that hospital charges are consistent with contract terms. Also, for two contracts that had contract terms stipulating that the hospitals supply copies of their rate schedules (charge masters), Corrections staff failed to obtain them.

Beginning July 1, 2004, a new state law will require hospitals to file copies of their charge masters annually with the Office of Statewide Health Planning and Development.

We recommended that Corrections work with the Office of Statewide Health Planning and Development to obtain hospitals' charge masters, and use this information to negotiate contract rates and obtain discounts specified in the contracts.

Department Action: Corrective action taken.

Corrections reported that it met with the Office of Statewide Health Planning and Development and they developed procedures that will allow Corrections to obtain hospital charge description masters (CDM) annually, beginning in July 2005, for each hospital it contracts with. In the interim, Corrections is requesting CDMs for existing and all renewals of existing hospital contracts prior to negotiating hospital contracts.

Finding #3: Corrections cannot show that it follows procedures it developed to ensure that rates exceeding its standard rates are favorable.

The mission of Corrections' Health Care Services Division (HCSD) is to manage and deliver to the State's inmate population health care consistent with adopted standards for quality and scope of services within a custodial environment. The HCSD does not always ensure that prisons negotiate favorable rates. Until Corrections modifies and enforces its procedures to evaluate the reasonableness of proposed rates that exceed its standards, it will continue to undermine the State's goal of obtaining favorable rates.

In addition, Corrections lacks procedures to address instances when HCSD initiates a rate exemption. According to HCSD, its analysts essentially apply the same standards that prisons must follow and require the signature of the assistant deputy director. Yet, we identified four instances of HCSD not providing analyses to justify its approval of higher rates.

We recommended that Corrections ensure that HCSD enforces rate exemption requirements, including obtaining and reviewing documentation to verify prisons' justification for higher rates.

We also recommended that Corrections establish procedures to ensure that the rate exemptions initiated by HCSD undergo an independent review and higher-level approval process.

Department Action: Partial corrective action taken.

Corrections reported that its HCSD is currently enforcing rate exemption requirements by reviewing all medical contract rates to ensure they meet rate exemption requirements. Analysts prepare written documentation and analysis of rate exemption requests and submit them for approval from the deputy director, HCSD. The written analysis addresses the need for the contract, communications regarding rate negotiations, comparisons with other contracts statewide, and review of utilization data and project costs. Corrections also indicated that it is in the process of developing a new rate approval process to replace its existing Request for Medical Rate Exemption process. The new process is being tested to ensure that all elements required are incorporated into the form and Corrections plans were to have the new process implemented by November 2004.

Corrections stated it believes its existing approval levels for rate exemptions initiated by HCSD staff are appropriate and consider the best interest of the State by providing a review of medical contracts for fiscal prudence and, equally important, clinical appropriateness. However, Corrections response is inconsistent with information Corrections' representatives presented in the Assembly Budget Pre-Hearing held in April 2004. Corrections' staff indicated that it would be possible for staff with accounting or financial expertise, in a division other than HCSD, to review the medical contracts for fiscal prudence.

Corrections also reported that it is in the process of contracting for additional services from an expert in heath care contract negotiations that will provide financial and technical expertise to improve contract rates and its negotiation process. Corrections anticipates that it will have the contract in place by the end of fiscal year 2004–05.

Finding #4: Corrections cannot demonstrate it uses historical data when negotiating contracts.

Corrections cannot show that it routinely uses cost and utilization data to negotiate contract rates. Without documentation to show that it employed cost and utilization data, it cannot display a thorough and good-faith effort to protect the State's interest.

We recommended that Corrections adopt procedures that require staff to consider cost and utilization data when negotiating medical service contracts. These procedures should also require staff to document the use of these data in the contract file.

Department Action: Corrective action taken.

Corrections stated that it verbally instructed the Health Contracts Services Unit (HCSU) staff in April 2004 to review utilization data. Also, in July 2004, HCSU initiated a final written procedure that requires staff that negotiate medical services contracts to consider utilization data. As part of the contract request review process, HCSU is required to routinely review utilization data to determine if the contract is necessary and cost effective, or if services can be provided through another existing contract. Further, the procedure requires that staff document the use of the utilization data in the contract file. Finally, effective July 2004, HCSU directed field staff to submit all contract requests to it first for approval, rather than the Office of Contract Services.

Finding #5: Negotiation staff could benefit from specialized training.

Staff at both HCSD and the prisons have varying degrees of expertise in negotiating rates in contracts with medical service providers. Because prison staff who negotiate the terms and conditions of contracts for medical services at the prisons have uneven levels of contracting ability, the contracting and negotiating practices throughout the State are inconsistent.

We recommended that Corrections ensure that HCSD offers specialized training for its negotiation staff so they can effectively negotiate favorable rates. HCSD should then share any strategies and techniques with the prisons' negotiation staff.

Department Action: Partial corrective action taken.

Corrections reported that its HCSU staff completed analytical skills training and some staff also completed cost benefit analysis and negotiation skills workshops. The remainder of HCSU staff are scheduled to complete these workshops by April 2005. Further, as previously mentioned, HCSD is in the process of contracting for additional services from an expert in heath care contract negotiations.

Finding #6: Corrections' hospital expenses vary widely according to the compensation method.

We found that Corrections negotiates various compensation methods for hospital services, such as per diem rates or flat percentage discounts. Generally, Corrections can get substantially better rates when paying a per diem rate than when paying a flat discount rate.

We recommended that Corrections ensure that HCSD tries to obtain per diem rates as a compensation method when negotiating hospital contracts. Additionally, HCSD should document its attempts to obtain per diem rates.

Department Action: Partial corrective action taken.

Corrections reported that HCSU staff were directed to document efforts to obtain per diem rates as part of the negotiation process in each contract file. Corrections plans to incorporate this directive into the HCSU policy and procedures scheduled to be developed by July 2005. Also,

beginning in January 2005, the HCSU staff will track in a database efforts to secure per diem rates for new and renewing hospital contracts.

Finding #7: HCSD and prisons have not submitted many medical service contracts to Corrections' Office of Contract Services' (Contract Services) Institution Contract Section (ICS) within required time frames.

We found that prisons and HCSD submitted late contract or amendment requests for 14 of 56 contracts we reviewed. Specifically, we found that ICS approved 5 of 14 requests even though the requests did not appear to meet the criteria allowed by Corrections' policy memo. In addition, the policy memo requires Contract Services to generate a quarterly report card outlining all late contract and amendment requests and to distribute a copy of the report card to its division deputies. However, we found that Contract Services does not use the report cards, thereby missing an opportunity to use the report cards to enforce compliance with Corrections' policy.

We recommended that Corrections direct ICS to evaluate late requests using the criteria outlined in the policy memorandum. Additionally, ICS should request HCSD and the prisons to provide relevant documentation to support their requests.

We also recommended that Corrections continue generating report cards periodically and establish procedures for staff such as prisons' associate wardens to submit corrective action plans to Contract Services to monitor.

Department Action: Partial corrective action taken.

Corrections reported that the ICS continues to evaluate each request utilizing the established criteria outlined in the policy memorandum and approves requests that are substantiated and deemed to be in the best interest of the State and or/ contractor. If prisons do not provide sufficient information to support a late justification, ICS will request additional information. ICS will deny late submittal justifications that are not substantiated and return them to the prisons' health care manager with an explanation for the denial and instructions to direct the contractor to seek payment through the Board of Control process. ICS will also send a copy of the denial notification to HCSU. Late submittal justifications that are substantiated are approved at the section chief level.

Corrections stated that the OCS continues to generate the report cards semi-annually and distributes them to the chief deputy directors, deputy directors, assistant directors, Institution and Health Care Services regional administrators, and wardens. OCS has added a summary displaying data shared with management for two prior reporting periods. The additional summary will enable program or institution management to determine if improvements have been made or if a pattern of lateness continues. Corrections has instructed the programs and institutions to utilize this data to assist in their efforts to reduce late contract requests. Corrections is currently developing procedures that include the submission of corrective action plans to OCS for monitoring. Corrections plans to implement these procedures by January 31, 2005.

Finding #8: Corrections does not always ensure that authorized prison spending remains within authorized contract amounts.

For four contracts, the prisons were given spending authority via their notice to proceed (NTP) process by ICS that exceeded the contract amounts by $5.9 million.

We recommended that Corrections ensure that ICS staff review the master contract and outstanding NTPs before issuing additional NTPs so that it does not exceed the master contract amount.

Department Action: Corrective action taken.

Corrections reported that it has corrected the errors identified and modified its procedures. It also stated that ICS would train staff, on an ongoing basis, to follow guidelines established in its Master Contract Procedures and would also conduct random audits of master contracts to ensure compliance with the procedures.

Finding #9: Some medical services are rendered before General Services approves the contracts.

We identified five contracts where services were rendered between 15 and 134 calendar days before Corrections obtained General Services' approval.

We recommended that Corrections evaluate its contract-processing system to identify ways for HCSD, ICS, and the prisons to eliminate delays in processing contracts and avoid allowing contractors to begin work before the contract is approved.

Department Action: Corrective action taken.

Corrections reported that OCS issued a new late submittal policy for contracts and amendments in June 2004, stressing the importance of timely submission and the risks involved when contractors provide services without a contract. ICS and HCSD continue to meet regularly to develop strategies to reduce the number of late contracts submitted by prisons. Corrections also reported that, on an ongoing basis, OCS would consider alternatives to reduce the number of late contracts.

Finding #10: ICS does not always require prisons to demonstrate the unavailability of medical registry contractors before approving their contract requests.

ICS is responsible for awarding and managing medical registry contracts but does not always verify that the prison made an effort to obtain the required services from a provider included in a medical registry contract before approving a prison's request for a contract with a nonregistry provider. Failure to document attempts to contact registry providers exposes the State to potential lawsuits from registry contractors for breach of contract terms and hinders ICS' ability to terminate the registry provider for nonperformance.

We recommended that Corrections modify its procedures to require prisons to submit documentation to ICS demonstrating their attempts to obtain services from registry contractors with their requests for services from a nonregistry contractor.

We also recommended that Corrections direct ICS to review prisons' documentation and ensure that prisons have made sufficient attempts to obtain services from registry contractors. ICS should use these data to identify trends of nonperformance and terminate registry providers, when necessary.

Department Action: Corrective action taken.

Corrections stated that the OCS issued a memorandum in April 2004 implementing a new policy requiring programs to submit documentation of their attempts to contact

contractors to obtain services before requesting additional contracts for services covered under existing contracts. OCS also developed forms to assist prisons in documenting their contacts and requires prisons to submit this documentation with their contract requests.

Corrections reported that ICS currently reviews prisons' documented efforts to obtain services from registry providers to ensure compliance with contract terms and conditions before processing additional contracts for services. If prisons do not provide documentation of their efforts, they are instructed to contact current registry providers and document efforts before resubmitting their contract requests. ICS and HCSD collectively review the documentation to determine if multiple prisons are being denied services by a contractor and will terminate the contract if it is deemed in the best interest of the State.

Finding #11: Corrections continues to significantly increase its use of medical registry contracts.

Corrections' use of medical registry contracts is the fastest growing component of contracted medical services. We found that Corrections has attempted to reduce registry expenditures by numerous efforts to recruit medical staff and requesting funding to establish additional positions.

We recommended that Corrections continue to monitor prisons' registry expenditures on a monthly basis and evaluate their need for services.

Department Action: Partial corrective action taken.

Corrections reported that it initiated a new process in July 2004 designed to evaluate usage and need of registries periodically. Specifically, HCSD's Financial Management Unit provides a copy of the vacancies versus registry report to the Health Care regional administrators and managers each month. Also, HCSD has established a process to regularly analyze and discuss the usage of registry contracts with the health care managers through their monthly budget review process. Due to the limited amount of data available, any savings that may be realized will not be available until December 2004.

Finding #12: Prisons cannot show that they consistently perform prospective and concurrent reviews when required.

Our review of invoices requiring prospective and concurrent reviews revealed that many of the prisons are unable to demonstrate that they complete the reviews. By not having the documentation of these reviews, prisons cannot show that they do not pay for unnecessary medical services.

We recommended that Corrections ensure that the Utilization Management (UM) nurses adhere to the UM guidelines requiring them to perform and retain documentation of their prospective and concurrent reviews.

We also recommended Corrections direct HCSD to establish a quality control process that includes a monthly review of a sample of prospective and concurrent reviews performed by the prisons.

Department Action: Partial corrective action taken.

Corrections stated that HCSD is implementing processes to integrate clinical appropriateness and administrative oversight into its UM program and expects full implementation in October 2004. Also, the UM program has begun a process to review and update its program guidelines and plans to present the revised guidelines to management in December 2004, including an implementation schedule for 2005. On the administrative side, the UM supervising nursing staff have initiated monitoring and compliance activities. Between October 2003 and May 2004, the UM program implemented a new data collection system. The data is collected at the prison level, appended to a statewide database, and used to generate a number of reports used by program management. The reports, as well as the raw data, allow the UM supervisors to monitor standardization and compliance. The UM staff are also actively exploring an alternate program structure for management of UM activities in the field, as well as other means to improve efficiency of services, and will work through the annual budget process if resource needs are identified.

Corrections stated that the HCCUP staff are in the process of contracting with a vendor to perform reviews of medical invoices and expects to have a contract in place by February 2005. In addition, the Budget Act of 2004 authorized HCSD to establish 24 additional positions for the HCCUP program. HCSD plans to fill these positions by January 2005.These additional positions will allow HCCUP to establish quality control processes, include reviewing a sample of invoices processed by the program's

field analysts. Corrections anticipates these processes will be in place by March 2005. In addition, as of August 2004, HCCUP established and is using 52 validation reports to ensure the accuracy of data entered by field analysts. Using the validation reports, HCCUP will begin performing monthly audits of a sample of invoices submitted by field analysts. These audits will begin by March 2005. Also, as HCCUP staff identify data entry errors from the standardized validation checks and development of reports, it will notify all analysts, on a flow basis, of the appropriate manner to enter the data. HCCUP staff will also provide a five-day training for new staff hired and any staff that do not receive the training scheduled between December 2004 and March 2005. Finally, HCCUP will establish a peer review program that includes identification of additional data integrity improvement needs. HCCUP staff will develop a training plan based upon peer review findings and the training will be delivered to staff during the annual statewide HCCUP meeting in May 2005.

Finding #13: With unclear guidelines, prisons inconsistently perform retrospective reviews.

Corrections has not provided prisons with clear guidance regarding changes to the retrospective review process resulting in confusion to the prisons and inconsistent performance of retrospective reviews.

We recommended that Corrections clarify and update the UM guidelines for performing retrospective reviews.

Department Action: Pending.

Corrections reported that HCSD continues to explore options for modifying its retrospective review process, including outsourcing to a private contractor, obtaining additional positions, redirection of duties to other clinical staff, or a proposal for reorganization of the current UM structure. HCSD continues to emphasize insufficient resources to perform 100 percent retrospective review, and reports that community standard is less than 100 percent review and varies as a function of automated systems designed to automatically flag provider targeted issues. Corrections reported that it lacks such a system but patterned the community standard by verbally directing review of 100 percent of noncontract providers and 10 percent intensive review, via random selection, on all contracted

facilities. HCSD is further analyzing the resources needed to increase its retrospective reviews, and may address this issue through a future budget process.

Finding #14: Failing to adequately monitor medical service invoices, prisons sometimes overpay providers, unnecessarily increasing the State's medical costs.

Prisons overpaid providers $77,200, did not take discounts totaling roughly $12,700, incurred late penalties of $5,900, and could not provide evidence that inmates received medical services totaling $69,200.

We recommended that Corrections direct HCSD to establish a quality control process that includes a monthly review of a sample of the invoices processed by the prisons' Health Care Cost and Utilization Program analysts.

We also recommended that Corrections ensure that prisons recover any overpayments that have been made to providers for medical service charges. Similarly, prisons should rectify any underpayments that have been made to providers.

Further, we recommended that Corrections evaluate its payment process to identify weaknesses that prevent it from complying with the California Prompt Payment Act.

Department Action: Pending.

Corrections reported that HCCUP and accounting staff met and discussed alternatives for identifying and recovering overpayments and underpayments. As previously stated, HCSD plans to contract with a vendor to review medical invoices. Also, accounting staff have begun to determine system or process changes necessary to allow Corrections to readily identify and provide reports on overpayments and underpayments. Corrections anticipates that it will be able to provide management and other staff with reports by January 2005.

Corrections stated that in August 2004, staff met to identify weaknesses that prevent it from complying with the California Prompt Payment Act. Due to the complexity of some issues, staff determined that a work group would be established to identify potential solutions. However, Corrections stated that its work group meetings were delayed because of unfilled positions and other priority assignments, including completion of year-end closing and the development and training associated with its 2004–05 contract monitoring database. Corrections anticipates regular monthly meetings to begin in November 2004 and implementation of procedures by the end of fiscal year 2004–05.

DEPARTMENT OF CORRECTIONS

Investigations of Improper Activities by State Employees, July 2003 Through December 2003

ALLEGATION I2003-0896 (REPORT I2004-1), MARCH 2004

Department of Corrections' response as of December 2004

Investigative Highlights . . .

The California State Prison-Los Angeles County mismanaged money collected from television and motion picture production companies that filmed at the prison as follows:

- ☑ *An employee directed a production company to pay $1,500 to an employee association fund, rather than reimburse the State for its costs.*
- ☑ *The Los Angeles County Prison failed to ensure it was reimbursed $1,800 in costs incurred to accommodate two film production companies.*
- ☑ *The Los Angeles County Prison violated federal tax laws by improperly directing $4,150 in donations received from production companies through an inmate religious account before transferring the money into the employee association.*

We investigated an allegation that the California State Prison-Los Angeles County (Los Angeles County Prison) of the Department of Corrections (Corrections) mismanaged money collected from television and motion picture production companies that filmed at the prison.

Finding #1: An employee misappropriated state funds by directing a $1,500 production company payment into an employee association account.

In violation of state laws, an employee responsible for coordinating with and billing production companies for costs incurred by Los Angeles County Prison, directed a television show that filmed at the institution to pay $1,500 to the prison's employee association, not to the State's General Fund (General Fund), as a reimbursement. The prison established the employee association to promote employee morale by paying for activities such as employee parties and bereavement acknowledgements, or by participating in activities involving community-based charities. On July 14, 2002, the television show's film crew shot a segment at the prison. However, we found no evidence that the employee billed the television show for costs the prison incurred to accommodate the film crew or that the television show reimbursed the State for these costs. The records provided to us indicate that the employee instructed the television show to make its payment to the employee association and that he handled the payment as a donation. Two days after receiving this payment, the employee association, which had only $254 in its account beforehand, spent $800 for an employee barbecue.

Finding #2: The Los Angeles County Prison failed to ensure it was reimbursed $1,800 in costs it incurred to accommodate film production companies, thereby violating state laws prohibiting a gift of public funds.

From October 2001 to July 2003, 12 production crews filmed at Los Angeles County Prison. Of these 12 productions, six shot scenes for feature or short films, four filmed documentaries, and two taped segments for television shows. Although it received some payments from production companies to offset its costs, Los Angeles County Prison failed to ensure the State was reimbursed for $3,300 of those monitoring costs. As previously discussed, this includes a $1,500 payment associated with a television production that Los Angeles County Prison did not return to the State. The remaining $1,800 relates to costs prison staff incurred while providing security for two films shot in April and May 2002. Because it could not demonstrate the State had been reimbursed the $1,800 for these private endeavors, Los Angeles County Prison violated state law, which prohibits the State from making a gift of public funds or resources for a private purpose.

Finding #3: Los Angeles County Prison violated federal tax laws by improperly routing donations received from production companies through an inmate religious account before transferring the money to the employee association.

According to federal tax law, only qualified organizations may use the charitable contributions it receives for those purposes for which the organization is created and holds money received "in trust" for those purposes. Despite these requirements, a prison official approved a plan to direct $4,150 in donations received from production companies through an inmate religious account maintained by Los Angeles County Prison, which was authorized to receive charitable contributions, before transferring the money to the employee association, which was not qualified to accept tax-deductible donations. Los Angeles County Prison deposited donations of $900, $250, $2,500, and $500 into the inmate religious account, and then transferred the money to the employee association. According to the employee who devised the plan, she asked a subordinate who managed the inmate religious account to accept these donations. The employee then had the money transferred to the employee association, even though the association lacked the authority to receive tax-deductible donations and intended to use the money for nonqualifying purposes. The employee association used most of the money, about $2,900, to purchase exercise equipment

for the prison employees' gym. By improperly receiving and handling these payments, Los Angeles County Prison violated the laws governing charitable donations that require the money be used for the purposes for which it was received.

Department Action: Partial corrective action taken.

As of December 2004, Corrections reported it completed its investigation of four of six employees involved in this case. Corrections rescinded the appointment of one employee, who held a high-level managerial position, and served another employee, a manager, with an adverse action in the form of a pay reduction. Corrections has not yet determined what action it will take against other employees who are still under investigation.

CALIFORNIA DEPARTMENT OF CORRECTIONS

Its Plans to Build a New Condemned-Inmate Complex at San Quentin Are Proceeding, but Its Analysis of Alternative Locations and Costs Was Incomplete

Audit Highlights . . .

Our review of the California Department of Corrections' (department) plans to build a new condemned-inmate complex at San Quentin revealed:

- ☑ *Current condemned-inmate facilities at San Quentin do not meet many of the department's standards for maximum-security facilities.*
- ☑ *The department received spending authority of $220 million to build a new condemned-inmate complex and estimates completion by 2007.*
- ☑ *The department's analysis of where it should house its male condemned population did not consider all feasible locations and relevant costs.*
- ☑ *Because the department's analysis was incomplete, we can conclude neither that San Quentin is the best location for the new condemned-inmate facility nor conclude that a better location exists.*
- ☑ *Benefits and drawbacks exist for both the continued use of San Quentin as a prison and its reuse for other purposes.*

REPORT NUMBER 2003-130, MARCH 2004

California Department of Corrections' response as of September 2004

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to evaluate the California Department of Corrections' (department) plans to build a new condemned-inmate complex at California State Prison, San Quentin (San Quentin). Further, the audit committee asked us to determine whether, in developing its plans, the department had considered all relevant factors. The audit committee asked us to review and assess the department's methodologies and assumptions in determining that construction of a new $220 million complex to house male condemned inmates at San Quentin is an appropriate investment for the State and whether the department's estimate is reasonable and based on adequate support and analysis. In addition, the audit committee asked us, to the extent possible, to compare San Quentin's costs to those of California State Prison, Sacramento, in areas such as operating costs, maintenance costs, and capital costs to construct or modify a facility to house condemned inmates.

Finding #1: The department did not include all reasonable alternatives in its analysis of other potential sites to house male condemned inmates.

In determining where to house its condemned inmates, the department considered certain existing prison facilities but concluded that most of them would not be appropriate, due primarily to their remoteness from metropolitan areas. The department did conclude that California State Prison, Sacramento, would be an appropriate location but determined that transferring the condemned inmates there would exacerbate the department's systemwide shortage of maximum-security beds. However,

the department limited its consideration to the seven facilities that currently have 180 housing unit facilities. The department considered only these prisons because it believes that the 180 housing unit, which is designed for maximum-security inmates, is the most appropriate facility for this population.

Additionally, although the department has land available at other prison sites on which to build a condemned-inmate complex with the 180 housing unit facilities it considers appropriate for condemned inmates, it did not analyze the feasibility of building such a complex at other locations. The deputy director of the department's facilities management division told us that the department has land available at many locations to accommodate 180 housing unit facilities such as the condemned-inmate complex it plans for San Quentin, although other factors such as wastewater and water capacity, severe recruitment and retention difficulties, community opposition, flood plains, and habitat preservation would limit the feasibility of using most sites. According to the department, it believed that the legislative direction it had received was to maintain condemned inmates at San Quentin. Nonetheless, the department would have better ensured that the best decision for the State was made if it had included all reasonable alternatives.

We recommended that if the Legislature decides that it wants a more complete analysis regarding the optimal location for housing male condemned inmates, it consider requiring the department to assess the costs and benefits of relocating the condemned-inmate complex to each of the current prison locations possessing either adequate available land for such a facility or an existing adequate facility, including in its assessment the relative importance and costs associated with each site's remoteness. Additionally, in the future, the department should include all feasible alternatives when it analyzes locations for any new prison facilities.

Legislative Action: Unknown.

Department Action: Pending.

The department states that it will continue its practice of assessing feasible alternatives and appropriate costs when it analyzes locations for any new prison facilities.

Finding #2: The department's comparison of costs was incomplete.

Although the department analyzed the costs of relocating its San Quentin activities, it did not compare the anticipated annual operating and maintenance costs between San Quentin and other potential locations. As part of an effort by the Department of General Services to study San Quentin's potential reuses, the department prepared an estimate of the costs associated with relocating all of its activities from San Quentin, including housing for its condemned, reception center, and level I and II inmates. However, the department did not compare the annual operating and maintenance costs once the condemned inmates had been relocated to those it could expect to incur at San Quentin. Such a comparison would have provided more complete information that would have assisted the department in ensuring that it made the most cost-effective decision.

We recommended that if the Legislature decides that it wants a more complete analysis regarding the optimal location for housing male condemned inmates, it consider requiring the department to analyze the estimated annual operating and maintenance costs of a new condemned-inmate complex at other locations with adequate available land or facilities, compared to those it expects to incur at San Quentin. Additionally, in the future, the department should include all appropriate costs when it analyzes locations for any new prison facilities.

Legislative Action: Unknown.

Department Action: Pending.

The department states that it will continue its practice of assessing feasible alternatives and appropriate costs when it analyzes locations for any new prison facilities.

Finding #3: The department's estimate of future condemned inmate populations is likely overstated.

Based on past experience, the department estimates that the condemned-inmate population could grow at a rate of 25 inmates per year. In arriving at its estimate of the annual increase in the numbers of condemned inmates, the department considered the number of male inmates the State sentenced to death each year since 1978, after the State enacted its current death penalty law. Based on these numbers, the department concluded that the State sentences an average of 25 men to death each year. However,

this analysis does not consider inmates who leave death row for various reasons, such as commuted sentences and death, by natural causes, and by execution. Our review of the department's log of condemned inmates, which tracks inmates coming into and out of death row at San Quentin, showed that as many as nine inmates left death row in a single year; over a 10 year period between 1994 and 2003, 48 inmates left death row. Therefore, the department's estimate is likely overstated.

Additionally, both the state public defender and the state capital case coordinator at the Office of the Attorney General told us that they expect the number of inmates being sentenced to death to decrease in the coming years. According to the state public defender, this is due primarily to the expense that the counties incur in capital cases. She stated that counties are seeing a sentence of life without parole as a better alternative. Also, according to the state public defender, lower crime rates and decreasing support for the death penalty will result in fewer capital cases. At the same time, both the state public defender and the state capital case coordinator believe that the number of executions will increase in the coming years as condemned inmates begin to exhaust their federal appeals.

We recommended that if the Legislature decides that it wants a more complete analysis regarding the optimal location for housing male condemned inmates, it consider requiring the department, in order to provide more accurate estimates of future numbers of condemned inmates, to include all relevant factors in future estimates, such as the number of inmates who leave death row for various reasons, including commuted sentences and death.

Legislative Action: Unknown.

TERRORISM READINESS

The Office of Homeland Security, Governor's Office of Emergency Services, and California National Guard Need to Improve Their Readiness to Address Terrorism

Audit Highlights . . .

Our review of the Governor's Office of Emergency Services' (OES) and the California National Guard's (National Guard) terrorism readiness activities revealed:

- ☑ *Both agencies have developed plans that adequately guide their response to terrorist events, but OES has not included a prevention element in the State's terrorism response plan.*
- ☑ *OES has not always identified the critical training that staff in the operations centers need to effectively complete their duties.*
- ☑ *OES does not regularly develop and administer state-level terrorism readiness exercises with other state and local agencies, as its terrorism response plan requires.*
- ☑ *Clarification of the roles and responsibilities of the State's Office of Homeland Security and OES would be beneficial.*

continued on next page . . .

REPORT NUMBER 2002-117, JULY 2003

Office of Homeland Security, Governor's Office of Emergency Services, and California National Guard responses as of July 2004

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the terrorism readiness efforts of the Governor's Office of Emergency Services (OES) and the California National Guard (National Guard). Specifically, the audit committee asked that we review and evaluate the terrorism prevention and response plans, policies, and procedures of these agencies and determine whether the plans are periodically updated and contain sufficient guidance. It also asked that we determine whether OES and the National Guard have provided sufficient training to their staff to effectively respond to terrorism activities and assess how the training compares to best practices or other reasonable approaches. The audit committee further requested that we determine whether both agencies take advantage of all state and federal funding for terrorism readiness. Finally, the audit committee asked that we determine whether the National Guard's recruitment and retention practices and staffing levels impact its readiness to respond to terrorism activities or its ability to attract qualified personnel for terrorism readiness positions.

Finding #1: The terrorism response plan guides the State's response but does not include ways to help prevent terrorism.

Although the State Emergency Plan (emergency plan) and terrorism response plan adequately define the roles and responsibilities of numerous state and local agencies in responding to various emergencies, including terrorism, they do not address how the State could help prevent terrorist attacks from occurring. Lacking in the terrorism response plan is guidance for terrorism prevention. One reason for this deficiency may be that

- ☑ *Although the National Guard generally relies on its members' military training to respond to terrorism missions, it has not provided all of the training its staff in its Joint Operations Center needs to adequately respond to these missions.*
- ☑ *The National Guard believes it has not had sufficient funding to participate in exercises involving other state and local emergency response agencies.*

the Legislature did not envision a prevention role when it established OES in the California Emergency Services Act (act). Rather, the act sets the focus of OES as coordinating the State's response activities. However, the State needs to plan how it can help prevent terrorist events from occurring to best protect the citizens of the State against the consequences of such events. Acknowledging this void in the current terrorism response plan, the director of the Office of Homeland Security (OHS) stated that his office plans to revise the current state plan to make it more concise and include a prevention component.

To ensure that the State is adequately prepared to address terrorist threats, OHS should continue its plans to develop a state plan on terrorism that includes a prevention element

OES/OHS Action: Corrective action taken.

OES states that it completed a draft revision of the terrorism response plan in December 2003 that addresses terrorism prevention as well as organizational and procedural changes that have occurred since the original plan was written. OES adds that it continues to coordinate with OHS to finalize the revised terrorism response plan.

Finding #2: OES has no formal process to periodically review and update the terrorism response plan.

OES lacks a formal process to regularly review the terrorism response plan and update it as determined necessary. Rather, OES staff state that they update the terrorism response plan when changes in statute affecting emergency management or changes occur in regulations, policies, or significant procedures. Although OES has not established a formal process to regularly review the terrorism response plan, other organizations and states we contacted do regularly update and incorporate lessons learned into their plans. Without an established process to regularly review the plan, OES cannot ensure that it remains current and adequately protects the State. Furthermore, OES would make its assessment more consistent and effective if it developed a checklist to guide its efforts in evaluating the terrorism response plan.

OHS and OES should ensure that the state plan addressing terrorism is reviewed on a regular basis and updated as determined necessary to ensure that it adequately addresses current threats and benefits from the lessons learned in actual

terrorist readiness events occurring both in California and nationwide. Additionally, they should develop a checklist to guide periodic evaluations of the state plan addressing terrorism to ensure that such assessments are consistent and effective.

OES Action: Corrective action taken.

OES indicates that it has drafted revisions to its Policies and Procedures Manual to address the need for a process to formally and periodically review the emergency plan, including the terrorism response plan. In conjunction with this effort, OES states that it has developed a checklist, which includes planning criteria from multiple state and federal publications that will guide its efforts in updating the emergency plan in the future. OES plans to update this checklist with the development of the National Response Plan in order to assure state practices and plans are in concert with federal operations. OES plans to finalize its review procedures once the National Response Plan is approved.

Finding #3: OES has not identified the training needs for all of its staff.

OES has not conducted a needs assessment to determine the training requirements for all personnel in its state and regional operations centers. Although OES does develop individual training plans for some of its staff, which identify an individual employee's career goals and objectives, it does not prepare them for all staff working in state and regional operations centers. Furthermore, OES does not provide guidance to all supervisors preparing the training plans to ensure that they include training related to core competencies. Core competencies are the key skills employees need to possess to perform their assigned duties.

To ensure that state agencies, including OES, are adequately prepared to respond to terrorist events occurring within the State, OES should identify the most critical training required by staff at state and regional operational centers and then allocate existing funding or seek additional funding it needs to deliver the training.

OES Action: Corrective action taken.

OES revised its training policies, outlining the core competencies for all OES staff. OES maintains that the several activations of the State Operations Center and Regional Operations Centers have provided additional

opportunities for appropriate on-the-job training. To further augment its training policy, OES has developed an internal working group to prepare an Emergency Operations Guide that will detail the agency policies and procedures for emergency operations.

Finding #4: OES has not conducted state-level terrorism readiness exercises as called for in its terrorism response plan.

With the exception of federally or state mandated exercises associated with nuclear power plants and hospitals, the State does not presently have an established program to provide exercises to ensure that state agencies are prepared to respond to terrorist events. According to OES, it has not regularly developed and administered terrorism readiness exercises because it is not funded to do so. However, it has not requested state funding to conduct the exercises. OES has participated in terrorism readiness exercises when other agencies have held them, and staff have received training through activation experiences. However, these activities would not necessarily test and enhance the capabilities of state agencies, local governments, and related entities to prepare for, respond to, and recover from terrorist events as called for in the terrorism response plan. OHS has recently decided that the California National Guard should be responsible for coordinating state-level exercises, awarding $1.6 million in federal funds to them. Because of the unique role that OES plays in coordinating emergencies, it will be important for OES to work with the National Guard to establish an effective exercise program.

To ensure that state agencies, including OES, are adequately prepared to respond to terrorist events occurring within the State, OES should assist the National Guard in providing state-level terrorism readiness exercises.

OES Action: Corrective action taken.

OES states that it will continue to work with the National Guard and local agencies in developing the statewide exercise program. It points out that it held a functional exercise of the State Operations Center and the Inland Regional Operations Center in March 2004, and was planning on participating in a terrorism exercise to be held in August 2004.

Finding #5: The effect of budget cuts are uncertain.

An OES analysis stated that budget cuts it is required to sustain due to the current state budget crisis will severely hinder its ability to fulfill its overall mission, including terrorism readiness. However, since February 2003, OES is to report to the Governor's Office through the OHS director, and the OHS director told us he believes that OES can meet its statutory mission despite budget cuts incurred as of June 2003. To optimize its efficiency, the OHS director intends to assess the OES organization to identify more efficient ways for OES to fulfill its statutory responsibilities, focusing its resources on mission-related activities.

To ensure that the State is adequately prepared to address terrorist threats, OHS should continue its plans to thoroughly assess OES functions to determine how it can optimize its efficiency.

OES/OHS Action: Pending.

OES states that no new budget cuts for OES were included in the enacted 2004–05 budget. OES adds that the programs of OES and OHS are both included in the California Performance Review (CPR), and anticipates that the CPR report will reflect recommendations for the public and Legislature to consider.

Finding #6: Clarification of the roles and responsibilities of OHS and OES would be beneficial.

The authority provided to OES under the act and the authority provided to OHS by the governor's February 2003 executive order appear to have the potential to overlap. Further, the directors of the two offices appear to have differing views on their roles and responsibilities. A lack of clarity in their respective roles and responsibilities could adversely affect the State's ability to respond to emergencies, such as a terrorist event.

To ensure that the State is adequately prepared to address terrorist threats, OHS should work with the governor on how best to clarify the roles and responsibilities of OHS and OES.

OHS/OHS Action: Pending.

➲ OES states that there have not been any formal changes that further define the relationship of the two agencies. It adds that OES and OHS recognize the many similarities, as well

as differences, in the prevention, preparedness, response, recovery, and mitigation of terrorism events and other emergencies and disasters. OES further states that it and OHS view their relationship as an opportunity to partner in order to maximize efforts in those common areas, and utilize each other's specific expertise in those areas that are not. OES concludes by stating that the agencies' roles and responsibilities should be viewed as a necessary partnership to manage the emerging threat of terrorism and homeland security issues, while also maintaining an all-hazards approach to emergency management.

Finding #7: Joint Operations Center staff have not yet completed all the training they need to effectively coordinate missions.

The Joint Operations Center is responsible for receiving state missions from OES and developing and overseeing the National Guard's response to requests for its services. In June 2002, the Joint Operations Center identified training it believes its staff need to adequately respond to state emergencies. However, 32 of the 38 members required to take specific courses had received less than half the designated training. According to the National Guard, lack of funding and limited availability of classes have hindered its ability to train its Joint Operations Center staff in the identified areas. Without proper training, the ability of the National Guard to respond promptly and effectively to state missions may deteriorate.

To ensure that its members are adequately trained to respond to terrorism missions, the National Guard should determine the most critical training its Joint Operations Center staff need to fulfill their duties and then allocate existing funding or seek the needed funding to provide the training, documenting why it is needed.

National Guard Action: Corrective action taken.

The National Guard states that it has developed a plan that identifies the training needed by the various members of the Joint Operations Center. The National Guard adds that it has not received any additional funding to provide training to members of the Joint Operations Center.

Finding #8: The Army Guard Division does not provide required terrorism awareness training to its members.

The National Guard's Army Guard Division does not provide terrorism awareness training required by U.S. Army regulations as part of its terrorism readiness force protection (force protection) program. According to the commanders of the Army Guard units we visited, the reason they have not fully implemented the terrorism awareness training is that they have not received the guidance to implement it. Further, although the regulation provides that one way the units can offer the required training is through an approved web-based course, the director of the Joint Operations Center stated that his office had been unaware of such a course until recently. However, while visiting an Air Guard unit in April 2003, we discovered that it had been using a Web-based course to fulfill the requirement for terrorism awareness training since June 2002. Therefore, despite its responsibility for implementing the force protection program in both the Air Guard and Army Guard divisions, the Joint Operations Center was unaware of the practices of the Air Guard Division that could have benefited the Army Guard Division. Had the Joint Operations Center been more aware of the training being utilized in the Air Guard Division, it could have identified this best practice and shared it with the Army Guard Division.

The National Guard should develop guidance for its Army Guard Division to implement its terrorism readiness force protection program. Additionally, it should ensure that its Joint Staff Division, including the Joint Operations Center, share best practices between its Air Guard and Army Guard divisions.

National Guard Action: Corrective action taken.

The National Guard states that it published guidance for its fiscal year 2005–06 training year in March 2004 and issued related operational plans in May 2004, which provide guidance for Army Division organizations to implement their terrorism readiness force protection programs. Additionally, the National Guard states that the chiefs of staff for the Army, Air, and Joint Staff Divisions meet each week and include a discussion of best practices among the divisions.

Finding #9: The National Guard would benefit from increased state-level terrorism exercises

The National Guard believes that it has not had sufficient opportunities to participate in exercises with other state and local emergency response agencies. In June 2003, OHS advised us that it has now allocated $1.6 million in federal funding to the National Guard to coordinate terrorism readiness exercises that include both state agencies and rural jurisdictions. Therefore, the National Guard should soon be able to participate in terrorism readiness exercises with other state and local emergency response agencies.

The National Guard should use the recently awarded funds from OHS to identify the type and frequency of state-level exercises responding to terrorist events that the State needs to be adequately prepared. The National Guard should then provide the exercises it has identified.

National Guard Action: Corrective action taken.

The National Guard states that it received funding and spending authority in December 2003 for its Homeland Security Exercise Team. The National Guard reports that it has coordinated 24 exercises throughout the State and has another 18 exercises planned. It adds that these exercises include several county exercises, several state agencies, and a statewide exercise that is part of a larger Department of Defense/U.S. Northern Command exercise.

GOVERNOR'S OFFICE OF EMERGENCY SERVICES

Its Oversight of the State's Emergency Plans and Procedures Needs Improvement While Its Future Ability to Respond to Emergencies May Be Hampered by Aging Equipment and Funding Concerns

REPORT NUMBER 2002-113, JULY 2003

Governor's Office of Emergency Services' response as of August 2004

Audit Highlights . . .

Our review of the Governor's Office of Emergency Services' (OES) and counties' ability to coordinate and respond to multijurisdictional and multiagency emergencies revealed the following:

- ☑ *OES lacks a formal process to regularly review and update the State Emergency Plan and its related annexes.*
- ☑ *OES does not consistently perform activities needed to evaluate and improve its coordination of emergency responses under the Standardized Emergency Management System.*
- ☑ *Clarification of the roles and responsibilities of the State's Office of Homeland Security and OES would be beneficial.*
- ☑ *With aging equipment and other equipment not in place, OES's ability to task its own resources during an emergency may be limited.*

The Joint Legislative Audit Committee (committee) requested that the Bureau of State Audits (bureau) review and assess the Governor's Office of Emergency Services' (OES) policies and procedures for assessing and coordinating multijurisdictional and multiagency responses to emergencies under the Standardized Emergency Management System (SEMS) and the State Emergency Plan (emergency plan). Further, the committee requested the bureau to determine if OES is maintaining the emergency plan as required by law and whether a sample of local government emergency operation centers (EOCs) are adequately prepared to respond to emergencies following SEMS. We found that the emergency plan and related annexes provide adequate guidance to agencies responding to multijurisdictional emergencies, but that OES lacks a formal process to regularly evaluate and update these plans. Additionally, OES is not consistently evaluating the use of SEMS by preparing statutorily required after-action reports following all declared disasters. Also, OES has had difficulty in acquiring and maintaining emergency response equipment due to what it asserts is inadequate funding. Finally, our review of six county EOCs found that they had adequate plans and training to prepare for emergencies. However, OES's recent survey of all county EOCs reveals that some counties are in need of potentially costly upgrades to improve their ability to respond to emergencies.

Finding #1: OES has not established a formal process to regularly evaluate and update the emergency plan and related annexes.

Although we found that the emergency plan and related annexes adequately guide agencies to respond to emergencies, OES lacks a formal process to regularly evaluate and update these documents as necessary. OES indicates that previous emergency plan updates were made in 1959, 1984, 1989, 1998, and 2003. OES's review of the plan in 2003 was part of a federal effort to ensure that the emergency plan is current. When we asked whether OES regularly updates the emergency plan and related annexes, the director of OES's Planning and Technological Assistance Branch explained that they do not, but that they are updated when changes in state or federal laws impact emergency management, or when changes in regulations, policies, or significant procedures occur. Although OES has not established a formal process to regularly review the emergency plan and its related annexes, other states regularly update their plans so that they may incorporate lessons learned into their plans. Absent a formal and regular evaluation process for the emergency plan and its related annexes, the emergency plan and annexes may not reflect current practices or provide sufficient guidance during an emergency.

To ensure that the emergency plan and its related annexes are regularly evaluated and updated when necessary, we recommended that OES develop and follow formal procedures for conducting regular assessments of these plans to determine if updates are required.

OES Action: Partial corrective action taken.

OES indicates that it has drafted revisions to its Policies and Procedures Manual to address the need for a process to formally and periodically review the emergency plan. In conjunction with this effort, OES states that it has developed a checklist, which includes planning criteria from multiple state and federal publications, that will guide its efforts in updating the emergency plan in the future. OES plans to update this checklist with the development of the National Response Plan in order to assure state practices and plans are in concert with federal operations. OES plans to finalize its review procedures once the National Response Plan is approved.

Finding #2: OES has not consistently evaluated the use of the SEMS.

OES is missing important opportunities to identify and make improvements to SEMS. This is because OES fails to consistently and adequately prepare, or follow up on, the statutorily required after-action reports following declared disasters to incorporate lessons learned during proclaimed emergencies. OES also does not follow its own policies of maintaining SEMS through regular meetings of its SEMS advisory board and technical group—two user groups that are intended to review SEMS issues and make recommendations for improvement. Since SEMS establishes the organizational framework through which multiple agencies can jointly respond to an emergency, it seems reasonable to expect OES to take a more proactive role in ensuring that this critical element of California's emergency response effort is consistently evaluated for further improvements and enhancements.

To ensure that SEMS remains a workable method to respond to emergencies, OES should more consistently evaluate its use and identify areas of weaknesses and needed improvements. Specifically, OES should do the following:

- Institute internal controls to ensure it receives after-action reports from all responding entities to an emergency, such as requiring after-action reports prior to reimbursing local agencies for response-related personnel costs. Further, OES should ensure that the reports by local governments evaluate the use of SEMS for any needed improvements and enhancements.

- Prepare after-action reports after each declared disaster that review emergency response and recovery activities.

- Develop a system that tracks weaknesses noted in the after-action reports, which unit is responsible for correcting those weaknesses, and what corrective actions were taken for each weakness.

- Reconvene the SEMS advisory board and technical group to foster more communication on the use of SEMS, and to provide OES advice and recommendations on SEMS.

OES Action: Partial corrective action taken.

OES reports adopting policies and procedures for the development of after-action reports that address response actions taken; application of and compliance to SEMS; suggested modifications to SEMS; and plans and procedures, training needs, and follow-up recommendations. These policies require that the after-action report begin with an initial critique of successes and areas in need of improvement at each response level. OES requires these levels to prepare and submit after-action report survey forms, which serve as the basis for a comprehensive review. OES uses statewide forums of the emergency response community to address and develop the recommendations cited in the after-action reports. OES is also in the process of developing a database to track after-action report findings and resolutions. Further, OES states that it is in the process of re-convening the SEMS technical and advisory groups in order to revitalize the SEMS Technical and Maintenance System. Finally, OES completed the after-action report for the fall 2003 wildfire siege and is working on reports for two more recent disasters.

Finding #3: Data problems prevent OES from evaluating how well it coordinates resources during emergencies.

Inaccurate and missing data in its Response Information Management System (RIMS) prevents OES from evaluating how well it coordinates responses during emergencies. Because OES is not using RIMS to capture accurate mission approval times and resource arrival times, it lacks data to evaluate how well it coordinates emergency responses. Mission approval times are important because the faster OES approves a resource request, the faster resources are likely to arrive on scene. Our review of RIMS data revealed that 13 out of 27 sampled mission approvals were late, and we were unable to determine the resource approval time for two of the requests. Furthermore, our testing showed that RIMS users did not report resource arrival times for 24 out of 27 resource requests in our sample. If OES had this information, it could evaluate whether resources are arriving promptly to emergency sites while better tracking the resources tasked to emergencies.

We recommended that OES take steps to ensure that it can accurately track how long it takes to approve resource requests and pinpoint when those resources arrived at the emergency.

OES Action: Partial corrective action taken.

OES indicates that it plans to update the capabilities of RIMS in order to address our recommendations. In October 2003, OES held a meeting of its RIMS Working Group that agreed upon enhancements to the RIMS system, including the addition of a web portal that will contain all secure reports, data, and forms. OES also is integrating new protocols of the federal Department of Homeland Security into RIMS. While OES was able to obtain federal grant money to make various improvements to RIMS, numerous disaster response activities have delayed implementation. Further, OES indicates that it is awaiting Department of Finance approval of a RIMS special project report.

Finding #4: OES needs to ensure key staff are properly trained.

Citing a lack of funding, OES has not conducted a needs assessment to determine the training needs for management and workers that staff state and regional centers. OES has developed an individual training plan (training plan) program; however, OES had only developed training plans for seven of the 14 state center staff we reviewed. Although the training plan can be a useful tool, because OES does not use it for all state center staff and does not provide guidance to all supervisors preparing training plans, OES cannot ensure that all state center staff receive the training they need to effectively respond to emergencies.

To ensure that state agencies—including itself—are adequately prepared to respond to emergencies within the State, OES should determine the most critical training that emergency operations center staff, at state and regional levels, need in order to fulfill their duties, and then allocate existing funding or seek the additional funding it needs to deliver the training.

OES Action: Corrective action taken.

OES revised its training policies in June 2003, outlining the core competencies for all OES staff. OES maintains that the several activations of the State Operations Center and Regional Operational Centers have provided additional opportunities for appropriate on-the-job training. To further augment its training policy, OES has developed an internal working group to prepare an Emergency Operations Guide that will detail the agency policies and procedures for emergency operations.

Finding #5: Clarification of the roles and responsibilities of OHS and OES would be beneficial.

In February 2003, the governor established the Office of Homeland Security (OHS) within the Office of the Governor. Some of the responsibilities assigned to OHS by the executive order and to the director of OES appear to have the potential to overlap. For example, under the California Emergency Services Act, the director of OES is assigned the responsibility of coordinating the emergency activities of all state agencies during a state of war emergency or other state emergency, and every state agency and officer is required to cooperate with the director in rendering assistance. However, under the executive order, OHS is assigned the responsibility of coordinating security efforts of all departments and agencies of the State and the activities of all state agencies pertaining to terrorism-related issues, and is designated as the principal point of contact for the governor. Moreover, the director of OES is required to report to the governor through OHS, but that reporting function is not limited to issues related to state security or terrorism, and thus appears to require OES to make all reports to the governor through OHS.

To ensure the State is adequately prepared to address emergencies and to avoid misunderstandings, OHS should work with the governor on how best to clarify the roles and responsibilities of OHS and OES.

OES Action: None.

OES indicated that there have not been any formal changes that further define the relationship of OES and OHS. OES maintains that both agencies' roles and responsibilities should be viewed as a necessary partnership to manage the emerging threat of terrorism and homeland security issues, while also maintaining an all-hazards approach to emergency management.

Finding #6: Equipment concerns may impact OES's future ability to respond to emergencies.

OES has had difficulty acquiring and maintaining emergency response and communication equipment due to what it asserts is inadequate funding. Specifically, 26 percent of OES's active fire engines have been in service for longer than the 17-year useful life that OES has adopted. OES also has no heavy urban search and rescue vehicles, which help extricate people from collapsed structures, despite a statutory mandate to obtain these vehicles.

With aging equipment, and other equipment not in place, OES's ability to task its own resources during an emergency may be limited. OES has recently acquired sufficient funding to replace its aging fire engines and has taken steps to replace older fire engines, but its request for 18 heavy urban search and rescue vehicles was not funded. However, OES has not performed a current needs assessment to determine how many heavy urban search and rescue vehicles it needs in order to respond to an emergency within one hour, as required under statute.

Further, OES has not tried to establish the thermal imaging equipment-purchasing program required by law. OES's failure to take the statutorily required steps to establish this program may have denied local governments from taking advantage of an opportunity to obtain this equipment at a lower cost than they could obtain on their own. Finally, OES is facing a problem with its Operational Area Satellite Information System (OASIS), a satellite network that serves as a backup communications system, which is degrading and threatens OES's ability to coordinate with local governments should phone communications become disabled during a major emergency.

To ensure that it and local governments have the equipment to adequately respond to emergencies, OES should take the following actions:

- For its fire engine program, OES should continue with its schedule for replacing older and poor performing fire engines in the fleet.

- OES should perform a needs analysis to determine the number of heavy urban search and rescue units that are required to respond to a major earthquake. If this needs analysis concludes that additional units are required, OES should submit a budget change proposal to acquire this equipment, and it should develop a maintenance and replacement schedule for this equipment.

- OES should take the required steps to establish a thermal imaging equipment-purchasing program, including determining the interest among local governments in purchasing this equipment. However, if OES determines that it cannot identify funding sources to pay its share, OES should explore the use of the State's buying power to enter into a contract that allows local governments to purchase this equipment at a lower cost.

OES should study options to extend the life of or replace OASIS. However, if it concludes that OASIS should be replaced, OES should justify this replacement by demonstrating that maintenance costs are exorbitant and that OASIS is down for excessive periods for repair.

OES Action: Partial corrective action taken.

OES states that it has taken the following corrective actions regarding the recommendations above:

- OES indicates that 25 engines out of its current 111 fire engine fleet have been in service longer than their 17-year useful lives. To prevent an impact to public safety, OES has taken possession of 21 new engines that were purchased with prior year budget appropriations and that all of these engines have been assigned throughout the State. OES states that it is currently awaiting approval from the Department of Finance to award the bid for the next 21 replacement engines. If funds are available, OES intends to replace seven fire engines each year to comply with the 17-year replacement cycle.
- OES states that the costs for heavy urban search and rescue units have increased significantly, costing approximately $750,000 each. However, OES continues to evaluate its prior needs assessment in order to update where these units are needed.
- OES has chaired a meeting of fire representatives across the State to address the thermal imaging equipment program. OES plans to complete a survey in August 2004 to address the feasibility of a cost-shared participation in the program, further indicating that the technical specifications will be developed in September 2004. OES indicates that it is exploring all possible funding sources for this program, including federal grants.
- OES received $3.5 million in federal grant funds for the modernization of its OASIS system. This funding will cover final engineering and basic conversion to a modernized radio and information processing system. If future funding is available, OES intends to further improve OASIS by enhancing its connections to both the Public Switched Telephone Network and Internet.

FEDERAL FUNDS

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

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 . . .

REPORT NUMBER 2002-123.2, AUGUST 2003

Department of Finance response as of September 2004 and Health Services response as of July 2004

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: Corrective action taken.

Health Services says that in collaboration with the Department of Social Services it submitted to the Centers for Medicare and Medicaid Services in May 2004 an Independence Plus federal waiver application seeking to cover all In-Home Supportive Services residual services through Medi-Cal. As of July 2004, Health Services indicated that the application was undergoing review to determine which services could be approved.

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 undertook several initiatives to reduce spending on personnel. These included 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: Corrective action taken.

Control Section 4.10 of the 2003 Budget Act, approved by Governor Gray Davis in August 2003, required 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. Finance says that in implementing Section 4.10, federal fund appropriations were reduced by $16.4 million.

FRANCHISE TAX BOARD

Significant Program Changes Are Needed to Improve Collections of Delinquent Labor Claims

Audit Highlights . . .

Our review of the Franchise Tax Board's (board) collection activities in connection with delinquent fees, wages, penalties, costs, and interest (claims) referred by the Department of Industrial Relations (Industrial Relations) found the following:

- ☑ *The board's success in generating collections for these claims is limited—our analysis of 310 claims filed in fiscal years 2001–02 and 2002–03 shows that Industrial Relations received payments on only 20 percent of them.*
- ☑ *Further, our review of 60 claims shows that, as of February 2004, the board has taken an average of almost 18 months to process these claims, and it still has not completed processing many of them.*
- ☑ *The board conducted two studies to improve its collection activities, by automating its system, however, the board abandoned the project after realizing it would not receive the additional funding to implement the changes.*
- ☑ *Although state law requires Industrial Relations to adopt rules and regulations to charge the employer a fee to cover the board's collection costs, it currently does not do so.*

REPORT NUMBER 2003-131, MAY 2004

Responses of the Franchise Tax Board and the Department of Industrial Relations as of November 2004

The Joint Legislative Audit Committee requested that the Bureau of State Audits review the Franchise Tax Board's (board) collection activities in connection with delinquent fees, wages, penalties, costs, and interest (claims) that the Department of Industrial Relations (Industrial Relations) referred to it. Many of the claims that Industrial Relations refers to the board involve an employer owing a wage earner unpaid wages; if Industrial Relations collects those wages, it passes them on to the wage earner.

Finding #1: The board's success rate in collecting money on Industrial Relations claims is limited.

We analyzed 310 Industrial Relations claims filed in fiscal years 2001–02 and 2002–03 and found that the board collected only 20 percent of them. The board often takes a significant amount of time to process these claims, and we believe it could be more successful if it responded more promptly to the cases Industrial Relations refers. The board took an average of over a year to process these 310 claims. Furthermore, our review of a sample of claims selected to determine where the delays occur in processing suggests that the board's process takes even longer, with the processing of 60 claims averaging almost 18 months by the end of February 2004, and many are still not completed.

Our review of the amount of time involved between the individual steps of the claim collections process found that a significant delay occurred after the board issued the demand-for-payment notice to the employer. Although the board's policy is to generate an order to withhold within 30 days after issuing the demand-for-payment notice, the board does not always follow its policy. We found that the board took an average of 277 days to generate an order to withhold.

According to the board's program manager, before issuing an order to withhold, her staff must engage in several time-consuming manual searches. The senior compliance representative who processes the claims must first locate a valid identification number, either a Social Security number if the employer is an individual or a federal employer identification number if the employer is a business. If Industrial Relations does not provide this information, board staff locate the number by searching several state databases, including those of the Department of Motor Vehicles, the Employment Development Department, and the Office of the Secretary of State. According to the program manager, the senior compliance representative then uses this number to search for banks located in the area surrounding the employer's place of business and to send them an order to withhold. If this search fails, the board returns the claim to Industrial Relations.

According to the board's program manager, the process for collecting claims could be expedited if Industrial Relations provided full and accurate identifying information such as a Social Security number, a federal employer identification number, a driver's license number, and any known bank information for the employer's business. We believe that Industrial Relations has the best opportunity to obtain this information when mediating a wage claim between the wage earner and employer. Because Industrial Relations has direct contact with employers during the initial stages of mediation, it can more easily collect this information at that time and pass it on to the board to speed up the collection process.

We recommended that to ensure the board has the information it needs to process each claim as promptly as possible, Industrial Relations should attempt to obtain more complete identifying information from the employer during its mediation process and provide this information to the board when referring any claims for collection. This information should include the employer's Social Security number or federal employer identification number, driver's license number, and any known bank information related to the employer's business.

Industrial Relations Action: None.

Industrial Relations indicated that whenever possible, its staff attempts to obtain information. However, Industrial Relations believes it does not have the authority to require employers to provide the information.

Finding #2: Industrial Relations does not monitor claims it has sent to the board.

Even though the board is authorized to collect delinquent fees, wages, penalties, costs, and interest (claims), Industrial Relations retains the responsibility for managing the claims at all times. The assistant chief labor commissioner told us, however, that Industrial Relations does not monitor these claims' status after sending them to the board and even closes the claims in its database. It would seem appropriate and useful for Industrial Relations to require the board to provide some type of status report on individual claims during the time the board is processing them. With this type of information, Industrial Relations could monitor the amount of time the board takes to process claims and could discuss its concerns with the board when the delays seem excessive. Currently, however, Industrial Relations does not monitor these claims' status. It provides the board with funds to pay for the salary and other administrative costs of only the one employee assigned to process these claims. Additionally, Industrial Relations was unable to provide the board with funding to fully automate the system that processes these claims, which the board believed would allow claims to flow through the system in a more expedient manner, thus allowing for better management of the workload and possibly an increase in collections.

To monitor the amount of time the board takes to process claims and discuss any concerns when the delays seem excessive, we recommended that Industrial Relations require the board to periodically provide it with a status report on individual claims.

Board Action: Corrective action taken.

The board stated that it provided Industrial Relations a report on the backlog of cases in October 2004 covering inventory from July through September 2004. In January 2005, the board plans to submit the next report covering October through December.

Industrial Relations Action: Pending.

Industrial Relations indicated that it will conduct regular meetings with the board to discuss problems and to resolve any issues as they arise.

Finding #3: The board and Industrial Relations abandoned a project that would improve their collection process.

Although the board's general fund and the Department of Motor Vehicles provided funds to automate two other collection programs, its collection of delinquent child support payments and vehicle registration fees, the board still manually inputs the claims that Industrial Relations refers to it into the Non-Tax Debt Consolidated Debt Collections system. Automated systems both speed up the process and use fewer staff to generate more dollars collected. Between 2001 and 2002 the board conducted two studies—a program proposal and a feasibility study—to improve its collection activities, decrease the substantial backlog in claims, and possibly increase resulting revenues. However, after realizing that it would not receive additional funding to implement the changes these would require, the board abandoned the project.

Three other states we reviewed operate similar collection programs and currently have or are working on implementing some level of system automation. One of these states retains a percentage of the amount collected on behalf of the wage earners to cover its own collection costs and the costs of sending the claims to a collection agency. We believe that charging employers a fee for the board's collection services is consistent with the language authorizing the board's collection activities and would clearly benefit California's wage earners, as well as the State.

We recommended that if the administration is unwilling to provide the additional resources needed to ensure that the board processes claims from Industrial Relations more promptly, Industrial Relations should consider taking the following actions:

- Adopt rules and regulations to charge a fee, as state law requires, to employers that delay paying their claims; the board and Industrial Relations could use such funds to automate the current system and increase staffing levels as needed.

- Prepare a cost analysis to determine the appropriate fee to charge employers that delay paying their claims.

Further, we recommended that if the board and Industrial Relations automate the current system and increase staffing levels, Industrial Relations should periodically resubmit unpaid claims for processing.

Board Action: Partial corrective action taken.

The board stated it submitted a request to Industrial Relations to increase the amount of funds allocated to the program for the fiscal year 2004–05 contract. The request consisted of several staffing options and funding needed to automate the program. According to the board, Industrial Relations approved the option to increase staffing by adding two temporary employees. The board stated that Industrial Relations also offered to loan the board one additional staff to enter cases into the board's automated system. The board indicated that it is currently exploring the details of this option, as well as other automation options. Finally, the board plans to continue to work with Industrial Relations to explore various methodologies to assist Industrial Relations in adding collection fees to accounts placed with the board.

Industrial Relations Action: Pending.

Industrial Relations indicated that it recognizes it must adopt a regulation to allow the board to charge a fee. In addition, Industrial Relations is prepared to begin the process of adopting a regulation as soon as it can obtain from the board, its estimate of the amount of the fee that will be required to automate the system and reimburse the board for its costs associated with collection activities.

FRANCHISE TAX BOARD

Its Performance Measures Are Insufficient to Justify Requests for New Audit or Collection Program Staff

Audit Highlights . . .

Our review of the Franchise Tax Board's (board) audit and collection activities revealed the following:

- ☑ *The board does not always describe the differing cost components of its various performance measures, potentially leading to confusion about program results.*
- ☑ *Between fiscal years 1998–99 and 2001–02, recently acquired audit staff returned $2.71 in assessments for each $1 of cost.*
- ☑ *Because of limitations in board data, we could not isolate the return on 175 new collection program positions.*
- ☑ *The board's process for assessing the incremental benefit of recently acquired audit and collection program positions is flawed.*
- ☑ *The board allows some collection program positions to remain unfilled in order to pay for other expenses.*

REPORT NUMBER 2002-124, MAY 2003

Franchise Tax Board response from the State and Consumer Services Agency as of May 2004

A primary revenue-generating agency for the State, the Franchise Tax Board (board) processes individual and corporation tax returns, audits certain tax returns for errors, and collects delinquent taxes. Between fiscal years 1990–91 and 2001–02, the board provided an average of $31 billion in annual tax revenues to the State, over 60 percent of the State's General Fund. Although many taxes are self-assessed by individuals and companies, the board's audit program reviews the accuracy of tax returns, assessing additional taxes when appropriate. In turn, the collection program pursues delinquent taxpayers identified through the board's various assessment activities.

The Joint Legislative Audit Committee requested that we review the board's audit and collection programs, identifying recently acquired audit and collection program positions, assessing the board's calculation of the costs and benefits of these positions, and determining whether the board uses these positions as the Legislature intended. We were also asked to review the board's methodology for calculating the costs and benefits of its audit and collection programs. Finally, we were asked to determine whether a point of diminishing returns exists where additional audit and collection program positions do not generate a $1 to $5 cost-benefit ratio (CBR) and, if so, to determine the board's actions to shift those positions to other activities. We found that:

Finding #1: The board uses a variety of performance measures and does not always describe their differences in public documents.

The board uses a variety of measurements to gauge audit and collection program performance and to assign workloads to staff. Most of these measurements take into account some of the costs and related benefits for program activities, but the various measurements may include differing calculations of costs, which the board does not always fully describe in public documents. As a result, misunderstandings of the board's performance may arise. Ideally, a performance measure should compare all the benefits of a program with all the costs of producing them. However, when the board's budget documents project a return of at least $5 in benefits, whether assessments or revenues, for each $1 of cost for new positions, the projected return does not reflect allocated costs for departmental overhead, such as rent and utilities, and the understated costs are not disclosed. In contrast, the historical measures reported in the board's annual operations reports are calculated using full costs.

The board's performance measures for its audit and collection programs also suffer from a partial overlap in claimed benefits, another potential source of confusion about returns on costs. After 120 days, tax assessments the audit program claims as benefits become the collection program's accounts receivable, which, if collected, are also counted as benefits of the collection program.

To more completely and clearly reveal its programs' costs and benefits, the board should consider using the complete measurement of the audit program's performance that we have described in our report. This measurement compares all the benefits—the total revenues that result over time from the auditors' assessments of additional taxes—with the total costs to produce them, including the costs of collection. If it determines that its current information system cannot produce the data necessary for such a measurement, the board should consider the needs of a complete measurement when it upgrades or changes its current information system.

If the board decides not to use the complete measurement and continues to use separate performance measurements for the audit and collection programs, in budget change documents and other reports given to external decision makers, it should:

- Explicitly disclose the elements not included in the cost components of various performance measures used to assess the audit and collection programs and the effect of their absence.

- Disclose the overlap in benefits claimed by its audit and collection programs.

Board Action: Partial corrective action taken.

The board reports that it has developed and deployed an enterprise Activity Based Costing (ABC) tool, which provides information on the costs to perform various processes and business activities. The ABC model includes both direct and indirect processes and activities, which contribute toward the board's programs, including programs that provide revenue to the state. The ABC model enables the board to calculate the "cost" element of the CBR. The board states that it is using the foundation of this model to link the cost of work to the revenue generated. With newly added "revenue streams," the board reports that it will be able to more completely measure program performance—that is, the total cost and total revenue by programs such as the audit and the filing enforcement programs.

The board states that to add revenue to the ABC model, it is initially using revenue stream data from existing fiscal year 2002–03 data sources in order to produce test performance measures. These test performance measures will be evaluated, and recommendations for improvements for fiscal year 2003–04 data collection will be developed. Furthermore, the board is analyzing changes required for existing information systems to produce the data required for a complete measurement for use in the ABC model, and will make recommendations for future changes. Long term, the board expects to use the ABC model to produce meaningful return-on-investment data that, along with other enterprise performance measures, can facilitate decisions about the best use of available resources.

Finally, the board reports that it has begun to provide clarification to performance measures reported to external decision makers. The board plans to continue this practice in future communications.

Finding #2: Prospective cost-benefit ratios for individual audit types do not reflect historical performance.

The board's historical performance measure of returns on its audit program includes the full effect of indirect costs, including departmental overhead, but the prospective CBRs for individual audit types do not. Thus, when full departmental overhead costs are taken into account, certain prospective CBRs drop below the anticipated return of $5 in assessments generated for every $1 of cost.

When we deflated the board's projected returns by actual departmental overhead costs, we found that had the board included full departmental overhead costs, the total actual return in assessments would closely resemble the board's projections. However, when we examined individual audit types, the variance was much greater, and the workplan projections failed to mirror historical returns. For example, the average assessment per $1 invested in personal income tax desk audits over the period was $3.87, whereas the board estimated that they would return $6.36. Even after deflating the workplan projections by departmental overhead costs, actual assessments per dollar of cost were still $1.75 less than originally projected.

The board believes that these differences generally arise from adjustments the audit program makes to historical data ultimately reported in operations reports. According to the board, the adjustments are made to correct misallocated charges and miscoded revenue and to better match costs to benefits. If the audit program corrects errors in the financial reporting system when it recalculates the basis for projections, we would expect that the board would use the corrected data in the operations reports, which it publishes after it prepares the workplans.

If the board believes that information it publishes in its operations reports is not accurate, even though it is based on the board's financial accounting system, the board should:

- Ensure that its financial accounting system reports accurate information, and

- Correct data it believes to be inaccurate before it publishes the information in its operations reports.

To track the accuracy over time of its calculations of the prospective CBRs for individual audit workload types, the board should compare these prospective CBRs against actual returns annually. The board should make the results available to Finance and the LAO and should also include them in the board's annual report to the Legislature on the results of its audit and collection activities. If the board believes this information is confidential, it can cloak the identity of the individual audit workloads in its annual report to the Legislature. Moreover, the board should use the results of the comparison in future calculations of prospective CBRs.

Board Action: Corrective action taken.

The board states that it is continuing to review the methods of gathering data for its operations reports. It reports that it is currently examining revenue as reported by one of its major taxpayer information systems. The board is working with system staff to more accurately capture the revenue from audit and filing enforcement activities. The board states that this has included rewriting system design documents as they relate to revenue, and working with staff to ensure the accuracy of the reporting of revenue. With respect to cost issues, the board reports that it is looking to use ABC to better link the costs and the activities.

The board further reports that it has compiled initial costs and benefit information for its current workplan process and has made this preliminary information available to both Finance and the LAO. The board states that it is continuing its analysis to perfect these initial computations to ensure that the cost components within the CBRs are accurate and attributed to the correct workloads. The board plans to use this information as one of several factors in its calculations of projected CBRs.

Finding #3: The board's budget change documents do not show how new audit positions have met projected results.

Although the board's current resource request format for new audit positions provides decision makers with more detail regarding audit workloads than the board typically provided prior to our 1999 report titled *Franchise Tax Board: Its Revenue From Audits Has Increased, but the Increase Did Not Result From Additional Time Spent Performing Audits,* its current format is still insufficient to demonstrate both the workload types to which the board intends to assign new staff and the historical return

on those workloads. In addition, historical actual returns on the specific workloads are not measured against the projections used to justify the staff increases.

While the board's resource request format does include many of the features we previously recommended, it does not detail historical and projected hours and assessments by audit type as we had suggested. Rather, the board summarizes all desk, field, and Internal Revenue Service follow-up audit activity into a single category, which obscures the very different returns on each of the personal income tax and corporation tax audit types. Without this information, decision makers are left without an accurate tool against which to measure whether the board's staffing increases return their projected assessments.

To provide useful information to decision makers when requesting additional audit positions, the board should use a format, shown in our 2003 report, that details the types of activities new auditors will perform as well as the projected assessments and historical assessments resulting from these activities. Additionally, the board should revise its supporting audit workplan to include the actual returns of each of the specific workload types for the most recently completed fiscal year.

Board Action: Corrective action taken.

The board reports that if it requests additional audit positions it will continue to adhere to the specific budget instructions provided by Finance for the establishment of new positions. This would include any information Finance may require in its review of any audit position request including an analysis of the work to be performed by the new auditors and the associated assessments to be derived. In addition, the board reports that it has modified its supporting audit workplans for both the current and budget year to include the actual returns of each of the specific workload types that are currently being performed. The board states that the confidential backup detail to the summary workload matrix is available to Finance or the LAO upon request and will include historical CBR information for each workload type. Finally, the board reports that in November 2003 it met with Finance staff and they accepted these changes to the CBR matrix.

Finding #4: The incremental benefit of new audit positions was originally negative but has increased recently and measuring the incremental benefit of additional collection program staff proves elusive.

Although sufficiently demonstrating the overall cost-effectiveness of its audit and collection programs, the board's process for assessing the incremental benefit of recently acquired audit and collection program positions is flawed. The board uses an inadequate methodology to determine whether increases in audit assessments or collection program revenues resulted from additional positions. Rather than using an incremental approach to isolate assessment or revenue pools likely to have been affected by additional audit or collection program positions, the board compares its total projected audit assessments against its total actual audit assessments and its total projected collection program revenue against its total actual collection program revenue.

To determine the incremental benefit of the 340 net new audit positions between fiscal years 1992–93 and 2001–02, we isolated their budgeted costs and the actual assessments associated with the audits to which the board would have likely assigned the new staff. We found that the new audit positions generated average assessments of only $0.79 for every $1 of cost. It is important to note that the return on the additional positions shows improvement over more recent fiscal years. Between fiscal years 1998–99 and 2001–02, the new positions produced average assessments of $2.71 for every $1 of cost. Changes in the economy probably affected the return on these audit positions, but a significant cause of the low return is that despite having additional staff, the board did not increase the number of hours staff spent performing audits. The collection program received 175 positions between fiscal years 1998–99 and 2001–02, promising increased revenue of $179 million over that period. However, because of limitations in board data, we could not determine the return on the collection program positions.

See the recommendation under finding #3 above for addressing the measurement of the effectiveness of additional audit positions. To better measure the effectiveness of its additional collection positions, the board should develop a methodology for determining the incremental return of new collection program positions received in any given year. This type of analysis should isolate changes over a base year in revenue pools that are affected by the new positions and compare the resulting revenue against all costs resulting from the new positions.

Board Action: Corrective action taken.

The board reports that it has tested and evaluated a refined methodology for measuring the effectiveness of manual collection efforts. Specifically, the board created a conceptual framework for measuring inputs in terms of time expended by direct collection staff and support staff, and matching the results in terms of dollars collected. The board states that it has populated this model, conducted testing, and implemented it within its manual collection process. The board states that the model allows it to establish a base year for comparison with subsequent year's results. The board reports that it has validated the accuracy of the data gathered to date. However, the board states that because of the three-year duration of the collection lifecycle, the revenue stream will not be fully populated until this period has elapsed for accounts paid incrementally.

Finding #5: The board's justification for new collection program positions does not reflect its current process for assigning work.

Unlike the audit program, which both justifies new positions and assigns work based on a workplan process that prioritizes work according to a CBR, the collection program currently uses a similar workplan process only to justify its increases in collection program positions. In actually assigning work, the board relies on the recently implemented Accounts Receivable Collection System (ARCS) to rank accounts according to various risk and yield factors that predict the likelihood of collection as well as the ultimate amount the system expects to collect. According to the director of the board's special programs bureau, now that the collection program has nearly two years of collecting experience using ARCS, analysis is under way to use data from the system to justify future staffing needs.

To more accurately represent how it actually allocates resources, the collection program should continue to develop a methodology based on ARCS for justifying future collection program positions. The revised process should include all relevant costs, including an allocation for departmental overhead, in addition to the ARCS' risk and yield factors. The estimated expenditures and projected revenues related to each new staffing request should be easy to compare against actual results.

Board Action: Partial corrective action taken.

The board reports that the workload tracking and revenue assignment methodology discussed above will complement the process used to project potential revenue from new collection positions that may be added in the future. Furthermore, the board states that the new reporting methodology was implemented on a limited basis in January 2004, and will continue to be implemented throughout the collection program in a phased approach over the next 12 to 18 months.

Finding #6: The board leaves some approved collection program positions unfilled.

The board is not using all of its funding for collection program salaries to actually fill authorized positions, but is instead using some funding for other costs. Periodically, the board rewards employees for meritorious performance through pay increases, or merit salary adjustments (MSA), above the initial salary funding for their positions. Before fiscal year 1999–2000, the board received budget augmentations to fund its MSAs, but beginning in fiscal year 1999–2000, the board's MSA funding ended. The difference between the total hours collection program staff worked and the total budgeted hours for the collection program increased by 5 percent shortly after the board lost its separate funding for MSAs.

Since the loss of separate MSA funding, the board has required each branch to achieve savings to pay for the branch employees' MSAs, allowing them to realize the savings from unfilled positions. The board believes state departments must leave positions vacant or they will overspend their salaries and wage budgets. However, Government Code, Section 12439, requires that positions that are continuously vacant for six months be eliminated and Finance recently began eliminating those positions in state departments.

For the board to be consistent with the intent of budget control language and Finance, it should not, as a long-term strategy, leave collection program positions unfilled beyond the normal time it takes to fill a position.

Board Action: Corrective action taken.

The board reports that it conducted a department-wide redeployment process to meet mandated budget cuts. As a result, the board contends that the vacancy rate for the collections program is at a historic low—less than 4 percent. The board also states that it is determined to fill vacancies as quickly as possible, but is sometimes prevented from achieving this goal by constraints that include meeting mandated salary savings, and because budget authority for new positions is often delayed due to the legislative cycle and budget constraints. To counteract these constraints in future hirings, the board plans to request position effective dates that more accurately reflect new hire start dates.

WORKERS' COMPENSATION FRAUD

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

Audit Highlights . . .

Our review of the State's program to reduce workers' compensation fraud revealed that:

- ☑ *Although employers are assessed annually to pay for efforts to reduce fraud in the workers' compensation system—an amount that has averaged about $30 million per year for the past five years—the Fraud Assessment Commission (fraud commission) and the insurance commissioner have not taken steps to measure fraud in the system or develop a statewide strategy to reduce it.*
- ☑ *Neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system.*
- ☑ *Shortcomings also exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.*

continued on next page . . .

REPORT NUMBER 2002-018, APRIL 2004

Department of Insurance, Department of Industrial Relations, and Fraud Assessment Commission responses as of October 2004

Section 1872.83 of the Insurance Code (Chapter 6, Statutes of 2002), requires the Bureau of State Audits (bureau) to evaluate the effectiveness of the efforts of the Fraud Assessment Commission (fraud commission), the Department of Insurance Fraud Division (fraud division), the Department of Insurance (Insurance), and the Department of Industrial Relations (Industrial Relations), as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and employers willful failure to secure workers' compensation benefits for their employees.

Finding #1: The fraud commission and the insurance commissioner cannot be certain that fraud assessment funds are effectively used to reduce fraud.

The California Constitution authorizes the Legislature to create and enforce a workers' compensation system that requires employers to compensate workers for job-related injuries and illnesses. Employers must pay for these benefits to injured workers either by purchasing workers' compensation insurance from an insurer or directly through self-insurance. The total cost of California's workers' compensation system has more than doubled recently—growing from about $9.5 billion in 1995 to about $25 billion in 2002—giving rise to sharp increases in employers' workers' compensation insurance premiums and prompting several efforts to reform various aspects of the system. Some of these reform efforts have been targeted at combating the fraud alleged to exist in the workers' compensation system, including fraud perpetrated by workers, medical and legal providers, insurers, and employers.

- ☑ *Industrial Relations has not implemented three statutory programs intended to identify and prevent workers' compensation fraud.*
- ☑ *The formulas the Department of Industrial Relations (Industrial Relations) uses to calculate and collect the workers' compensation fraud assessment surcharges have, in recent years, consistently resulted in insured employers being overcharged.*
- ☑ *Although Industrial Relations suspects that some insurers do not report and remit all of the fraud assessments they collect from employers, it states it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessments they collect from employers.*
- ☑ *Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys.*
- ☑ *The fraud division does not facilitate an effective system to obtain referrals of suspected fraud from insurers and other state entities involved in employment related activities.*

One of the reform efforts, Senate Bill 1218 passed in 1991, created an annual assessment collected from employers and paid into a fund dedicated to increasing the investigation and prosecution of fraud in the workers' compensation system. This legislation also established the fraud commission, which is responsible for determining the annual assessment after considering the advice and recommendations of the fraud division and the insurance commissioner.

However, neither the fraud commission nor the insurance commissioner has acted to ensure that the assessments employers pay are necessary or are put to the best use for reducing the overall cost that fraud adds to the workers' compensation system. Specifically, no meaningful steps have been taken to measure the extent and nature of fraud in the system. Instead, the fraud commission, the insurance commissioner, and the fraud division rely primarily on anecdotal testimony from stakeholders in the workers' compensation community, unscientific estimates, and descriptions of local cases involving fraud included in county district attorneys' applications for antifraud program grants. According to the fraud division chief, lacking the necessary resources and expertise, the fraud division cannot measure the extent and nature of fraud in the workers' compensation system or determine the effectiveness of activities to deter it.

Additionally, neither the fraud commission nor the insurance commissioner has made a meaningful effort to establish baselines for measuring the current level of fraud and gauging future changes in that level. If baselines were available, it would be possible to systematically and periodically measure the level of fraud, using available data, to determine the effectiveness of programwide strategies in reducing fraud in the workers' compensation system. Instead, the fraud division collects and publishes discrete statistics showing the number of investigations, arrests, convictions, and restitutions; revealing only that some sources of fraud may have been removed, not whether antifraud efforts are cost-effective—that is, whether they have reduced the overall cost that fraud adds to the system by as much or more than what is spent annually to fight it.

We recommended that to better determine the assessment to levy against employers each year for use in reducing fraud in the workers' compensation system, the fraud commission and the insurance commissioner should direct the fraud division to measure the nature and extent of fraud in the workers' compensation system. To establish benchmarks to gauge the

- ☑ *The fraud division's special investigative audit unit lacks a program that effectively targets insurers to achieve maximum compliance with suspected fraud reporting requirements, a standardized approach to conducting audits, timely reports and follow-up, and effective penalties to promote compliance.*
- ☑ *Improvement is needed in sharing information between the Industrial Relations and the fraud division to identify potential workers' compensation fraud.*

effectiveness of future antifraud activities, these measures should include analyses of available data from insurers and state departments engaged in employment-related activities, such as Industrial Relations and the Employment Development Department. In addition, the insurance commissioner should consider reactivating an advisory committee comprising stakeholders focused on reducing fraud in the workers' compensation system to contribute to the data analyses, provide input about the effects of fraud, and suggest priorities for reducing it. This advisory committee should meet regularly and in an open forum to increase public awareness and the accountability of the process.

Insurance Action: Pending.

Insurance reports that it is preparing a research plan to determine the nature of fraud within the workers' compensation insurance system. This plan will address emerging trends in fraud schemes and the return-on-investment of the anti-fraud program in California.

Fraud Commission Action: None.

The fraud commission did not submit the six-month response to our report that was due on October 29, 2004.

Finding #2: The fraud commission and the insurance commissioner have no overall strategy for using funds assessed against employers to most effectively and efficiently reduce fraud in the workers' compensation system.

Such a strategy could be translated into the goals and objectives, priorities, and measurable targets that state and local entities involved in fraud reduction efforts need to work effectively. These systemwide goals and priorities could be broken down into regional elements to accommodate any unique regional fraud problems. Having a measured level of fraud and a strategy for combating it could provide the fraud commission with criteria to use in arriving at the appropriate assessment to be paid by employers each year and in allocating the fraud assessment funds to state and local entities that are considered most effective in the efforts to reduce fraud. As a result, the fraud commission has limited authority to hold the fraud division or local district attorneys accountable for their antifraud efforts.

To assure California's employers that their fraud assessment has been used effectively to reduce the amount of fraud and thereby reduce the overall cost of the workers' compensation

system, the fraud commission and the insurance commissioner need (1) a systematic effort to measure the extent of workers' compensation fraud in the system and the types of fraudulent activities most responsible for driving up premiums, (2) an overall strategy to combat them, and (3) a means to periodically evaluate the effectiveness of the efforts (at both the State and local level) to reduce the occurrence of those types of fraud. Neither the fraud commission nor the insurance commissioner has met these three requirements. Simply put, they cannot justify the amount employers are assessed each year to combat fraud. According to some members of the fraud commission, one of the motivations behind the chosen funding level is to levy an assessment that allows both the fraud division and county district attorneys to maintain their current effort in pursuing workers' compensation fraud. However, at the December 2003 meeting to determine the fiscal year 2004–05 aggregate fraud assessment, one member of the fraud commission voiced her concern that the commission was voting without enough information to make an informed decision.

We recommended that once the nature and extent of fraud in the system has been identified, the fraud commission and the insurance commissioner and his staff should design and implement a strategy to reduce workers' compensation fraud. The strategy should be systemwide in scope and include objectives, priorities, and measurable targets that can be effectively communicated to the fraud division and the county district attorneys participating in the antifraud program. Efforts to achieve the strategy targets should be both a condition for receiving awards of fraud assessment funds and a measure of how well the fraud division and the county district attorneys pursue the systemwide objectives. The strategy should clearly define the roles and responsibilities of the participants in antifraud activities.

In addition, we recommended that the fraud commission take the following steps to gather the information it needs to determine the annual amount to assess employers to fight fraud in the workers' compensation system:

- Revamp its decision-making process so that it includes the best information available, including (1) the results of Insurance's analyses of the nature and extent of fraud in the workers' compensation system, once they are completed; (2) analysis of the effectiveness of efforts by the fraud division and district attorneys in the prior year to reduce fraud in accordance with their respective antifraud program objectives; and (3) any newly emerging trends in fraud schemes that should receive more attention.

- Request an annual report from the fraud division that outlines (1) its objectives from the prior year that are linked to measurable outcomes and (2) its objectives for the ensuing year, together with estimates of the expenditures the fraud division needs to make to accomplish those objectives.

- Request, in addition to the information currently required of each county district attorney planning to participate in the antifraud program, a report listing the district attorney's accomplishments in achieving the goals and objectives outlined in the prior year's application and the goals and objectives for the ensuing year. The report should also include the estimated cost of the grant year's activities to achieve the district attorney's goals and objectives and a description of how those goals and objectives align with the program goals described by the fraud commission and the insurance commissioner.

If the fraud commission believes that altering the funding formula from the statutorily required levels—under which 40 percent of fraud assessment funds are automatically awarded to both the fraud division and the district attorneys—would increase accountability over the use of antifraud program funds, we recommended that the fraud commission encourage legislation that would allow it more discretion in how these funds are distributed.

Insurance Action: Pending.

Insurance reports that it has been working to develop a strategy to improve the efficiency, consistency, and accountability in the decision-making process. Together with the fraud commission and district attorneys it will work to provide the best information available on reported fraud and trends, continue with round-table discussions pertaining to anti-fraud efforts, and make adjustments to program objectives focused on reducing fraud.

In addition, Insurance reports that it has formed a Performance Measurement Committee (committee) with representatives from the department, county district attorneys, and the fraud commission. The committee met four times during 2004 and reviewed the current request for grant fund application, district attorney program reports, and the workers' compensation grant review score sheet. The committee's recommendations to change these forms will be forwarded to the insurance commissioner. Insurance also reported that it planned to meet in November 2004 to discuss topics that included performance

measurements for the workers' compensation antifraud program, legal issues and opinions, suspected fraud referral standards, proposed regulations for special investigative units, and other regulatory changes.

Insurance reports that it will work closely with the fraud commission so that its vision, objectives, and priorities align with the insurance commissioners' strategic initiatives. To provide information to the fraud commission, the division commenced an analysis of its anti-fraud program for fiscal year 2003–04 to review its achievements and establish a benchmark for future comparisons. The division will outline its planned objectives and expenditures for fiscal year 2004–05 and present them to the fraud commission to be used in funding allocation decisions.

Insurance reports that it intends to amend the regulations relevant to grants of anti-fraud funds and will be presenting future guidelines to the fraud commission that focus on district attorney performance, past and future. The majority of counties that applied for fiscal year 2004–05 funding identified goals, objectives, anticipated expenses, and program accomplishments for fiscal year 2003–04.

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our report.

Finding #3: Shortcomings exist in the process used to distribute fraud assessment funds to county district attorneys in a way that maximizes their effectiveness in fighting fraud.

A review panel comprising fraud commission members, representatives of the fraud division and Industrial Relations, and an independent criminal expert makes recommendations to the insurance commissioner regarding how to allocate fraud assessment funds to district attorneys who have applied for grants. In making its recommendations, the review panel evaluates grant applications and uses the recommendations it receives from fraud division staff who also conduct a review of the grant applications. However, both the fraud division and the review panel fail to consistently apply criteria or document the rationale they use in making funding recommendations. Rather, each review panel member uses a personal, subjective set of criteria when developing recommendations for grant awards, without retaining any evidence of the basis of any decision.

Further, the panel members do not share their decision-making criteria or rationale with the district attorneys or with other review panel members. Nor does the fraud division retain documentation showing the reasoning it used to arrive at its funding recommendations to the review panel. As a result, neither the review panel nor the fraud division staff can provide evidence justifying their decisions to recommend specific grant awards, leaving the process open to the perception that it may not be equitable. Finally, the review panel did not always comply with open-meeting requirements when developing funding recommendations.

To better ensure that fraud assessment funds are distributed to district attorneys so as to most effectively investigate and prosecute workers' compensation fraud and increase their accountability in using the funds, we recommended that the fraud commission and the insurance commissioner take the following steps:

- Develop and implement a process for awarding fraud assessment grants that provides for consistency among those making funding recommendations by incorporating standard decision-making criteria and a rating system that supports funding recommendations.

- Include in the decision-making criteria how well county district attorneys' proposals for using fraud assessment funds align with the strategy and priorities developed by the fraud commission and the insurance commissioner, as well as the district attorneys' effectiveness in meeting the prior year's objectives.

- Document the rationale for making decisions on recommendations for grant awards.

- Change the past policy of awarding the base portion of fraud assessment grants to county district attorneys exclusively on whether they submit a completed application by required deadlines and instead, make recommendations for total grant awards, including the base allocations, on evaluations of county district attorneys' plans that include how they will use the funds, as required by Insurance regulations.

- Continue current efforts to establish performance measures to use in evaluating the effectiveness of the fraud division and participating district attorneys in reducing workers' compensation fraud. The measures can also assist in determining recommendations for grant awards to the county district attorneys and the fraud division.

- Determine whether the Bagley-Keene provisions apply to the review panel's meetings to recommend fraud assessment grants to county district attorneys and, if they do, seek a specific exemption for discussions of portions of the county district attorneys' applications for grant awards that include confidential criminal investigation information. All other parts of these meetings should remain open to the public.

Insurance Action: Partial corrective action taken.

Insurance reports that it will adopt amended regulations that base grant awards on measurable performance criteria.
Insurance reports that during the July 2004 Workers' Compensation Review Panel (review panel) hearing, the panel strived for a greater level of consistency and clarity. The panel required applicants to explain and justify the data forming the basis for their grant requests and to state their strategic objectives relative to those articulated by the insurance commissioner. Insurance and the review panel could make only limited criteria modifications during this funding cycle to ensure alignment of district attorney proposals for the use of grant funds with the insurance commissioner priorities because regulations need to be amended to make significant changes.
During an August 2004 hearing, the insurance commissioner articulated his priorities for the anti-fraud program as high impact cases involving providers and employer failures to appropriately secure workers' compensation coverage, allocating funds based on performance, building effective partnerships with state and local agencies, and addressing bureau recommendations.
However, although three fraud commissioners articulated their priorities, as of October 29, 2004, the fraud commission as a whole has not articulated its official strategies and priorities for the program.
Insurance reports that it is evaluating comments and recommendations regarding the funds allocation process from the review panel and its committee to incorporate them into the appropriate standardized criteria for allocating funds to be included in amended regulations.

Insurance Action: Pending.

Insurance reports that the division is working to develop a business plan that will align with Insurance's vision, goals, and strategic initiatives, and acknowledges it needs to address performance measures for both investigations and prosecutions within its business plan and will be working with the fraud commission, district attorneys, and other stakeholders to accomplish this result.

Insurance Action: Corrective action taken.

Insurance reports that it has changed the policy of awarding grant funds to county district attorneys based exclusively on whether they submitted a completed application by the required deadline. Rather, these grants are awarded based on whether the applying county met criteria based on the evaluation of the county district attorney's plans and past performance.
Legal counsel for Insurance has determined that the open public meeting requirements of the Bagley-Keene Act apply. Counsel's opinion encourages communication between program participants and individual review panel members and that district attorneys designate information that is confidential so it can be redacted for public disclosure

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our audit report.

Finding #4: Controls intended to restrict how county district attorneys use their grants of fraud assessment funds to pay for indirect costs are not always effective.

Insurance regulations allow county district attorneys three options for charging counties' indirect costs to fraud assessment grants; each option is intended to place a limit on these charges. However, one option is based on cost rate proposals approved under requirements of the United States Office of Management and Budget, without any input from the fraud commission or insurance commissioner, and does not provide the control of charges of indirect costs provided by the other two options. As a result, one county district attorney charges county administrative costs to the grant at a rate equal to 43 percent of the total salaries and wages charged to the grant.

We recommended that Insurance reevaluate its regulations pertaining to how indirect costs are charged to fraud assessment grants to determine whether the regulations provide the desired amount of control. The fraud commission and the insurance commissioner should also seek changes in the regulations if required and ensure that all county district attorneys that apply for fraud assessment grants disclose their methods of charging indirect costs.

Insurance Action: Pending.

Insurance reports that it is in the process of developing amended regulations to require one standardized methodology for all counties to use when charging indirect costs to program funds.

Fraud Commission Action: None.

The fraud commission did not provide a six-month response to our report.

Finding #5: The fraud division has not conducted adequate strategic planning to ensure it has met all its noninvestigative responsibilities.

Because the fraud division has not conducted adequate strategic planning, it has not met all its noninvestigative responsibilities and spends a significant portion of its workers' compensation antifraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by county district attorneys. The fraud division pays for its workers' compensation antifraud activities using its share of the fraud assessment funds—averaging more than $13 million per year over the five years ending with fiscal year 2002–03—that are levied on California employers.

Lacking a sound strategic plan, the fraud division dedicates too few of its workers' compensation fraud resources to the noninvestigative activities that its statutory responsibilities demand. For example, the fraud division has put little effort into conducting the research necessary to measure the magnitude of the various types of workers' compensation fraud, a yardstick that could help the fraud division guide its antifraud approach and measure its actions and effectiveness in reducing the fraud problem. Further, the fraud division has not developed the information on fraud needed to prepare reports for individuals and entities overseeing the antifraud program, such as the insurance commissioner, the Legislature, and the fraud commission. However, the fraud division's ability to successfully identify goals and objectives is somewhat limited because, as

previously discussed, the fraud commission and the insurance commissioner have not established a statewide strategy for the antifraud program.

In addition, our review of workers' compensation fraud cases in its case management database reveals that the fraud division could manage its investigative efforts more effectively. For example, 87 percent of the referrals of suspected workers' compensation fraud the division receives do not end up in the hands of district attorneys for prosecution. Between September 2001 and December 2003, the fraud division spent more than 16 percent of its investigative hours on cases that it closed and did not submit for prosecution. Moreover, based on past trends, one-third of the hours charged to open cases as of December 2003 will probably be spent on cases not submitted to district attorneys for prosecution. Similarly, during the same time period, the division closed 83 percent of the high-impact, high-priority cases referred to it without submitting the cases to district attorneys, frequently citing insufficient evidence as the reason.

To ensure that it fulfills all aspects of its role in the workers' compensation antifraud program, the fraud division should take the following steps:

- Recognize its responsibilities beyond investigating fraud by: (1) conducting the research needed to advise the fraud commission and the insurance commissioner on the optimum aggregate assessment needed by the program annually to fight workers' compensation fraud, (2) using documented past performance and future projections to advise on the most effective distribution of the funds assessed to investigate and prosecute workers' compensation fraud, and (3) reporting on the economic value of insurance fraud and making recommendations to reduce it.

- Modify its business plan to meet noninvestigative responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

- Establish benchmarks to measure its and the district attorneys' performance in meeting goals and objectives and to determine whether the antifraud program is operating as intended and resources are appropriately allocated.

- Reevaluate the process it has established for insurers and other state entities involved in employment-related activities to report suspected fraud. The fraud division should identify the

type of referrals and level of evidence it requires to reduce the number of hours it spends on referrals that it ultimately does not pass on to county district attorneys for prosecution.

To justify the use of fraud assessment funds, we recommended that the fraud commission and the insurance commissioner require the fraud division to conduct a return-on-investment analysis for the workers' compensation antifraud program as a whole and to annually report the results to the fraud commission and the insurance commissioner.

Insurance Action: Partial corrective action taken.

Insurance reports that it will allocate resources to address fraud research, trend analysis, and effective funding disbursement methods, and improved oversight of county grants. Pending research will result in a plan that Insurance stated would address the return-on-investment of the anti-fraud program.

Insurance Action: Pending.

In addition, Insurance reports it is taking steps to meet its noninvestigative responsibilities, including revising its business plan and realigning its resources as an advisor regarding the level of funding and the direction of fraud reduction efforts.

Finding #6: Independent audit reports submitted by county district attorneys participating in the antifraud program do not assure the fraud division that the district attorneys use grants of fraud assessment funds appropriately.

Although an audit unit within Insurance conducts reviews of district attorneys' use of workers' compensation fraud assessment funds that are effective and have resulted in the detection and recovery of questionable expenditures, the audit unit's limited resources hinder its ability to audit all district attorneys, including those receiving the largest grants. As a result, the fraud division cannot verify that county district attorneys receiving grants use the funds in accordance with state law, Insurance regulations, and the terms of the grant agreements.

To improve the level of assurance contained in the independent audit reports submitted by county district attorneys regarding fraud assessment funds being spent for program purposes, we recommended that the fraud division do the following:

- Clarify its expectations for the independent audits by seeking a change in Insurance regulations that require audit reports to provide an opinion on county district attorneys' level of compliance with key provisions of the applicable laws, regulations, and terms of the fraud assessment grants.

- Ensure that county district attorneys comply with the independent audit requirements and submit their audit reports in a timely manner.

Insurance Action: Partial corrective action taken.

Insurance reports that it is developing amendments to its regulations to clarify the independent audit requirements and ensure that county district attorneys comply with those requirements.

Finding #7: The fraud division does not offer insurers an effective system for referring suspected workers' compensation fraud to the fraud division.

An effective fraud referral system is important to the fraud division because its ability to investigate is dependent on the number and quality of referrals it receives. Despite a legal requirement to investigate suspected fraud and to report cases that show reasonable evidence of fraud, insurers' frequency of reporting varies significantly. In fact, some of the larger insurers in the workers' compensation system reported no suspected fraud referrals in 2001 and 2002. The chief of the fraud division stated that past regulations poorly defined when insurers should refer suspected fraud to the fraud division. Insurance and the fraud division have recently adopted emergency regulations in an attempt to better define when reporting is required. Additionally, the fraud division is currently working to increase and improve its monitoring of insurers' special investigative units, which are responsible for reporting fraud. Included in the fraud division's planned improvements is developing a new method for auditing the special investigative units.

Nonetheless, the fraud division's efforts to ensure that it receives referrals of suspected fraud from insurers still have many internal weaknesses. A lack of strategic planning has left the fraud division's special investigative audit unit without a program that effectively targets insurers to achieve maximum

compliance with reporting requirements, a standardized approach to its audits that will ensure an adequate review, timely reports and follow-up on audit findings, and effective penalties to promote compliance.

To ensure that it receives the suspected fraud referrals it needs from insurers to efficiently investigate suspected fraud, we recommended that the fraud division continue its efforts to remove the barriers that prevent insurers from providing the desired level of referrals. Additionally, Insurance should seek the necessary legal and regulatory changes in the fraud-reporting process. Barriers to adequate referrals include the following:

- Lack of a uniform methodology and standards for assessing and reporting suspected fraud.
- Regulations that poorly define when insurers should report suspected fraud to the fraud division.
- Perceived exposure to civil actions when criminal prosecutions of referrals are not successful.

Given the number of referrals of suspected fraud cases by insurers that the fraud division has decided not to investigate because of a perceived lack of sufficient evidence, the fraud division should work with insurers to reduce the number of referrals that are not likely to result in a successful investigation or prosecution, thereby preserving limited resources. It should also work to ensure that the referrals that insurers do make contain the level of evidence necessary for the fraud division to assess the probability of a successful investigation and prosecution.

Once the fraud division has determined the level of evidence included with the suspected fraud referrals it needs from insurers, it should implement a strategy for its special investigative audit unit to focus the unit's limited resources on determining whether insurers are following the law in providing the referrals the fraud division needs.

Insurance Action: Pending.

Insurance points out that it has certain responsibilities under existing statutes to investigate reported suspected fraud and reports that it will evaluate its suspected fraud referral process and evidence standards within the context of those existing statutes.
Insurance reports that its special investigative unit management has analyzed staff duties and classified positions within this unit to better complete reviews in compliance with government auditing standards. In addition, special investigative unit staff now use a policy manual to conduct reviews of insurers, providing for more consistent, accurate, and timely reviews, and periodic follow-up on audit findings.

Insurance Action: Partial corrective action taken.

Finally, Insurance reports that it has developed a pilot audit plan utilizing risk factors such as line of business and market share to develop a more comprehensive audit plan for future fiscal years.

Legislative Action: Corrective action taken.

Assembly Bill 1227 was chaptered on September 20, 2004, to provide authority and an appropriate penalty structure to increase insurance company compliance with special investigative unit statutes.

Finding #8: The fraud division's ability to gather identifying information of potential workers' compensation fraud is hampered by other departments' failure to share it.

The Division of Labor Standards Enforcement (DLSE) within Industrial Relations investigates violations of certain labor laws, including the failure to provide workers' compensation insurance and benefits to employees. However, the DLSE does not routinely refer its findings to the fraud division for consideration of possible criminal prosecution. During 2003, the DLSE cited nearly 1,300 employers for failing to provide workers' compensation insurance and benefits for their employees. Having information on some of these cases, particularly those involving repeat offenders, might have alerted the fraud division of noncompliance with the law and helped it detect potentially fraudulent activities. The fraud division chief told us he has sought to improve information sharing between the fraud division and divisions within Industrial Relations.

Also, recent legislation required the DLSE, in conjunction with the Employment Development Department and the Workers' Compensation Insurance Rating Bureau, to establish a program to identify employers that fail to secure workers' compensation insurance for their employees. This requirement is similar to a pilot project that demonstrated that such a program provides an effective and efficient method for discovering illegally uninsured employers. Industrial Relations' Division of Workers' Compensation (DWC) is also required by recent legislation to implement a protocol for reporting suspected medical provider fraud and a program to annually warn employers, claims adjusters and administrators, medical providers, and attorneys who participate in the workers' compensation system against committing workers' compensation fraud. Notification of the legal risks is regarded as an important step in deterring fraud.

To help the fraud division investigate employers that fail to secure payment for workers' compensation insurance for their employees, the DLSE should track employers that do not provide workers' compensation insurance for their employees and report to the fraud division any employer that repeatedly fails to provide workers' compensation insurance.

To ensure that it effectively targets employers in industries with the highest incidence of unlawfully uninsured employers, we recommended that the DLSE establish a process that uses data from the Uninsured Employers Fund, the Employment Development Department, and the Workers' Compensation Insurance Rating Bureau, as required by law.

To provide a mechanism to allow reporting of suspected medical provider fraud, the DWC should implement the fraud-reporting protocols required by law.

To help deter workers' compensation fraud, the DWC should warn participants in the workers' compensation system of the penalties of fraud, as required by law.

Industrial Relations Action: Partial corrective action taken.

Industrial Relations stated that it has entered into a memorandum of understanding with Insurance to exchange information concerning uninsured employers. Industrial Relations reports that it is in the process of implementing a mechanism to allow reporting of suspected medical provider fraud. The mechanism will include a reporting protocol and report form, an internal process for receiving and screening reports of suspected provider fraud and routing them to the appropriate licensing and disciplinary entities or law enforcement agencies, and efficient and cost effective ways to broadly disseminate the protocol to the public upon its completion.
Industrial Relations reports that it is also in the process of implementing the statutory requirement to warn participants in the workers' compensation system of the penalties of fraud.

Industrial Relations Action: None.

Industrial Relations reports that it has not secured funding to implement a program where data obtained from the Uninsured Employers' Fund, Employment Development Department, and the Workers' Compensation Insurance Rating Bureau can be compared to determine employers potentially operating without workers' compensation insurance coverage.

Finding #9: Improvement is needed in the process used to collect the fraud assessment funds that finance increased antifraud activities.

The formulas Industrial Relations uses to calculate the workers' compensation fraud assessment surcharge rates have, in recent years, consistently resulted in insured employers being overcharged. In addition, Industrial Relations suspects that not all insurers correctly report and remit all the workers' compensation fraud assessment surcharges they collect from employers. Industrial Relations estimates that a range of roughly $8 million to more than $13 million has been unreported and unremitted during 1999 through 2001. However, Industrial Relations stated it does not have the authority, nor has it established a process, to verify that insurers remit all of the fraud assessment surcharges collected from employers.

To avoid overcharging the State's insured employers for the workers' compensation fraud assessment, we recommended that Industrial Relations work with the Workers' Compensation Insurance Rating Bureau to improve the accuracy of the projected premiums for the current year, which it uses to calculate the fraud assessment surcharge to be collected from insured employers.

To make certain that insurers do not withhold any portion of the fraud assessment surcharge, we recommended that Industrial Relations seek the authority and establish a method to verify that insurers report and submit the fraud assessment surcharges they collect from employers.

Industrial Relations Action: None.

➲ Industrial Relations did not address these recommendations in its six-month response to our report.

CALIFORNIA GAMBLING CONTROL COMMISSION

Although Its Interpretations of the Tribal-State Gaming Compacts Generally Appear Defensible, Some of Its Actions May Have Reduced the Funds Available for Distribution to Tribes

Audit Highlights . . .

Our review of the California Gambling Control Commission's (Gambling Commission) administration of the Indian Gaming Revenue Sharing Trust Fund (trust fund) revealed the following:

- ☑ *Some tribes have questioned the Gambling Commission's decisions about such matters as:*
  - *The number of gaming devices that may be operated statewide.*
  - *The offsetting of quarterly license fees by the amount of nonrefundable, one-time prepayments.*
  - *The formula for calculating trust fund receipts.*
  - *The process for allocating gaming device licenses.*

continued on next page . . .

REPORT NUMBER 2003-122, JUNE 2004

California Gambling Control Commission response as of December 2004

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the California Gambling Control Commission's (Gambling Commission) administration of the Indian Gaming Revenue Sharing Trust Fund (trust fund). Specifically, the audit committee asked that we determine whether the Gambling Commission is complying with applicable requirements to collect and distribute money in the trust fund, as well as with the requirements regarding the allocation of gaming device licenses. Additionally, we were asked to evaluate the Gambling Commission's procedures for identifying and addressing conflicts of interest.

The Gambling Commission has operated amidst controversy since its inception in August 2000, with wide-ranging questions raised about its appropriate role, authority, and many of its actions related to Indian gaming. We found that certain provisions contained in the 1999 Tribal-State Gaming Compacts (compacts) between the State and various Indian tribes are susceptible to multiple interpretations. Ultimately, although tribal organizations and individual tribes have contested many of the Gambling Commission's actions, they are likely defensible given the ambiguous language used in the compact. We also concluded that the Gambling Commission generally administered the trust fund in compliance with its understanding of the requirements in the compact.

Finding #1: Some of the Gambling Commission's interpretations of compact provisions have been disputed.

- ☑ *Distributions to noncompact tribes were generally consistent with the Gambling Commission's policy, with the possible exception of one quarter.*
- ☑ *The Gambling Commission did not follow its procedures for allocating gaming device licenses for two of the three draws it conducted.*
- ☑ *The Gambling Commission has not adequately communicated its conflict-of-interest policy to staff and commissioners, and the law governing the outside financial activities of commissioners is not clear.*

Concerns have arisen about specific decisions the Gambling Commission has made in collecting and distributing trust fund receipts and in allocating gaming device licenses. For example, the statewide limit on gaming devices is one of the most contentious issues arising from the compact. The number of available licenses has contributed to the importance of the debate about many of the Gambling Commission's decisions because the tribes are competing for a limited resource. Unfortunately, rather than specifying an actual maximum number of gaming devices, the compact describes the process to be used to arrive at the total number of gaming devices to be allowed in operation. Ambiguity in this description has resulted in a number of different interpretations on the maximum number of gaming devices allowed, ranging from 45,206 to 110,189.

The Gambling Commission's decision to offset quarterly license fees with prepayments has also met with opposition. The Gambling Commission interprets the compact language as requiring it to offset tribes' quarterly payments by the amount of the nonrefundable one-time prepayments the tribes paid to acquire and maintain the gaming device licenses. However, the California Tribes for Fairness in Compacting (coalition), a coalition of several noncompact tribes, believes the Gambling Commission is misinterpreting the intent of the prepayments, noting that the Gambling Commission's staff conceded that the probable intent of those who drafted the compact was to establish the prepayment as a separate nonrefundable fee rather than as a credit against quarterly payments. Nevertheless, the Gambling Commission notes that the compact's use of the term prepayment creates a high level of doubt as to the meaning of the language. The Gambling Commission focused on the term prepayment and argues that this term, in ordinary usage, means payment in advance. The Gambling Commission further points out that the compact specifies the quarterly payments are to "acquire and maintain a license." It reasons that the quarterly payments cannot logically be for the purpose of acquiring a license unless the prepayment is credited against them. Finally, the Gambling Commission staff believe that any ambiguities in the compact language should ultimately be resolved in favor of the compact payers as opposed to the compact beneficiaries, the noncompact tribes. The coalition believes this position does not comply with the Gambling Commission's role as trustee of the trust fund, which, according to the coalition, is to act in the best interest of the noncompact tribes. If the

Gambling Commission had used the coalition's interpretation, approximately $37 million more would be available for distribution to noncompact tribes from the trust fund through December 2020, given the current allocation of gaming device licenses.

Further, inconsistent compact terms have caused disagreements over the calculation of quarterly fees for deposit in the trust fund. The Gambling Commission does not assess any quarterly fees on the first 350 licenses a tribe has. The coalition disagrees with the Gambling Commission's methodology, arguing that the intent of the compact was for fees to be assessed on all licenses and that the Gambling Commission's method for calculating fees has significantly reduced the amount of trust fund money available for distribution. The compact provides that the number of certain gaming devices a tribe operates determines the quarterly fee it pays per device. However, the terms of the compact are unclear as to which gaming devices are to be counted. Specifically, the compact's schedule of graduated payments indicates a tribe will pay nothing for its first 350 licensed devices. Consequently, the Gambling Commission not only does not assess any quarterly fees on the entitlement and grandfathered devices a tribe has—devices any tribe with a compact is allowed to operate without a license—but it also does not assess fees on the first 350 licensed devices. However, the coalition believes the intent of the payment schedule was to assess fees on all licensed devices instead of excluding the first 350 licenses. The coalition argues that the only devices for which no fees should be assessed are the entitlement and grandfathered devices. Using the coalition's interpretation, an additional $19.1 million in gaming device license fees would have been paid from September 2002 through December 2003 for the 15 tribes we reviewed. Given the inconsistencies in the compact provisions, both interpretations appear defensible, and the compact terms again confused rather than clarified the intent of the compact.

Questions have also been raised about when to require tribes to begin making quarterly license fee payments. The Gambling Commission has taken the position that tribes should begin making quarterly payments when they receive licenses for gaming devices rather than after they put the devices into operation, but the tribes themselves have disagreed on this issue. For example, the Ewiiaapaayp Band of Kumeyaay Indians has contended that its payment obligation to the trust fund should begin only with the commercial operation of the licensed gaming device. Because the tribe had not put any of its

licensed gaming devices into commercial operation, it believed it did not owe any quarterly fees to the trust fund. However, the Gambling Commission charged this tribe and continues to charge other tribes quarterly fees from the time the licenses are issued until the licenses are surrendered. Furthermore, according to summaries of meetings the Gambling Commission held with various tribes, at least seven tribes agree with its decision. The Gambling Commission indicated that it based its decision on the operative language of the compact. Specifically, it concluded that the quarterly payments are in exchange for acquiring and maintaining "a license to operate a gaming device" rather than for the actual operation of the gaming device. Additionally, the Gambling Commission stated that it found no expression in the language of the compact requiring quarterly payments for a license to begin only when the tribe begins to receive revenues for the gaming device. The Gambling Commission has not established when tribes begin operating their gaming devices, so we are not able to determine the extent to which trust fund deposits would have been reduced if the Gambling Commission had charged quarterly fees only when gaming devices were put in operation.

Additionally, some tribes disagree with the Gambling Commission's process for allocating gaming device licenses. Under the Gambling Commission's interpretation of the process described in the compact for allocating licenses to tribes that have applied for them, two tribes that applied did not receive any gaming device licenses during the Gambling Commission's third license draw. The compact indicates that gaming device licenses are to be awarded through a mechanism that places tribes into five categories of priority based on the number of gaming devices the tribes already have and whether they have previously drawn licenses. Noting the compact provisions state that tribes in a particular priority include those that received licenses under a previous priority, the Gambling Commission moves the tribe to a lower priority for the next draw that it participates in, regardless of how many licenses it receives in the first draw as long as it received at least one license. At least two tribes, the Colusa Indian Community of the Colusa Rancheria (Colusa) and the Paskenta Band of Nomelaki Indians (Paskenta), disagree with the Gambling Commission's interpretation of the license draw process. These tribes believe the compact bases the priority for awarding gaming device licenses solely on the number of gaming devices they have. Had the Gambling Commission interpreted the compact as the two tribes do, Colusa would have received 108 licenses and Paskenta would

have received 75 during the Gambling Commission's third license draw. However, under the Gambling Commission's interpretation, neither tribe received any licenses.

If the governor concludes the Gambling Commission's interpretation and policies do not meet the intended purposes of the compact, the governor should consider renegotiating the compact with the tribes to clarify the intent of the compact language, to help resolve disputes over the interpretation of compact language, and to enable the efficient and appropriate administration of the trust fund in each of the following areas:

- The maximum number of licensed gaming devices that all compact tribes in the aggregate may have.
- The offset of quarterly license fees by nonrefundable one-time prepayments.
- The number of licensed gaming devices for which each tribe should pay quarterly license fees.
- The date at which tribes should begin paying quarterly license fees.
- Automatic placement of a tribe into a lower priority for subsequent license draws.

Governor's Office Action: None.

The Governor's Office has renegotiated compacts with several Indian tribes. However, it has not taken any specific action on the issues discussed above.

Finding #2: Some tribes believe the Gambling Commission staff's interpretation of "commercial operation" is not equitable.

According to the compact, the license for any gaming device should be canceled if the device is not in commercial operation within 12 months of the license being issued, but the compact does not define what is meant by "commercial operation." At least three tribes have argued that the Gambling Commission staff's definition of commercial operation does not agree with the compact language and that the staff have added requirements not stated in the compact. Gambling Commission staff believe the intent of the 12-month rule, including the term "in commercial operation," is to keep tribes from hoarding licenses for gaming devices, which would prevent other tribes from having the opportunity to obtain the licenses. They have

therefore been applying a definition of commercial operation that requires all gaming devices, licensed and unlicensed, to be available to the public on a continuous basis and to be simultaneously placed in service on the casino floor. The underlying rationale for the continuous and simultaneous requirements is the staff's position that the license grants a tribe the right to operate a gaming device, but the license is not attached to any particular gaming device. However, the commissioners have not yet formally endorsed this definition. Nevertheless, the Shingle Springs Band of Miwok Indians had 650 licenses canceled, and the Cahuilla Band of Mission Indians had 100 licenses canceled when they did not challenge the Gambling Commission's notice of intent to cancel them. Two other tribes—the Campo Band of Diegueno Mission Indians and the Pauma Band of Luiseno Mission Indians—challenged the Gambling Commission staff's position that all devices, licensed and unlicensed, must be in commercial operation. They argue that the compact does not require unlicensed devices to be in commercial operation.

If compact language is not renegotiated, to permit the efficient and effective tracking of gaming devices in order to determine whether tribes are appropriately placing them in operation rather than hoarding licenses, the Gambling Commission should finalize its definition of what constitutes commercial operation of gaming devices.

Gambling Commission Action: Corrective action taken.

The Gambling Commission has determined that in order to meet the compact requirement that a gaming device authorized by a license is "in commercial operation" within 12 months of the date of issuance of that license, an Indian tribe must establish each of the following elements:

- The gaming device must be operable and available for play to the public.
- The gaming device must be capable of accepting consideration or something of value that permits play.
- The gaming device must be capable of awarding a prize.

The Gambling Commission further stated that once a gaming device is placed into commercial operation, the compact provision would be satisfied. Therefore, the Gambling

Commission would consider the Indian tribe in compliance with the compact provision even if the gaming device were placed into operation for only one quarter, one month, or one day.

Finding #3: A decision regarding multiterminal gaming devices may result in some tribes being ineligible for trust fund disbursements and others exceeding the gaming device limit.

The Gambling Commission has had to address how to count certain electronic games for the purposes of determining the tribes' eligibility for receiving trust fund disbursements and establishing their gaming device allotments under the compact. The compact limits the number of gaming devices a tribe may operate to 2,000. However, certain electronic roulette and craps games are played from multiterminals, meaning that one machine has several terminals, and at each separate terminal a player wagers against a common outcome. The Gambling Commission's concern was whether it should count the entire system or each separate terminal as a gaming device. Although the commissioners have yet to formally adopt a position on multiterminal devices, the staff's position is that it should count each separate terminal as a gaming device, reasoning that such an interpretation gives meaning to every provision in the compact's definition of a gaming device.

For reasons involving a multiterminal gaming device, Gambling Commission staff determined that one tribe, the Augustine Band of Cahuilla Indians (Augustine), was ineligible for trust fund distributions during one quarter in fiscal year 2002–03 for which the tribe claimed that it was eligible because Augustine had counted a multiterminal gaming device as one device on its self-certification of the number of gaming devices it was operating, making it appear eligible for a trust fund disbursement that quarter. However, Gambling Commission staff determined that the tribe operated 351 gaming devices for this quarter, exceeding the eligibility requirement by two gaming devices.

Similarly, tribes that count multiterminals as a single gaming device may exceed the 2,000 maximum for gaming devices they can operate. In fact, according to a February 2004 report on a review performed jointly by the Gambling Commission and the Department of Justice, eight tribes were found to be operating more than 2,000 gaming devices at least in part because they were counting a multiterminal device as only one device.

The Gambling Commission should finalize its position regarding gaming devices with more than one terminal to determine whether these devices are counted as one device or as more than one device. Once its position is final, the Gambling Commission should enforce compliance with the provisions of the compact for those tribes operating more than 2,000 gaming devices and should determine whether any tribe could lose its eligibility for trust fund distributions by exceeding 350 gaming devices.

Gambling Commission Action: Pending.

The Gambling Commission has conducted workshops with compact tribes to discuss and receive input on how multiterminal gaming devices should be counted—as one device or more than one device. However, as of December 2004, the Gambling Commission has not made a final decision.

Finding #4: The Gambling Commission may have underpaid the Lower Lake Rancheria on one of its quarterly distributions from the trust fund.

The Gambling Commission may have inappropriately underpaid Lower Lake by $416,000 and overpaid by $5,100 each of the other tribes eligible in a quarterly distribution from the trust fund. The former chief counsel of the Gambling Commission indicated that it did not distribute funds to Lower Lake for the quarter ending September 30, 2000, because the federal register did not list it as a federally recognized tribe. Although the federal Bureau of Indian Affairs (BIA) acknowledged that it erred in excluding Lower Lake from the register, the former chief counsel explained that the Gambling Commission bases eligibility for such payments from the date stated in written evidence of that recognition, and the BIA did not officially reaffirm the government-to-government relationship with the tribe until December 29, 2000. Consequently, the Gambling Commission concluded that Lower Lake was eligible to receive a share of trust fund receipts only beginning with the quarter ending December 31, 2000. However, the BIA also stated in writing that the government-to-government relationship between the federal government and Lower Lake was never severed. Therefore, although Lower Lake did not appear on the register, the federal government acknowledged that the tribe had consistently retained its status as a federally recognized tribe. Furthermore, only an act of Congress can terminate a tribe's federal recognition, and to date no act has terminated Lower Lake's federal recognition. Finally, the Gambling

Commission was made aware of the BIA error when it received a letter of protest from the tribe's attorney 11 months before it made the adjustment distribution in question. However, because it chose to focus on the date that Lower Lake's status as a federally recognized tribe was reaffirmed, the Gambling Commission concluded that Lower Lake was ineligible for distributions prior to that date and, consequently, it did not adjust its first quarterly allocation to include Lower Lake.

The Gambling Commission should confer with the federal Bureau of Indian Affairs and determine whether there is any federal requirement that it pay Lower Lake for the quarter ending September 30, 2000, and, if not, whether anything prohibits it from paying Lower Lake. Barring any prohibition, we believe it is appropriate for the Gambling Commission to provide Lower Lake a share of the funds allocated that quarter and to deduct that amount from distributions to tribes that received distributions in that quarter. If any one of these tribes is no longer eligible to receive trust fund distributions, the Gambling Commission should either bill the tribe for the overpayment or seek other remedies to recover the overpayment.

Gambling Commission Action: Pending.

The Gambling Commission's chief counsel is reviewing the proper action to be taken with regard to Revenue Sharing Trust Fund distributions to Lower Lake Rancheria. According to the Gambling Commission, outside interests have raised legal issues recently concerning the validity of the federal re-recognition process of Lower Lake Rancheria. As such, the Gambling Commission's legal office is continuing to research this matter. The chief counsel will be providing advice on this issue to the Gambling Commission within the next several months.

Finding #5: The Gambling Commission did not always follow its license draw procedures.

Although staff developed procedures for allocating gaming device licenses, they did not follow these procedures when the Gambling Commission conducted its first gaming device license draw in September 2002 or when it held its second draw in July 2003. As a result, some tribes received licenses that should have been allocated to other tribes under the Gambling Commission's established procedures.

The compact requires gaming device licenses to be awarded to tribes through a priority mechanism with five categories. Under the Gambling Commission's established procedures, a tribe's priority for each draw is based on the priority it was placed in when it last drew licenses, with each tribe automatically moved to a lower priority category for each draw, and on the total number of gaming devices it has. In addition, the compact limits the number of licenses a tribe can draw in each of the first four priorities (150, 500, 750, and 500, respectively). For the fifth priority, the only limit in compact language is the number of licenses that would bring a tribe's total gaming devices, licensed and unlicensed, to 2,000. The Gambling Commission followed these procedures for only one of its three gaming device license draws. Overall, for the two draws for which it did not follow its procedures, the Gambling Commission did not award 307 gaming device licenses to the appropriate tribes according to its official allocation process.

To ensure that all tribes applying for gaming device licenses are provided the appropriate opportunity to obtain the number of licenses they are applying for, the Gambling Commission should consistently follow the license allocation procedures it has adopted. Further, it should change its current policy of limiting to 500 the number of licenses a tribe in the fifth priority may draw, allowing tribes instead to draw up to their maximum total authorization to operate up to 2,000 gaming devices.

Gambling Commission Action: Corrective action taken.

Effective September 28, 2004, the Gambling Commission adopted a policy that is intended to clarify the gaming device license draw process and ensure that draws are conducted in accordance with the compact provisions. The adopted policy no longer limits the number of licenses a tribe in the fifth priority may draw to 500.

Finding #6: The Gambling Commission does not have a thorough system for avoiding potential conflict-of-interest issues.

Although the Gambling Commission has a conflict-of-interest policy, it has not adequately communicated the policy to designated staff. For example, key staff we interviewed stated that they were not aware of any formal, written conflict-of-interest policy. In fact, after repeated requests for a copy of its conflict-of-interest policy, the Gambling Commission finally

provided us with a copy, two months after our initial request. Additionally, a former commissioner had to file an amended statement of economic interest because he was not fully aware of the requirements for completing the form. By not ensuring that the commissioners and its staff are aware of its conflict-of-interest policy, the Gambling Commission runs the risk that affected employees will not understand their obligations under the law.

The Gambling Commission should ensure that all staff are informed of its conflict-of-interest policy. Additionally, the Gambling Commission should seek clarification of the law governing the outside financial activities that commissioners may engage in.

Gambling Commission Action: Pending.

The Gambling Commission is in the process of adopting a conflict-of-interest policy in accordance with the provisions of Government Code, Section 19990. A draft was presented to the commissioners in October 2004. The Gambling Commission is still in the meet-and-confer process with unions and anticipates that a final version will be provided to the Department of Personnel Administration for its review and approval in January 2005.
Also, the Gambling Commission's chief counsel is reviewing the recommendation concerning the clarification of the law governing outside financial activities in which a commissioner may engage. It is anticipated that the chief counsel's legal opinion and advice will be available in the next few months.

WIRELESS ENHANCED 911

The State Has Successfully Begun Implementation, but Better Monitoring of Expenditures and Wireless 911 Wait Times Is Needed

Audit Highlights . . .

Our review of the State's wireless enhanced 911 (wireless E911) program revealed that:

- ☑ *Under the leadership of the Department of General Services' 911 Office (General Services), California has addressed many of the concerns raised by two federal reports on nationwide implementation of wireless E911.*
- ☑ *Although much work remains to be done, General Services plans to have wireless E911 implemented throughout most of the State by December 2005.*
- ☑ *Most California Highway Patrol (CHP) centers do not have systems to monitor how long they take to answer 911 calls, and more than half the centers that tracked wait times did not meet the State's goal to answer 911 calls within 10 seconds.*
- ☑ *Wait times were high, in part, because dispatchers at CHP centers handled significantly more 911 calls per dispatcher than did local answering points we contacted.*

continued on next page . . .

REPORT NUMBER 2004-106, AUGUST 2004

Department of General Services' and California Highway Patrol's responses as of October 2004

Since 1993, Californians have relied on a landline enhanced 911 (landline E911) system for fast, lifesaving responses from police, fire, and emergency medical services. The landline E911 system improved on the original "basic" 911 system by routing calls to dispatchers at the appropriate public safety answering points (answering points) and providing the callers' locations and telephone numbers on dispatchers' computer screens. However, the increasing use of mobile phones for 911 calls has created the need for a similar wireless emergency call system (wireless E911).

According to a 2002 report from the Federal Communications Commission (Hatfield report), national progress toward a fully functioning wireless enhanced 911 system has been delayed, with many states lacking the central coordination and dedicated funding source to implement such a system. Thus, 911 callers using mobile phones may have trouble connecting to appropriate answering points, and may not have their locations or mobile-phone numbers transmitted to dispatchers. Such problems with wireless emergency calls can compromise the success of emergency response teams in protecting life and property.

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the State's emergency 911 response program to explore efficiency improvements and identify the cause of answering delays. We were also asked to determine the status of the State's implementation of the wireless E911 project and to identify obstacles that are contributing to any delays. Further, the audit committee asked us to identify the locations in the State where wireless 911 call wait times are longest and to determine the factors that contribute to the delays.

- ☑ *Unfilled dispatcher positions at CHP centers contributed not only to longer wait times but also to significant overtime costs for the CHP.*
- ☑ *The CHP does not expect the number of wireless 911 calls diverted to local answering points to exceed 20 percent statewide.*

The Department of General Services' 911 Office (General Services), which is responsible for coordinating the State's implementation of wireless E911, has helped the State avoid problems other states face during implementation. We are concerned, however, that the California Highway Patrol (CHP), which responds to the great majority of wireless 911 calls, has inadequately monitored the calls and has had difficulty hiring dispatchers.

Finding #1: General Services cannot readily differentiate expenditures for the wireless E911 project from those for the landline 911 program.

General Services enters expenditures from the 911 program into an expenditure database it maintains, enabling it to track its costs and manage the 911 program as a whole. However, General Services does not include elements in its database that would enable it to readily differentiate expenditures for the wireless E911 project from those for the landline 911 program. Rather, General Services can easily determine only its expenditures for the entire 911 program. As a result, when we asked General Services how much it had spent to date on the wireless E911 project, it could not provide us with that information. However, we analyzed data from General Services' database and determined it had spent at least $4.7 million on wireless E911 as of June 2004. We were not able to obtain all of the wireless costs because some are not distinguished from landline 911 costs. Although the chief of General Services' 911 Office told us that a report that captures monthly costs for wireless E911 costs is under way, the report may not completely capture all wireless E911 costs because of the missing data elements in the database. Adding data elements to uniquely identify costs as wireless or landline would enable General Services to produce accurate expenditure information for both the landline and wireless E911 systems, use the information to make ongoing comparisons of actual expenditures and planned spending, and monitor the wireless E911 project to determine if its cost estimates are reasonable.

To adequately monitor the funding and progress of the implementation of wireless E911, General Services should separately track expenditures related to the wireless E911 project, comparing actual to anticipated expenditures.

General Services' Action: Corrective action taken.

General Services states that it has revised the existing project database to allow wireless 911 costs to be more easily identified, and developed a reporting system to assist management in monitoring those costs. Further, its staff have been trained on the new expenditure tracking and reporting system.

Finding #2: The State has diverted more than $150 million of 911 program funds to the General Fund.

Although the Revenue and Taxation Code states that the money collected from the telephone surcharge must be used solely for the 911 program, the State Emergency Telephone Number Account (emergency account) has been tapped for other purposes. In six fiscal years since 1981–82, a total of almost $177 million has been transferred from the emergency account to the State's General Fund, and only $24.6 million has been transferred back. The latest transfer was in fiscal year 2001–02 for more than $63 million. It appears that the State does not intend to repay these transfers because it does not show any amounts receivable from the General Fund on its financial statements for the emergency account.

Although General Services believes these transfers will not adversely affect its ability to implement wireless E911, we believe the transfers could jeopardize future improvements to the 911 system. The Hatfield report raises serious questions about the nation's 911 infrastructure. Specifically, the report states that the existing landline E911 infrastructure, although generally reliable, is seriously antiquated and built on outdated technology. To be effective in an overwhelmingly digital world, the analog infrastructure may need major upgrades to extend E911 access to a rapidly growing number of nontraditional devices. In response to these issues, General Services has indicated it is currently in the conceptual stages of a project to update the State's landline E911 infrastructure, but it does not have a financial plan or cost estimate for such a project at this time. Should the State decide it is necessary to upgrade the infrastructure, the $152 million in net transfers may hamper its efforts. Moreover, because the current surcharge is close to the legal maximum, if additional revenue is needed, legislation would be necessary to authorize that increase.

To ensure adequate funding is available for future upgrades of the 911 system infrastructure, General Services should complete its conceptual plan for the project and, if it determines significant upgrades are needed, complete a financial plan for the project.

The Legislature should consider the effects on future 911 projects when diverting funds from the 911 program.

General Services' Action: Pending.

General Services reports that it is continuing work on the project it calls Next Generation E911 Network, in which General Services is evaluating ways to incorporate emerging

technologies with a more flexible, sophisticated and cost effective 911 system. General Services states that it is currently evaluating responses to a request for information that it sent out to obtain industry feedback on the 911 database requirements. General Services estimates that it will complete the evaluation process in February 2005. If it determines that significant upgrades are ultimately needed, General Services states that it will complete a financial plan for the database enhancement phase of the project.

Finding #3: Most CHP centers do not have systems to monitor how long they take to answer calls.

As required by state law, the CHP answers 911 emergency calls that originate from wireless phones and are not routed to local answering points, such as police, fire, or sheriff's departments. To respond to these calls, the CHP operates 24 centers that function as answering points for wireless 911 calls. Of the CHP's 24 centers, 15 lack systems to track either the amount of time a caller waits before a dispatcher answers a call or how many calls are unable to get through because all the center's lines are busy. Therefore, at these 15 centers, the CHP can neither determine how long a caller waits before reaching a dispatcher nor monitor its activities adequately to ensure that it answers 911 calls promptly. Thus, the CHP may be unaware that problems exist.

At nine of its 24 centers, the CHP has installed an automatic call distributor to improve its ability to answer calls. The call distributor routes incoming calls to available dispatchers and, when a dispatcher is not available, places the call in a queue until one becomes available. With these systems, the CHP is generally able to monitor how long callers must wait before being answered. However, according to its 911 coordinator, the CHP has not installed automatic call distributors in 15 of the 24 centers because it believes the volume of calls received by those centers does not merit the cost of installing and using the system. Rather, each of the 15 centers has a phone system with a certain number of phone lines. When a call comes into one of the centers, an available dispatcher answers the call. If no dispatcher is available, the call continues to ring until a dispatcher can pick up the line. Additionally, if the number of calls coming into the center exceeds its number of phone lines, the caller receives a busy signal. This type of system is likely to leave already-distressed callers even more upset by the lack of assurance that someone is responding to their emergencies.

Further, the system lacks a mechanism to track how long callers wait for dispatchers to answer. Although the CHP does not have a good system to monitor wait times, the chief of the CHP's Information Management Division has indicated that the CHP closely tracks citizen's complaints about its handling of 911 calls.

According to the CHP's 911 coordinator, as part of its implementation of wireless enhanced 911 (wireless E911), the CHP will be equipping each of these 15 centers with technology that will allow the CHP to monitor the amount of time callers wait before a dispatcher answers the call. The CHP expects to have the new systems in place by the end of 2005, consistent with the State's plan for implementation of wireless E911.

To assist it in answering 911 calls in a timely manner, as the CHP implements wireless E911, it should include a wait time monitoring system at the 15 centers that currently are without one.

CHP Action: Partial corrective action taken.

The CHP states that it is in the process of purchasing a management information system for all of its communications centers that will enable each center to monitor wait times. The CHP estimates that installation will be complete by December 31, 2005, dependent upon availability of funding and personnel resources.

Finding #4: The CHP handles significantly more 911 calls per dispatcher than any of the four local answering points we reviewed.

For the nine centers that collected data, the CHP received between 598 and 1,733 calls per dispatcher each month from January through March 2004, whereas the local answering points we contacted received from 95 to 214 calls per dispatcher in the same period. The difference in the calls per dispatcher between the CHP and the local answering points is significant because even with the implementation of the wireless E911 project and its associated benefits, if the CHP does not have enough dispatchers to answer the wireless 911 calls it receives, it will likely continue to struggle to answer calls within the 10-second goal set by the State.

Disparities in staffing, however, do not fully explain the wide range in wait times at the nine CHP centers. For January through March 2004, the center with the highest average number of calls (1,733) per staff person, the Orange County Region, also

had the shortest wait time, 4.7 seconds on average. On the other hand, the Los Angeles and San Francisco Bay Area regions had significantly fewer calls per staff and longer wait times—862 calls with a wait time of 49.2 seconds for Los Angeles and 598 calls with a wait time of 38 seconds for the San Francisco Bay Area Region. Dispatchers at CHP centers, as well as those at some local answering points, have duties other than answering emergency calls, such as answering nonemergency calls, but we do not know the relative impact on wait time of these additional duties at the various sites. The performances at the Los Angeles and San Francisco Bay Area CHP centers may also have been affected by their implementation of wireless E911. The 911 supervisor at the Los Angeles CHP center points out that implementation presented an additional challenge because the center's staff had to accustom themselves to the display information from the wireless E911 calls they answered while continuing to work with the original system on other calls. Further, he indicated that test calls for wireless E911 implementation take up time, as the dispatcher has to confirm that various data are correctly transmitted.

To assist it in answering 911 calls in a timely manner, the CHP should identify additional practices that enable some centers, such as Orange County, to answer 911 calls in a timely manner despite high calls to staff ratios, and determine if the practices can be incorporated at other centers.

CHP Action: Corrective action taken.

The CHP reports that it is addressing this recommendation through its Command Assessment Program, which requires biennial evaluation of the management practices and the essential functions of each CHP command. The CHP will incorporate innovations noted in these assessments into the training materials and curriculum at its statewide Dispatch Academy. The CHP also states that in November 2004, it will prepare written policy requiring division commanders to forward the assessment findings and recommendations pertaining to dispatch operations directly to the Information Management and Training divisions. The CHP believes this will expedite the review and consideration of findings by CHP personnel with responsibility for statewide dispatch policy. The CHP also adds that successful practices will be added to the agenda of its Communication Center Commander Conference, which it will convene no later than the third or fourth quarter of 2005, assuming funding is available for travel.

Finding #5: The CHP does not have a benchmark for the number of staff needed to answer calls.

According to the assistant commander of its Telecommunications Division, the CHP has not established a benchmark for the number of 911 calls per dispatcher that would allow the CHP to answer 911 calls promptly. If it had a benchmark, the CHP could compare its centers' current ratios of 911 calls per dispatcher against the benchmark to assess the need for additional dispatchers. To establish a reasonable benchmark, the CHP would need to develop a better system for tracking the total number of 911 calls received at each of its centers.

Currently, to monitor the number of 911 calls it receives, the CHP requires each center to track the number of 911 calls it handles during one day each month and report these counts to the CHP's Telecommunications Division. The CHP then multiplies the counts by the number of days in that month to arrive at an estimate of the total 911 calls the CHP answered for the month. However, this process has resulted in unreliable data. The CHP used a fully manual tally system to count 911 calls in 19 of the 24 centers. In these centers, the CHP relied on dispatchers to make tally marks on a sheet each time they completed a 911 call. However, administrators at several centers told us this process did not produce accurate results because it is difficult for dispatchers to remember to tally after each call. In fact, four of the 19 centers preparing manual counts had automatic call distributors, which enable the centers to produce automated reports detailing the number of 911 calls they receive each month.

Additionally, this process assumes that the activity level of one day will be representative of the entire month. However, the volume of 911 calls the CHP receives is affected by factors that are highly variable, such as weather and major incidents. Therefore, one day would not necessarily be representative of others. Because these centers report the number of 911 calls for only one day each month, the results are not necessarily reliable and may result in an overstatement or understatement of call activity. Only the San Diego center reported calls for each month based on its automated call distributor data. Additionally, another center with the automated call distributor, Stockton, had not submitted tally reports during 2003.

During 2003, the Los Angeles CHP center performed manual tallies of its 911 counts. However, these manual counts significantly understated its actual number of 911 calls—by almost 705,000, or 43 percent. On the other hand, the Fresno CHP center produced

manual call tallies that significantly overstated its 911 calls—by almost 222,000, or 76 percent. Because the CHP does not track actual 911 calls at all its centers, we are unable to determine whether, in total, the CHP overstated or understated its 911 calls. Nonetheless, it is clear that the CHP's current process to develop an estimate of the number of 911 calls it receives produces unreliable results. Without reliable data relating to the number of 911 calls its centers answer, the CHP will have difficulty developing a benchmark for the number of 911 calls per dispatcher that would allow the CHP to answer 911 calls promptly.

To assist it in answering 911 calls in a timely manner, the CHP should implement a reliable system for monitoring the number of 911 calls its centers receive. Additionally, it should develop a benchmark reflecting the ratio of 911 calls per dispatcher that would allow the CHP to answer 911 calls within the state goal of 10 seconds.

CHP Action: Partial corrective action taken.

The CHP states that the management information system it is implementing, as described in finding #3 above, will also enable it to monitor the call volume at each of its call centers. Additionally, the CHP states that it intends to develop a benchmark that will consider call volume data, communication center size, and incorporate shift parameters that affect high traffic volumes along with seasonal and special events that can induce peaks. The benchmarks will be used to evaluate and validate dispatch staffing levels. The CHP reports that it is developing a committee comprised of management and dispatch personnel to evaluate study findings and develop a valid staffing matrix. This committee will first meet during the second quarter of 2005.

Finding #5: CHP dispatchers' salaries are generally lower than those of dispatchers at the local answering points.

We compared the dispatcher salaries paid by the CHP in its Los Angeles and Sacramento centers with those paid by selected local answering points in the same areas. The salaries of CHP dispatchers are generally lower than those of dispatchers at the local answering points we contacted. Although the starting pay for dispatchers at the Sacramento County Sheriff's Office is lower than the CHP's, all other local answering points we contacted paid starting salaries ranging from $40 to $842 per month more than the starting salaries for CHP dispatchers.

To help attract and retain dispatchers at its centers, the CHP should request that the Department of Personnel Administration perform a statewide salary survey to determine the adequacy of the current salaries for CHP dispatchers.

CHP Action: Partial corrective action taken.

The CHP states that it will request the Department of Personnel Administration conduct a statewide survey of dispatcher salaries prior to the end of March 2005.

DEPARTMENT OF GENERAL SERVICES

Investigations of Improper Activities by State Employees, January 2004 Through June 2004

INVESTIGATION I2003-0703 (REPORT I2004-2), APRIL 2004

Department of General Services' response as of July 2004

Investigative Highlights . . .

An employee at the Office of Fleet Administration in the Department of General Services (General Services) engaged in the following improper governmental activities:

- ☑ *Stole 68 gallons of gasoline worth $136 from a General Services' garage.*
- ☑ *Failed to adequately explain inconsistencies or discrepancies involving an additional 1,910 gallons of gasoline worth $3,752 he dispensed.*
- ☑ *Benefited from several deficiencies in General Services' controls over its gasoline that allowed the employee to steal gasoline.*

We investigated and substantiated an allegation that an employee at the Office of Fleet Administration (fleet administration) in the Department of General Services (General Services) stole gasoline from a General Services' garage.

Finding #1: The employee improperly fueled his personal vehicle with gasoline he stole from a state garage.

The employee admitted that on at least five occasions he improperly fueled his car with gasoline from a General Services' garage. We estimate that for these five transactions, the employee stole 68 gallons of gasoline worth $136. In addition, we identified 141 other questionable fuel transactions, occurring before 5:45 a.m. when the garage opened, by the employee between August 2001 and March 2004 involving a total of 1,910 gallons of gasoline worth $3,752. Although the employee claimed that most of these transactions were legitimate, many involved inconsistencies or discrepancies that he could not sufficiently explain. For instance, five of these early-morning transactions indicated that the employee fueled vehicles that another employee later fueled on the same day. In one of these five transactions, the employee dispensed more fuel than the vehicle's tank was capable of holding. In another instance, the employee fueled a vehicle at 4:46 a.m. even though the vehicle log showed that the vehicle in question was not returned to the General Services garage until 7:42 a.m., almost three hours later. In each instance, the employee failed to provide an explanation for the discrepancy.

Finding #2: General Services' internal controls do not adequately prevent gasoline theft.

We noted several deficiencies in General Services' controls over its gasoline that allowed the employee to steal gasoline. Before a fleet administration employee can dispense fuel, he or she must enter their employee number and the vehicle's odometer reading and license plate number into an automated fuel tracking system via a keypad. However, this system allows employees to enter incorrect data. For example, employees may enter a valid state license plate number and then fuel a vehicle with a different license plate. In addition, although its fuel tracking system has the capability to require employees to enter a secret personal identification number, or PIN, General Services has not established PINs for most of the employees who fuel vehicles. Instead, most employees need enter only their two-digit employee access code in order to gain authorization to pump fuel. These codes were posted next to the terminal where employees enter transaction information, so anyone could have used them to operate General Services' gasoline pumps. Furthermore, the garage manager estimated that General Services had issued 30 keys to various state employees. Because General Services has issued so many keys, and because its fuel tracking system allows employees to input incorrect information, it cannot assure itself that no one will access the garage to steal gasoline.

Department Action: Pending.

General Services issued the employee a counseling memo and recovered $139 from him for the value of the gasoline the employee admittedly stole. General Services also reported that it has strengthened its controls over gasoline dispensing activity by restricting fuel pump access hours to between 8 a.m. and 5 p.m., scheduling training for garage managers on the automated fuel management system, and pursuing the installation of a card key entry system to track employee access to the garage.

STATEWIDE PROCUREMENT PRACTICES

Proposed Reforms Should Help Safeguard State Resources, but the Potential for Misuse Remains

Audit Highlights . . .

Our review of the State's procurement practices revealed the following:

- ☑ *Until the governor's May 2002 Executive Order, departments did not compare prices among California Multiple Award Schedule vendors.*
- ☑ *Inadequate oversight by the Department of General Services (General Services) contributed to the problems we identified with departments' purchasing practices.*
- ☑ *Without comparing prices, the State purchased millions in goods and services for the Web portal from vendors that played a role in defining the approach and architecture for the project.*
- ☑ *Estimated Web portal project costs given to administrative control agencies and the Legislative Analyst's Office were sometimes inaccurate.*
- ☑ *Before the Executive Order, departments frequently misused alternative procurement practices—sole-source contracts and emergency purchases.*

REPORT NUMBER 2002-112, MARCH 2003

Department of General Services and the Stephen P. Teale Data Center responses as of March 2004

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to audit the California Multiple Award Schedule (CMAS) program and the State's sole-source contracting procedures. Specifically, the audit committee asked that we review the process used by General Services when establishing the CMAS vendors list and the procedures and practices used to identify qualified contractors and consultants when using noncompetitively bid and CMAS contracts to procure goods and services. The audit committee also asked us to include in our review procurements related to the state Web portal.

Finding #1: Departments largely ignored recommended procedures for purchasing from CMAS vendors.

Our review of CMAS purchases made by nine state departments revealed that, before May 2002, when an Executive Order called for wholesale changes in the State's procurement practices, few departments took prudent steps, such as comparing prices, to ensure that they obtained the best value when acquiring goods and services from CMAS vendors. For example, largely at the request of two former officials of the Governor's Office, the Department of General Services (General Services), the Stephen P. Teale Data Center (Teale Data Center), and the Health and Human Services Data Center purchased more than $3.1 million in goods and services for the state Web portal from one CMAS vendor without comparing prices or using some other means to determine that the selected vendor provided the best value to the State. Additionally, General Services and the Teale Data Center purchased items for the Web portal totaling $690,000 that were not included in the vendors' CMAS contract.

Recent changes to the CMAS requirements have slowed but not halted departments' misuse of the CMAS program. Specifically, departments did not obtain at least three price quotes, as required, for two of the 25 CMAS purchases made after the date of the Executive Order.

In order to ensure that the State receives the best value when acquiring goods and services, we recommended that departments stress adherence to all CMAS requirements and reject requested purchases if these requirements are not met. Additionally, departments should review the appropriate CMAS contract to ensure that the requested good or service is included in the contract.

General Services' Action: Corrective action taken.

In February 2004, General Services issued a new Purchasing Authority Manual (PAM) governing the State's procurement function. The PAM provides the requirements for obtaining and maintaining delegated purchasing authority. It also serves as the resource that assists in ensuring departments apply consistent and sound business practices in state purchasing. The PAM contains purchasing authority requirements, including statutes, regulations, and policies and procedures applicable to information technology (IT) goods and services and non-IT goods. The PAM also includes information on how departments maintain compliance with the purchasing authority program.

Finding #2: The State's failure to compare prices created the appearance that some companies may have had an unfair advantage in selling Web portal components to the State.

The Web portal was developed with guidance from a group of executives from several private businesses, some of which later sold products for the project. Members of this group, called the Web Council, gave their "unanimous blessing to the portal's conceptual approach and its specific architecture." According to the minutes and agendas from Web Council meetings, representatives of several companies participating in the council made presentations to discuss their companies' products. Three of these companies ultimately sold hardware and software components to the State for the Web portal totaling $2.5 million. These companies sold their products to

the State, either directly or indirectly through resellers with CMAS contracts. The concept of obtaining guidance from industry experts is meritorious if, after obtaining the guidance, the State engages in an open, competitive procurement process. However, if obtaining advice from industry experts is followed by procurement of their goods or services without comparing prices to those offered by others, as was the case with numerous CMAS purchases for the Web portal, an appearance of unfairness is created.

In September 2002, the Teale Data Center assumed responsibility for providing management, maintenance, and support for the Web portal project. To ensure that the State's investment in the Web portal is a prudent use of taxpayer resource, it should use the competitive bidding process for purchasing goods and services for the project.

Teale Data Center Action: Corrective action taken.

Teale Data Center regularly utilizes General Services' contract registry to seek competition. Further, it is standard Teale Data Center practice to exceed the minimum number of bids required for informal bids as this practice ensures diverse vendor participation. Finally, as the existing Web portal services and maintenance contracts required renewal, Teale Data Center has competitively bid all subsequent new contracts.

Finding #3: General Services and former officials of the Governor's Office did not follow state policy governing information technology projects.

General Services—the administrator of the Web portal project—failed to obtain the necessary approvals from the former Department of Information Technology (DOIT) and the Department of Finance (Finance) before significant changes were made to the Web portal project. The changes, which increase previously approved project costs by 94 percent, were made at the direction of the former director of eGovernment. Among the changes, estimated to cost $9.2 million, were significant enhancements related to the energy crisis and terrorist threats and ongoing maintenance provided by consultants rather than state personnel, as was originally planned. General Services submitted a special project report to DOIT and Finance explaining the reasons for the increased cost and seeking approval for the enhancements. However, the enhancements were completed four to six months before General Services submitted the report.

Additionally, General Services did not adequately coordinate and monitor Web portal purchasing and reporting activities. As a result, the special project reports submitted to DOIT, Finance, and the Legislative Analyst's Office (LAO) did not accurately account for all Web portal purchases. Specifically, at least one special project report that General Services submitted was inaccurate because it did not include more than $1.3 million in Web portal costs incurred by its Telecommunications Division and the Health and Human Services Data Center. According to the former chief of General Services' Enterprise Business Office, only costs that were under her control were reported to the individual preparing the special project reports.

Finally, it appears that responsible officials at General Services were unaware that a revised Web portal project report, which nearly doubled the estimated cost of the project, had been submitted to DOIT, Finance, and the LAO reflecting a significant increase in total project costs. According to officials at Finance, they met with former officials of the Governor's Office and representatives from General Services to discuss the proposed cost increases. The officials at Finance stated that it is not uncommon for minor modifications to be made to a special project report after it has been submitted for approval. However, we believe that changes to a project that effectively double the estimated cost of the project do not constitute minor modifications. Moreover, Finance could not provide any documentation of its analysis of the proposed project changes and resulting cost increase. Nevertheless, it approved submitting the revised estimates to the Legislature based on available information, given the high priority of the project.

To ensure that Web portal costs are properly accounted for, the Teale Data Center should monitor project expenses by recording estimated costs when contracts and purchase orders are initiated and actual costs when paid. The Teale Data Center should also submit special project reports to Finance and the LAO when required and ensure that reported costs accurately reflect actual expenditures and commitments to date. Finally, the data center should make certain that special project reports contain estimates for at least the same number of years that earlier reports cover so that reviewers can easily identify changes in the overall projected costs.

Teale Data Center Action: Corrective action taken.

The Teale Data Center's administrative processes require an internal analysis and approval of estimated costs prior to the initiation of the bidding process. If the resulting procurement activity results in costs that exceed the original estimate, approval is required before acquisition can be completed. Teale Data Center's Finance Division has developed a spreadsheet used to monitor projected versus actual expenditures. Should requests for acquisitions vary from the original plan, they are analyzed to determine the reason for the change and if it is within budget authorization prior to the expenditure being made. The spreadsheet is updated monthly and is shared with the manager of the Web portal and the assistant director of the Enterprise Division. Furthermore, the Teale Data Center will continue to submit special project reports to Finance and the LAO, when required, which will accurately reflect all costs for the Web portal. Finally, the Teale Data Center will ensure that any future special project report and feasibility study report have consistent reporting periods.

Finding #4: The use of multiple departments to make purchases for the Web portal resulted in payments for services that were required under earlier agreements.

Several departments made Web portal purchases rather than one office coordinating and making all purchases. Consequently, no one office carefully tracked existing purchases and compared them to newly requested purchases, and the State contracted for some services even though the same services had already been required under earlier agreements. For example, General Services' Telecommunications Division issued a $173,000 purchase order to a consulting firm for project management of ongoing operations and maintenance of the Web portal. However, the terms and services of this contract duplicated some of the terms and services of another purchase order that General Services' Enterprise Business Office had previously issued to the consulting firm.

Similarly, the Health and Human Services Data Center entered into a $246,000 agreement with a consulting firm to create a plan to develop a Web portal mirror site. In reviewing the three reports that the consulting firm submitted in fulfillment of its agreement with the Health and Human Services Data Center,

we found that the content of the reports was information the consulting firm was already obligated to provide under an earlier contract with General Services.

General Services should review past payments to the consulting firm and another vendor by General Services, the Health and Human Services Data Center, and the Teale Data Center to ensure that the State has not paid for goods or services twice. If duplicate payments were made, General Services should recover them.

General Services' Action: Corrective action taken.

General Services reviewed the transactions in question and concluded that duplicate payments did not occur. However, General Services did note several instances when the scope of work supporting a purchase order did not clearly, concisely, or accurately reflect key information. Consequently, General Services has recognized that this is an area for improvement within the State's contracting program and is including this subject matter within its training and certification program.

Finding #5: Recent actions by General Services and the Teale Data Center have reduced Web portal costs.

According to the most recent special project report, jointly submitted by General Services and the Teale Data Center, total estimated costs of the Web portal were nearly $6 million less than previously reported. The reduced costs were largely due to cutbacks in Web portal maintenance that included a major reduction in the number of hours for the consulting firm to maintain the portal.

In June 2002, the interim director of DOIT stated that the consulting firm's Web portal agreements were expensive and little had been done to transfer the consulting firm's expertise to state employees so that a state department could ultimately operate the portal. He recommended that General Services extend the consulting firm's contract until a competitively selected contractor became available. He also recommended reducing the size of the contract by restricting the consulting firm's role to limited maintenance and knowledge transfer functions, ultimately turning over the maintenance of the Web portal to state employees.

In January 2003, the Teale Data Center entered into a six-month contract with the same consulting firm for $350,000 in Web portal maintenance. Unlike the manner in which previous maintenance contracts had been established, however, the Teale Data Center solicited proposals from 20 different companies and six firms responded. The Teale Data Center evaluated the responses and eventually chose the consulting firm, achieving a 39 percent average reduction in the hourly rate over previous noncompetitively bid agreements with the firm. Therefore, the Teale Data Center should continue to use the competitive bidding process for purchases of goods and services for the project.

Teale Data Center Action: Corrective action taken.

The Teale Data Center strongly supports the competitive bid process. The Teale Data Center independently seeks alternative suppliers and uses the General Services' contract registry to seek competition. Further, it is standard practice at the Teale Data Center to exceed the minimum number of bids required for informal bids.

Finding #6: State departments improperly used sole-source contracts and emergency purchase orders.

Before the May 2002 Executive Order, state departments often did not adequately justify the need for sole-source contracts. Requests for sole-source contracts were often ambiguous or failed to demonstrate that the contracted good or service was the only one that could meet the State's needs. In addition, because they failed to make sufficient plans for certain purchases, departments often used sole-source contracts inappropriately. We reviewed 23 requests for sole-source contract approval submitted by various departments and found eight examples of departmental misuse of this type of exemption. General Services, however, approved all 23 requests. In four requests that General Services approved, the departments failed to provide the kind or degree of justification we expected to see. We could not determine whether the circumstances warranted a sole-source contract for one of the 23 requests because the department's justification was ambiguous. Finally, in three of the 23 sole-source requests, the departments sought the contracts because they failed to properly plan for the acquisition and, as a result, did not have time to acquire the goods or services through the normal competitive bidding process.

Similarly, departments frequently misused the State's emergency purchasing process by failing to meet the legal requirements for this type of procurement. For 17 of the 25 purchase requests we reviewed, the departments were requesting emergency purchases. In the remaining eight cases, the departments were requesting approval for reasons other than meeting emergency needs, such as seeking the purchase of items to meet special needs. Although General Services did not have the proper authority to grant exceptions for these purchases, it approved all eight.

Of the 17 emergency purchase requests totaling $21.3 million, nine totaling $2.3 million completely failed to identify the existence of an emergency situation that fell within the statutory definition or to explain how the proposed purchase was related to addressing the threat posed by an emergency.

State departments should require their legal counsel to review all sole-source contracts and emergency purchases to ensure they comply with statutes governing the use of noncompetitively bid contracts. Departments should also ensure that adequate time exists to properly plan for the acquisition of goods and services.

Moreover, General Services should require its Office of Legal Services to review all sole-source contract requests above a certain price threshold. General Services should also implement review procedures for sole-source contracts and emergency purchase orders to ensure that departments comply with applicable laws and regulations and require departments to submit documentation that demonstrates compliance. General Services should reject all sole-source and emergency purchase requests that fail to meet statutory requirements. Finally, General Services should seek a change in the current contracting and procurement laws if it wants to continue to exempt purchases from competitive bidding requirements because of special or unique circumstances.

General Services' Action: Partial corrective action taken.

General Services has implemented policies and procedures that provide for its Office of Legal Services to review all non-competitively bid contract requests that exceed $250,000. Additionally, General Services has developed a form that requires detailed information be provided to justify non-competitively bid procurements. Specifically, the form requires departments to provide detailed responses

for various issues, including (1) why the acquisition is restricted to one supplier, (2) background events that led to the acquisition, (3) the consequences of not purchasing the good or service, and (4) what market research was conducted to substantiate the lack of competition. Finally, General Services is working to enhance the form to provide additional assurance that non-competitive procurements are properly justified. General Services has existing policies in place to review and reject all sole-source and emergency purchases requests that fail to meet statutory requirements.

Legislative Action: None.

General Services is reviewing the need for additional exemption authority related to competitive bidding. At this time, a final decision has not been made on the need to pursue additional authority in this area.

Finding #7: General Services needs to strengthen its oversight of state purchasing activities.

General Services has provided weak oversight and administration of the CMAS program. We found that General Services, which is responsible for auditing state departments for compliance with contracting and procurement requirements, is not performing the audits required by state law. Specifically, between July 1999 and January 2003, General Services had completed only 105 of 174 required reviews. Moreover, less than one-half of the 105 reviews were completed on time.

Additionally, General Services does not sufficiently review CMAS vendors to ensure that they comply with the terms of their contracts with the State. For instance, from July 1998 through September 2002, General Services had only reviewed 29 of 2,300 active CMAS vendors. Perhaps more importantly, General Services does not always make sure that other state and local government contracts on which CMAS contracts are based are, in fact, awarded and amended on a competitive basis. As a result, the State may be paying more than it should for the goods and services it purchases. Finally, General Services does not consistently obtain and maintain accurate data on departments' CMAS purchases. Consequently, it is sometimes charging other state departments more than it should for administrative fees. For example, we reviewed 90 CMAS purchases at nine departments and found 24 instances in which General Services had either entered the incorrect amount in its accounting system or had no record of the

transaction. We further reviewed 10 of the 24 transactions and determined that General Services had overcharged departments more than $219,000.

We recommended that General Services implement the recommendations made by the Governor's Task Force on Contracting and Procurement Review (task force), which include increasing the frequency of audits and reviews of state departments. General Services should consider reducing or eliminating the delegated purchasing authority of departments that fail to comply with contracting and procurement requirements. Additionally, General Services should increase the frequency of its reviews of CMAS vendors and ensure that processes established by other governmental entities for awarding and amending contracts are in accordance with CMAS goals. Finally, General Services should consult with departments to determine what can be done to facilitate monthly reconciliation of CMAS purchasing and billing activities.

General Services' Action: Partial corrective action taken.

General Services is committed to fully addressing the recommendations contained in the task force's report and is continuing to assign resources to that activity. For instance, General Services has initiated a cornerstone of the procurement reform effort—the training of state procurement officials. Additionally, General Services implemented a uniform process for reporting the State's procurements. Specifically, a database is now readily accessible to provide comprehensive information on the State's purchasing and contracting activities. Beginning July 1, 2003, all state agencies were required to enter summary information via the Internet for all purchasing and contracts over $5,000. The system, entitled State Contract and Procurement Registration System, captures information that provides General Services with data to oversee the State's contracting and procurement functions.
Further, representatives of General Services have met with executive management of Finance's Office of State Audits and Evaluations (OSAE) to discuss the feasibility of revising existing audit procedures to provide additional coverage of CMAS and sole-source bid contract transactions. The OSAE agreed that its existing guide for evaluation of internal controls within state agencies should be strengthened in those areas. It was estimated that the revised guide would

be complete by April 2004. In addition to the revised guide, General Services' audit and review staff will limit their activities in an individual department if the work performed by that department's internal audit unit sufficiently addresses areas under the purview of General Services. General Services noted that compliance with purchasing and contracting requirements is a major part of maintaining approved purchasing authority. If these requirements are not met, purchasing authority will be reduced or eliminated. General Services believes implementing a program that results in more frequent vendor reviews should be a priority. However, the State's current budget situation limits General Services' ability to assign additional resources to this activity. In the interim, General Services is focusing its limited resources on the review of the most frequently used CMAS suppliers. General Services has also implemented policies and procedures intended to strengthen the review of processes used by other governmental entities when awarding contracts to ensure that they meet the State's standards for solicitation assessment. Policies and procedures also provide that only the most senior CMAS analysts perform the reviews.

Finally, General Services believes that the implementation of a mandatory statewide electronic procurement system would enable it to capture department purchasing activity in real time and would provide the ultimate solution to its billing challenges. However, implementation of such a system is not feasible in the current fiscal environment. As an interim corrective measure, in September 2003, General Services issued a memorandum to all departments advising them of the importance of regularly reconciling their purchasing information with invoices.

Finding #8: Although task force recommendations address most weaknesses, some cannot be immediately implemented and others are needed.

In August 2002, the task force recommended 20 purchasing reforms, completing its directive from the governor's Executive Order issued on May 20, 2002. The recommendations, which focus on the use of the CMAS program and noncompetitive bid contracts, call for comprehensive changes in the State's contracting and procurement procedures. Prompted by the controversy surrounding the Oracle enterprise licensing

agreement, the governor asked the task force to review the State's contracting and procurement procedures and recommend the necessary statutory, regulatory, or administrative changes to "ensure that open and competitive bidding is utilized to the greatest extent possible." The task force's recommendations include the following:

- Departments must compare prices among CMAS vendors.
- Acquisitions of large information technology projects using CMAS contracts and master agreements should be prohibited unless approved in advance.
- General Services needs to establish specific criteria to qualify piggybacking vendors.[1]
- General Services should increase the frequency of its compliance reviews of purchasing activities of state departments.
- General Services should implement a new data integration system to address deficiencies in its ability to capture data and report on contracting and procurement transactions.

In general, we believe the task force's recommended changes, if properly implemented, should address many of the weaknesses in the CMAS program and noncompetitive bidding procedures we identified in our report. However, we believe that additional steps should be implemented based on the results of our audit. For example, General Services should revise its procedures for awarding contracts to vendors based on contracts they hold with other government entities because it often awards CMAS contracts without adequately evaluating the competitive-pricing processes that other state and local governments use to award base contracts.

General Services also needs to develop classes that provide comprehensive coverage of sole-source contracts, emergency purchases, and CMAS contracts, and departments need to ensure that affected personnel attend the classes periodically. Also, because most of the departments we surveyed indicated they had experienced problems working with CMAS vendors, General Services should also consider holding periodic information sessions with the vendors. Further, in addition to implementing a new data integration system, which both

[1] Vendors that do not have an existing federal multiple-award schedules contract but obtain a CMAS contract by agreeing to provide goods and services on the same terms as vendors that do have a multiple-award contract through the federal or some other government entity, are commonly referred to as piggyback contracts.

General Services and the task force acknowledge is a long-term solution, we believe General Services should work with departments to establish a process to reconcile their purchasing information with invoices and reports prepared by General Services. Such reconciliation would allow departments to report and correct errors to General Services, thereby preventing incorrect billings and increasing the reliability of purchasing data. Finally, to increase departments' ability to access online information about the CMAS program, General Services should explore the possibility of including copies of vendor contracts on its Web site.

General Services' Action: Partial corrective action taken.

As previously stated, General Services is continuing to focus efforts on obtaining assurance that processes used by other governmental entities to execute contracts are in accordance with CMAS goals. For instance, General Services' staff, through a review of documents and conversation with the awarding entity, must ensure that the process used by the awarding entity meets the State's standards for solicitation assessment. As of June 2003, approximately 700 state employees had attended classes within General Services' comprehensive training and certification program. These classes dealt with acquisition ethics and leveraged procurement. However, a backlog of approximately 900 potential participants existed. Consequently, General Services is continuing to provide these courses as part of its Basic Certification Program. Additionally, General Services is offering a number of workshops on such subject matters as preparing a statement of work, documenting the procurement process, evaluating bids, and contracting for services. Procurement professionals who have completed the Basic Certification Program and at least two workshops will be eligible for the Intermediate Certification Program that is scheduled for implementation in September 2004. The Advance Certification Program, General Services' final certification program, is also planned for implementation during fiscal year 2004–05.

CALIFORNIA'S WORKERS' COMPENSATION PROGRAM

Changes to the Medical Payment System Should Produce Savings Although Uncertainty About New Regulations and Data Limitations Prevent a More Comprehensive Analysis

REPORT NUMBER 2003-108.2, JANUARY 2004

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

Audit Highlights . . .

Our analysis of medical claims payment data from the State Compensation Insurance Fund (State Fund) to determine the extent to which new reforms would have produced savings in workers' compensation medical costs had they been in effect during 2002 revealed that:

- ☑ ***Although data limitations constrained our analysis, the data we were able to analyze showed that the reforms would produce savings in the form of lower payments for outpatient surgical facilities (surgical centers) and pharmaceuticals.***
- ☑ ***Our analysis of the $14.5 million in surgical center payments resulted in a range of potential savings with a midpoint of approximately $8.5 million, or 58 percent.***

continued on next page . . .

The Joint Legislative Audit Committee (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. As the audit committee requested, in August 2003 the Bureau of State Audits released a report of the workers' compensation medical payment system, titled *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*. To address the audit committee's request that we focus on payments for workers' compensation medical services that hospitals and surgical centers provided and insurance companies (insurers) paid for, we relied on medical payment data from the State Compensation Insurance Fund (State Fund), which paid more for than a quarter of the medical costs related to California's insured employers in 2002. However, State Fund was not able to provide us with all the information we sought in order to analyze facility fees paid to surgical centers and pharmaceutical payments. Therefore, we were unable to present this information in our August 2003 report. As a result, we presented our analysis of payment data in this follow-up report.

Finding: Changes to the state workers' compensation medical payment system will cause payments for outpatient surgical facility services and prescription drugs to drop sharply, but savings depend on the careful implementation of the medical payment fee schedules and monitoring of the medical payment system.

- ☑ *Under the new reforms, State Fund would have saved $18 million (24 percent) on its 2002 payments for pharmaceuticals that we were able to analyze. However, if litigation related to the pricing of Medi-Cal pharmaceuticals is successful, the savings would be $14.6 million (19 percent).*
- ☑ *Our analysis was limited because the data entered into State Fund's medical bill review file were often incomplete, individual items were summarized without retaining their unique identifiers, and the database design prevented certain detailed analysis.*
- ☑ *The savings we identified depend on the careful implementation of the newly legislated reforms. However, according to the Division of Workers' Compensation's (division) former administrative director, his efforts to implement reforms have been hampered by hiring freezes and budget shortfalls.*
- ☑ *The division continues to lack a comprehensive database to monitor workers' compensation medical payments.*

Effective January 1, 2004, Chapter 639, Statutes of 2003, brought major changes to the workers' compensation medical payment system. The new law requires that payments for services performed in an outpatient surgical facility outside of a hospital setting (surgical center) or an outpatient surgical facility in a hospital not exceed 120 percent of the fee for the same procedure under Medicare's ambulatory payment classification (APC) facility fee schedule. The new law also requires that for pharmacy services and drugs that Medicare's APC fee schedule does not otherwise cover, payments be limited to 100 percent of the relevant Medi-Cal fee schedule. Although data limitations constrained our analysis, the data we were able to analyze showed that the recent reforms would produce savings in the form of lower payments for fees for the use of facilities (facility fees) at outpatient surgical facilities and for pharmaceuticals.

For this second report, we obtained medical payment data from State Fund to determine the extent to which the new legislative reforms would have produced savings in workers' compensation medical costs had they been in effect during 2002. Because of limitations in State Fund's data, we were able to analyze only $14.5 million of the $43 million in identifiable facility fee payments to surgical centers that State Fund processed through its medical bill review database during 2002. Because these limitations precluded a comprehensive analysis of the data, we used for our analysis Medicare's ambulatory surgical center (ASC) fee schedule, which has only nine groups of procedure classifications, rather than Medicare's APC fee schedule, which has 569 procedure groups. Because the APC fee schedule is more generous overall than the ASC fee schedule, the potential savings would have been less if we had used the APC fee schedule.

Our analysis of the $14.5 million in surgical center payments resulted in a range of potential savings with a midpoint of approximately $8.4 million, or 58 percent. The payments State Fund made to surgical centers was to compensate providers for the use of the facilities and to pay for the supplemental supplies and other services related to medical procedures performed. The physicians who perform the medical procedures are compensated according to separate fee schedules. Because of the limitations in State Fund's medical bill review database, we had no basis for calculating whether this level of savings would have been possible in the remaining $28.5 million in payments State Fund made to surgical centers or in the unknown amount of settlements it paid to surgical centers as a result of litigated payments. Therefore, we cannot reliably conclude that the

payments we analyzed are representative of State Fund's total payments to surgical centers or that the savings we found are representative of the savings possible in all of State Fund's payments to surgical centers. However, we were able to analyze approximately $76 million, which represents 83 percent of the total $91.7 million paid for prescription drug purchases in 2002 for which State Fund recorded sufficient information and estimated that it would have saved $18 million, or 24 percent, had the new reforms been in place during that year.

Our analysis was limited for three reasons: (1) the data State Fund entered into its medical bill review database were often incomplete, (2) individual items were summarized into general categories and entered into the system without retaining their unique identifiers, and (3) the database design is such that certain detailed analysis is impossible. We could not make a comprehensive estimate of the potential savings associated with the change in the maximum facility fee payments to surgical centers that the new law called for because of the manner in which State Fund collects and classifies facility fee payments it makes to surgical centers for supplemental items such as drugs and supplies in addition to the fee it pays for using the facility. Also, although State Fund often pays surgical centers less than the amounts billed when it considers the amounts excessive, it neither tracks the additional litigated settlement payments it makes—payments that arise from its capping these charges—nor links such payments to the original payment amounts in the medical bill review database to reflect the total amount State Fund pays the surgical centers. We also encountered limitations in the data related to payments for pharmacy services and drugs. Lacking such data, we could not compute all of the potential savings that would have resulted had the new law already been in effect during 2002.

Although the condition of the data in State Fund's medical bill review file limited our analysis of individual payments to surgical centers, and to a lesser degree payments for pharmaceuticals, State Fund contends that its data meets its business purposes and the needs of other research entities. According to State Fund's management, "The State Fund's databases were designed to allow the State Fund to carry out our mission to provide workers' compensation coverage to California employers and to provide those benefits due to their injured employees under California's workers compensation law. Our databases were not designed for public policy research purposes. As we recognize the importance of

accurate information to further research and study the workers compensation system we provide data as well as financial and manpower support to the California Workers Compensation Institute, the Workers Compensation Insurance Rating Bureau and the Workers Compensation Research Institute. Our data has been consistently and successfully used by each organization in their studies and reports. State Fund databases are fully sufficient to the task of making and recording accurate compensation and medical benefit payments. Difficulties encountered in completing public policy research must be differentiated from the process of making accurate benefit payments. We are currently implementing two major claims systems development initiatives. Upon completion of these initiatives we will realize a number of business efficiencies. These improvements will include improved data capture at the detail level that, while not altering reimbursement amounts, will further increase the value of the data for research analysis purposes."

In our analysis of State Fund's payments to surgical centers during 2002, we found a number of instances in which a fee schedule would have standardized payments and resulted in savings. For example, the average amount State Fund paid to individual surgical centers for the use of their facilities sometimes exceeded 300 percent of the Medicare ASC rate, adjusted to reflect the highest California wage index. In addition, the State's official medical fee schedule in place during 2002 required that State Fund pay a reasonable fee for a broad range of items, such as drugs and supplies, associated with outpatient surgical procedures. In some instances, these supplemental payments far exceeded the facility fees involved. Medicare's APC and ASC fee schedules include such items in the facility fee and do not require separate payment.

Savings may not be fully realized, however, unless the administrative director of the Division of Workers' Compensation (division) ensures that the new reforms are promptly and effectively implemented. On December 30, 2003, the division's former administrative director posted on the division's Web site proposed emergency regulations to implement the medical fee schedules that the law required. On the same day, the former administrative director submitted the proposed emergency regulations to the Office of Administrative Law for review and approval. These proposed regulations attempt to address the issues we identify in this report relating to implementing the newly mandated payment system for services that surgical centers

performed, including capping payments at fee schedule amounts and bundling the amounts that insurers pay for drugs and supplies into the facility fee.

Nonetheless, the emergency regulations that the administrative director proposed do not assure the permanent successful implementation of the workers' compensation payment system that the new law mandated. Assuming that the Office of Administrative Law accepts the regulations as written, the emergency regulations will remain in effect for only 120 days. Prior to their expiration, the administrative director must either provide permanent regulations, along with a statement that the regulations comply with all regular rule-making procedures, to the Office of Administrative Law or request that it approve the readoption of the emergency regulations. Therefore, the savings that will result from the payment system that the new law requires will remain unknown until the Office of Administrative Law finalizes and approves the emergency regulations and providers, insurers, and claims administrators who participate in the workers' compensation program interpret and implement them.

Having adequate and reliable medical payment data is critical to any attempt to analyze and monitor how well the workers' compensation system delivers quality care to injured workers at costs that the law allows, as well as to efforts to track the effect of policy changes on the system's performance and costs. However, based on the findings in our first report on California's workers' compensation medical payment system and the knowledge we gained regarding State Fund's medical bill review database during this review, we found that California does not have a database of workers' compensation medical payments that can provide detailed and reliable data for such analysis and monitoring. The division's former administrative director told us that the State's hiring freeze and budget shortfalls have hampered his efforts to implement workers' compensation reform.

The division is currently developing a workers' compensation database, the Workers' Compensation Information System, intended to provide the type of information the division needs to analyze and monitor system performance. However, both the division's survey of insurers and our own analysis of the medical payment data that State Fund provided revealed that both State Fund's and the other insurers' data files appear to be incomplete or the data in the files are inaccurately and inconsistently classified. Therefore, neither the insurers nor the division—once these data are reported—will be able to use the data to make informed decisions.

We recommended that to fully realize the savings from the new reforms to the workers' compensation medical payment system, the division's administrative director must continue to provide the workers' compensation community with the ongoing education and guidance that will ensure that the reforms are promptly and effectively implemented.

The division should ensure that the medical payment data it collects in the Workers' Compensation Information System provides the specific information the division needs to adequately monitor medical payments for compliance with the payment system and for the effectiveness of policy decisions. Specifically, the division should first clearly define the data elements it requires from insurers and claims administrators; second, it should obtain the medical payment data using a standardized reporting instrument, which will ensure that insurers and claims administrators consistently and completely report the data in such a way that it will be useful for the division's analysis and monitoring.

Department Action: Partially implemented.

The Department of Industrial Relations (department) reports that it is currently focusing its attention on the implementation of the reforms from four legislative bills. Included in those bills are changes regarding the workers' compensation system's official medical fee schedule and medical treatment utilization. In addition, the department reports that it is implementing standardized billing forms and electronic billing. The department states that it has completed formal rulemaking for the official medical fee schedule and posted the final regulations on the division's Web site.

The department reports that it has adopted the interim medical treatment utilization standards required by legislative reform and has contracted for a study to identify a permanent medical treatment utilization schedule. It anticipates beginning the formal rulemaking process to adopt a permanent utilization schedule in the fall of 2004. In addition, the department states that it is continuing its efforts to implement standardized electronic billing procedures and expects full implementation by January 1, 2006.

The department reports that it is continuing to implement its workers' compensation database, the Workers' Compensation Information System (WCIS), intended to provide the type of information the division needs to analyze and monitor system performance. The department reports that it has met with its advisory committee for the development of the WCIS to discuss draft regulations. In addition, it has established a task force to refine the list of data elements needed to accomplish the goals of the system and work through technical issues for implementation of data reporting. The department reports it anticipates implementing medical data reporting regulations effective June 30, 2005.

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.*

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REPORT NUMBER 2003-108.1, AUGUST 2003

Division of Workers' Compensation, Department of Industrial Relations' response as of October 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: Corrective action taken.

Industrial Relations notes that the user funding provided by Chapter 639, Statutes of 2003, and the support of the governor to properly fund the division through the budget process are providing the essential resources needed to implement legislative reforms to the workers' compensation system.

Industrial Relations states that recent legislative reforms were designed to address the issues that have been identified by stakeholder groups and research organizations. Further, the department states that the current administration is committed to implementing the reforms, monitoring the effect of the reforms, and pursuing further legislative change as the need becomes apparent.

Finally, Industrial Relations states that the Labor and Workforce Development Agency and the division worked very closely with the Legislature and the Governor's Office on the proposals that were included in the 2003 reforms.

Legislative Action: Legislation passed.

Chapter 639, Statutes of 2003 (Senate Bill 228), eliminates funding for the administration of the workers' compensation program from the General Fund and establishes funding through surcharges levied on employers.

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 states that the division is awaiting the completed survey required by Chapter 639, Statutes of 2003, mentioned below. When the division receives the final results of the survey, it will immediately initiate an emergency rulemaking action to adopt the utilization treatment schedule.

Legislative Action: Legislation passed.

Chapter 639, Statutes of 2003 (Senate Bill 228), eliminates the medical council and requires that the commission survey and evaluate nationally recognized standards of care and report to the administrative director its recommendations for adopting a medical treatment utilization schedule. This chapter also requires the administrative director to adopt a medical treatment utilization schedule, based on the recommendations of the commission that, at a minimum, provides recommended guidelines for the frequency, duration, intensity, and appropriateness of treatment for workers' injuries or illnesses.

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: Partial corrective action taken.

The department points out that when the division adopts the new utilization schedule required by Chapter 639, Statutes of 2003, that statute also mandates that the schedule will be presumptively correct on the issue of extent and scope of medical treatment. This Labor Code change ensures that all insurers and claims adjusters are required to follow the standardized treatment guidelines and that treatment guidelines are accepted in judicial proceedings. The department further states that the division is in the process of amending its regulations to set parameters for the establishment and operation of utilization programs to ensure the standardized treatment guidelines are applied in an appropriate and timely manner.

Legislative Action: Legislation passed.

Chapter 639, Statutes of 2003 (Senate Bill 228), establishes that the guidelines in the medical treatment utilization schedule adopted by the administrative director shall be presumptively correct on the issue of extent and scope of medical treatment. This chapter further establishes that this presumption of correctness is rebuttable and the guidelines may be deviated from when evidence demonstrates that alternative treatment is reasonably required to cure and relieve the effects of workers' injuries or illnesses. Further, this chapter requires employers to establish a treatment utilization review process that contains policies and procedures to ensure that proposed treatments to cure and relieve workers' injuries and illnesses are based on the medical treatment utilization schedule adopted by the administrative director.

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: Corrective action taken.

Industrial Relations points out that legislative reforms passed in 2003 mandate the payment schedules for medical treatment and equipment to be provided to injured or ill workers in the workers' compensation system. Industrial Relations further states that the legislative reforms reduced the existing fee schedule for physician services by 5 percent and will remain in effect until January 1, 2006, at which time the division has the authority to adopt a new physician fee schedule. Industrial Relations states that the division is recruiting a medical director to manage its medical unit and assist the division in implementing legislative reforms and develop further fee schedules to cover all medical services. Finally, Industrial Relations states that it will study the feasibility of securing rebates from drug manufacturers for pharmaceuticals dispensed in workers' compensation cases. However, it notes that because workers' compensation is not a single-payer system it may be limited in its ability to negotiate lower pharmaceutical prices.

Legislative Action: Legislation passed.

Chapter 639, Statutes of 2003 (Senate Bill 228), requires that the administrative director adopt and revise periodically a medical fee schedule that establishes reasonable maximum fees for medical services other than physician services, drugs and pharmaceutical services, and certain other specified medical services. This chapter further requires the administrative director to contract with an independent consulting firm to perform an annual study of access to medical treatment for injured workers and make appropriate adjustments to the medical fees schedules to ensure injured workers' have sufficient access to quality health care or products.

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: Partial corrective action taken.

Industrial Relations reports that the division is continuing to work with the Industrial Relations' Information Systems Unit, the WCIS advisory committee, and a special task force to refine the list of data elements needed to accomplish the goals of the system and to work through technical issues for implementation of data reporting. The division projects it will implement its regulations for data reporting by June 20, 2005.

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.

DEPARTMENT OF INSURANCE

It Needs to Make Improvements in Handling Annual Assessments and Managing Market Conduct Examinations

REPORT NUMBER 2003-138, JUNE 2004

Department of Insurance's response as of August 2004

Audit Highlights . . .

Our review of the California Department of insurance's (Insurance) effectiveness in improving consumer services and reducing organized automobile activity through the use of SB 940 and AB 1050 funds and its market conduct examinations found that:

- ☑ *Insurance lacks adequate data to know how much it should have received from insurers since the enactment of SB 940 and AB 1050. Unaudited data from the Department of Motor Vehicles indicate that Insurance is collecting revenues for far less than the number of registered vehicles in the State, resulting in the possible loss of as much as $7 million in assessments for fiscal year 2002–03 alone.*
- ☑ *Insurance has not made sufficient efforts to verify that insurers are remitting all revenues due, even though it identified discrepancies in the number of insured vehicles reported by them.*

continued on next page . . .

The Joint Legislative Audit Committee (audit committee) requested that we assess the California Department of Insurance's (Insurance) effectiveness in improving consumer services and its Fraud Division activities as a result of the additional funding it received through SB 940 and AB 1050. Our audit found Insurance does not ensure that it receives all annual assessments due under Chapter 1119, Statutes of 1989 (regular automobile fraud program), Chapter 884, Statutes of 1999 (SB 940), and Chapter 885, Statutes of 1999 (AB 1050). Further, Insurance spent some annual assessment funds on inappropriate activities. The audit committee also requested that we examine the functions of Insurance's bureaus that perform market conduct examinations to determine the efficiency and necessity of having two separate examination bureaus. We found that Insurance would not realize a great deal of time or cost savings by combining its Field Claims Bureau and two Field Rating and Underwriting bureaus that perform market conduct examinations. However, opportunities exist for Insurance to improve management of its market conduct examinations because the Market Conduct Division does not fully utilize Insurance's database and cannot report on the time and cost associated with its examinations.

Finding #1: Insurance has no way of knowing if it receives all assessments due and lacks sufficient oversight for collecting annual assessments.

Insurance lacks adequate data to verify that the amounts insurers remit to it for the three annual automobile assessments constitute all amounts due. Currently, it does not collect complete data on the number of insured vehicles in the State. Lacking complete information on the number of insured vehicles in the State means that Insurance does not know how much it should have received since the enactment of

- ☑ *Despite reducing the backlog of cases in its Investigation Division by 51 percent, Insurance can improve how it reviews and assigns cases to ensure they are not outstanding for long periods of time.*
- ☑ *Insurance cannot easily demonstrate that its Legal Division used SB 940 funds for allowable activities only.*
- ☑ *Insurance could not demonstrate that all AB 1050 expenditures were for allowable activities. Specifically, Insurance spent $22,000 on cases that do not meet the criteria in state law.*
- ☑ *Insurance does not ensure that it follows state laws and regulations for monitoring district attorneys' and the California Highway Patrol's use of AB 1050 funds.*
- ☑ *Its Market Conduct Division does not fully utilize Insurance's database. Therefore, Insurance cannot report on the time and cost associated with its examinations or measure the efficiency of its market conduct operations.*

the regular automobile fraud program, SB 940, and AB 1050. However, it appears that Insurance is collecting assessments for far fewer than the number of registered vehicles in the State, and thus may have missed out on collecting revenues of roughly $7 million due to it during fiscal year 2002–03 alone.

Insurance has not made sufficient efforts to verify that the amounts insurers remit are based on the actual number of vehicles they insure. In May 2003, Insurance's Budget and Revenue Management Bureau analyzed annual assessments received from 349 insurers between calendar years 1998 and 2002 and found that many companies failed to make one or more quarterly payments over the five-year period and that some paid annual assessments for fewer total vehicles in calendar year 2002 than the number of private passenger vehicles they reported having insured to Insurance's Statistical Analysis Division. However, Insurance has yet to follow up with most of these insurers to determine whether they actually underpaid their assessments, and if so, to collect additional amounts that may be due.

We recommended that to ensure it receives all assessments due, Insurance should do the following:

- Move forward in its efforts to make regulatory changes that will result in capturing more specific data from insurers about the number of vehicles they insure.
- Compare the number of private passenger vehicles insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and investigate discrepancies.
- Direct its Field Examination Division to follow up on the discrepancies identified in the Budget and Revenue Management Bureau's analysis.
- Periodically perform analytical reviews of insurers' data, such as comparing changes in written premiums to changes in the assessments insurers remit, and investigate unusual trends.

Insurance Action: Partial corrective action taken.

Insurance reported that it filed a Notice of Proposed Rulemaking to make changes to the existing vehicle assessment regulations. Due to extensive discussions with insurance industry representatives, additional revisions are being made to the proposed regulations. Insurance expected to have these changes ready for public comment before December 31, 2004. Insurance also reported that it established written procedures in September 2004 to (1) perform a comparison of the number of private passenger vehicle insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and investigate discrepancies and (2) periodically perform analytical reviews of insurers' data. Finally, Insurance reported that its Field Examination Division continues to review the fraud auto assessment filings as part of the regularly scheduled financial examination of California domestic insurers. Any discrepancies noted will be forwarded to the Budget and Revenue Management Bureau for billing and collection or resolution.

Finding #2: Although Insurance has made improvements to consumer services, it cannot demonstrate that it spends all SB 940 funds on allowable activities.

Insurance used the additional staff and resources provided to it by SB 940 to reduce the backlog of open cases in its Investigation Division by 1,580 cases, or 51 percent, since the program's inception. However, Insurance can improve how it reviews and assigns cases to ensure that suspected violations of insurance laws and regulations by agents, brokers, and insurers do not remain unresolved longer than necessary. Further, Insurance used SB 940 funds to increase its outreach and communication efforts related to several automobile insurance programs, and in doing so, may have increased public awareness of the services it provides. However, because the case tracking system used by Insurance's Legal Division is not linked to its time reporting system, Insurance's Legal Division cannot demonstrate that it used the $9.4 million it received in SB 940 funds for only allowable activities.

To improve its services to consumers and provide appropriate oversight of SB 940 funds, we recommended that Insurance do the following:

- Revise its Investigation Division's policies and procedures to ensure that cases are not outstanding for long periods of time. For example, Insurance should assign cases to an investigator as soon as they are received and establish a goal that investigators take no more than a year from the date they receive a case to complete their investigations, barring extenuating circumstances.

- Review its open cases, both assigned and unassigned, to determine whether any should be closed.

- Eliminate the Investigation Division's backlog of unassigned cases by requiring staff to work a reasonable amount of overtime or seeking additional staff.

- Link its Legal Division's case tracking system to its time reporting system to better document the use of SB 940 funds.

Insurance Action: Corrective action taken.

Insurance reported that it issued a directive to the Investigation Division staff on September 23, 2004, requiring investigators to establish a goal completion date when the initial investigative plan is drafted. During monthly case reviews, supervisors are to monitor investigations and determine if they are proceeding in line with the projected completion date. Insurance also reported that it issued a directive on June 21, 2004, requiring Investigation Division staff to review and assess reports of suspected violations every three months to ensure that the reports are assigned and closed based on their viability. Further, Insurance stated that it received approval to establish five additional investigative positions and that its hiring efforts are in progress. Insurance plans to monitor the impact that these new positions have on reducing its backlog and, if necessary, seek additional resources in fiscal year 2006–07. Finally, Insurance reported that it implemented a time reporting system in the Legal Division to track time and activity for specific cases, including SB 940 cases. All bureaus have received training in the use of the system and are now using it.

Finding #3: Insurance needs to significantly improve its oversight of AB 1050 funds.

Since its inception, the AB 1050 program has supported a joint approach to investigating 446 organized automobile fraud activity cases, which have led to 432 arrests. However, Insurance used roughly $22,000 in AB 1050 funds to work on 20 cases that do not meet the criteria in state law. Although some cases were initially investigated as AB 1050 cases and later transferred to Insurance's Program for Investigation and Prosecution of Automobile Insurance Fraud (regular automobile fraud program), Insurance did not transfer the expenditures it already incurred on these cases to the regular automobile fraud program. Further, Insurance does not adequately monitor the use of AB 1050 funds by district attorneys receiving grants and by the Department of the California Highway Patrol (California Highway Patrol). Specifically, Insurance did not receive all required reports from district attorneys, and does not follow state regulations that require it to perform a fiscal audit of each county receiving AB 1050 grant funds at least once every three years. Moreover, although state law requires the California Highway Patrol to report annually to Insurance its use of AB 1050 funds, since the inception of the program, Insurance has neither requested nor received these reports. Thus, it cannot ensure that the California Highway Patrol is accurately charging the salaries and benefits of those investigators working on allowable activities under AB 1050.

To ensure that it uses AB 1050 funds appropriately, we recommended that Insurance do the following:

- Transfer the hours and billable expenses it charges to AB 1050 from its organized automobile fraud program when it transfers cases to the regular automobile fraud program.

- Follow state laws and regulations governing fiscal and performance audits of counties to ensure that the district attorneys use AB 1050 funds only for allowable activities and in the most effective and efficient manner.

- Require the California Highway Patrol to submit annual reports of its expenditures as state law requires.

Insurance Action: Corrective action taken.

Insurance reported that it established new procedures to follow when there is a need to transfer hours and expenditures from one fraud program to another. Insurance stated that it has reorganized the Fraud Grant Audit Unit and approved the hiring of two additional auditors. Insurance believes the new audit positions will provide adequate audit coverage that includes fiscal and performance audits of county district attorneys who receive AB 1050 funds. Finally, Insurance reported that it has obtained all annual expenditure reports from the California Highway Patrol for fiscal years 2000–01 through 2003–04.

Finding #4: Combining the Market Conduct Division's bureaus would not likely result in increased efficiencies, but opportunities to improve its management of market conduct examinations exist.

Combining Insurance's Field Claims and two Field Rating and Underwriting bureaus would not greatly reduce either the time or cost to perform market conduct examinations. The objective of the two examinations—claims examination and rating and underwriting examinations—is separate and distinct. Further, the claims examiners and the underwriting examiners possess separate expertise and experience. Thus, combining the three bureaus would require all examiners to become knowledgeable of both types of examinations. However, Insurance could benefit from preparing an analysis to quantify any savings that can be generated from combining administrative tasks such as timekeeping, scheduling and coordinating examinations with insurers, and preparing reports.

To determine whether it could generate savings from combining the administrative tasks of the three bureaus, we recommended that Insurance prepare an analysis and quantify possible savings.

Insurance Action: Partial corrective action taken.

Insurance stated that it has consolidated the timekeeping of the Field Rating and Underwriting Bureaus and currently one support staff handles this function in each of its bureaus. Additionally, one support staff now handles report publishing for the Market Conduct Division. Insurance stated it would conduct further reviews to eliminate, consolidate, or redistribute administrative tasks.

Finding #5: Insurance's Market Conduct Division cannot measure the efficiency of its operations because it does not take full advantage of Insurance's database.

Insurance's Market Conduct Division does not take full advantage of Insurance's database and does not adequately capture or tally the time or costs associated with its market conduct divisions; thus, it cannot measure the efficiency of its operations. Insurance's database has modules designed to capture data on insurers licensed to operate in California, including tracking examinations, staff hours, or how much to bill insurers. However, the Market Conduct Division has not taken full advantage of this database's capabilities and the other means this division uses to track examination data are inefficient and do not provide the necessary information.

To ensure that it has sufficient data to assess the efficiency of its Market Conduct Division, including an analysis of the average length of time and cost of its examinations, we recommended that Insurance's Market Conduct Division should work with its Information Technology Division to make full use of Insurance's database. At a minimum, we recommended that the Market Conduct Division's plans should include the following:

- Modifying its examination-tracking module to create an identification number that allows it to identify multiple insurers that are under examination using the existing company identification number.

- Eliminating the need for examiners to manually prepare the monthly timesheets and billing summaries by allowing them to enter their hours directly into the timekeeping module.

- Linking its examination tracking, timekeeping, and accounts receivable modules using the examination identification number.

Insurance Action: Partial corrective action taken.

Insurance reported that the Information Technology Division and the Market Conduct Division continue to work together to improve the examination-tracking module. It also stated that an examination activity summary form and an examination team and costs form are under development. When completed, these forms will allow the Market Conduct Division to track enforcement activities, remedial action,

exam recoveries and penalties, billable expenses, Proposition 103 expenses, and costs to date. Further, Insurance stated that it completed and tested an interface that will allow the Market Conduct Division to enter an identification number for each examination. Finally, Insurance stated that it completed a timekeeping interface and is working toward automatically populating billable hours and Proposition 103 hours into a monthly expense report from the timekeeping system.

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.*

continued on next page . . .

REPORT NUMBER 2003-112, DECEMBER 2003

Department of Health Services' response as of December 2004 and Department of Justice's response as of July 2004

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: Corrective action taken.

Health Services stated that it has improved the coordination of its antifraud efforts internally and with other departments, implemented a system to track issues and ideas for appropriate follow up, and designated the deputy director of audits and investigations as the person responsible for coordinating Medi-Cal antifraud activities within Health Services. This deputy director is also participating in the antifraud and provider enrollment workgroup the California Health and Human Services Agency (agency) convened. Health Services indicated that it was finalizing the Medi-Cal payment error study for release and that this study would set the benchmark for evaluating the effectiveness of its antifraud efforts. Health Services also stated that it would use the study to finalize its Medi-Cal antifraud strategic plan, targeted for completion in March 2005, which will encompass all the components of a model fraud control strategy, and the roles and responsibilities of Health Services' programs and its external partners.

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: Corrective action taken.

Health Services reported that it made beneficiary confirmation of product receipt an integral part of its error study and that it is routinely sending beneficiary confirmations to aid in focusing antifraud efforts. Additionally, Health Services indicated that the California Department of Justice (Justice) will become an integral part of the process for identifying areas for sending beneficiary confirmations. Further, Health Services stated that it plans to conduct annual error rate studies and has begun holding meetings to discuss the methodologies for the next annual study.

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: Corrective action taken.

Health Services stated that it is committed to a continuous evaluation of antifraud projects over time. It indicated that it has a new antifraud savings methodology that will be further refined for use in developing the May 2005 Medi-Cal estimate. Additionally, Health Services stated that it has implemented a new time-reporting system to monitor and track staff time spent on antifraud activities. Health Services reported that it will be able to compute the cost-benefit of its antifraud activities through the use of the refined savings methodology and the time-reporting system.

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 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: Corrective action taken.

Health Services stated that it has developed a plan and implemented procedures that ensure the enrollment applications are complete or that it gives the appropriate notice to providers within the required timeframes. Health Services indicated that it has prioritized risk so that providers defaulting to provisional status are in its lowest risk pools. It reported that it has completed an internal workload analysis, but is hiring a consultant to further study its provider enrollment business practices and conduct a formal workload analysis to streamline the application review process. Health Services also noted that the enrollment branch and audits and investigations have improved overall coordination, and cited actions taken to improve communication and coordination over provider enrollment and antifraud efforts.

Health Services reported that it developed a form that can be used by other Health Services programs and by other departments that enroll Medi-Cal providers. According to Health Services, the form includes information providers must disclose for participation or continued participation in the Medi-Cal program. Health Services will be amending its agreements with other state departments to require that the providers they approve for program participation have disclosure statements on file that meet federal regulatory requirements. Additionally, Health Services stated that the agency established an antifraud and provider enrollment workgroup to develop a proposal for coordinating all antifraud and enrollment activities within the agency. Finally, Health Services indicated that it developed a plan to reenroll all providers, is ensuring that provider numbers are properly deactivated, and is working with professional licensing boards to ensure that provider licensing information is received on a timely basis.

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: Corrective action taken.

Health Services stated that it has modified its claim payment system to delay claim payments and allow more time to conduct a pre-checkwrite review of claims for potential fraud, waste, or abuse. It also reported it is randomly selecting 100 claims per week to review for legitimacy before making the payment. Health Services indicated that it completed a preliminary assessment of fraud risk in the Medi-Cal program and that its field audits focus on high-risk provider types.

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 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: Corrective action taken.

Health Services stated that it signed a new agreement with Justice and has been referring all cases of suspected provider fraud to Justice.

Justice Action: Corrective action taken.

Justice reported that it successfully executed an agreement with Health Services that establishes meaningful guidelines to facilitate a successful and long 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: Corrective action taken.

Health Services stated that it started a clearinghouse process through its fraud and abuse steering committee where issues are assigned and tracked until completed. Additionally, the agency created an antifraud and provider enrollment workgroup, which includes all departments within the agency, to develop a proposal for agency-wide antifraud efforts.

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: Corrective action taken.

Health Services stated that its contracted vendor was able to determine that Medi-Cal managed care member dissatisfaction was at the provider level and not the managed care plan level. Additionally, Health Services indicated that it is continuing to assess and develop methods for enhancing its use of encounter data to monitor managed care plan performance. Further, Health Services stated it consulted with its legal office and found no legal authority for requiring managed care plans to estimate improper payments, but will review the results of its own error studies with the managed care plans and discuss what measures the managed care plans take to verify their provider payments.

CALIFORNIA LAW ENFORCEMENT AND CORRECTIONAL AGENCIES

With Increased Efforts, They Could Improve the Accuracy and Completeness of Public Information on Sex Offenders

Audit Highlights . . .

*Our review of the Department of Justice's (Justice) database of **serious** and **high-risk** sex offenders, known as the Megan's Law database, disclosed the following:*

- ☑ *The Megan's Law database contains thousands of errors, inconsistencies, and out-of-date information.*
- ☑ *Because it excludes records for some serious and high-risk sex offenders and erroneously lists others as incarcerated, the Megan's Law database does not inform the public about these offenders.*
- ☑ *Conversely, because it includes hundreds of duplicate records and erroneously indicates that 1,142 incarcerated sex offenders are free, it may unnecessarily alarm the public.*
- ☑ *The address information for roughly 23,000 records in the Megan's Law database has not been updated for at least a year largely because sex offenders have not registered.*

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REPORT NUMBER 2003-105, AUGUST 2003

Department of Justice's response as of August 2004

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits (bureau) to evaluate the accuracy of the State's database of registered sex offenders. Further, the audit committee asked us to determine if state and local law enforcement agencies are implementing Megan's Law in a manner that maximizes the registration data's accuracy. Lastly, we were asked to identify deficiencies in the current state Megan's Law that hinder the accuracy of the sex offender data and to provide legislative recommendations to address identified deficiencies.

Finding #1: The Megan's Law database omits some records of juvenile sex offenders tried in adult courts, and inappropriately includes others.

The law provides that only juveniles with juvenile court adjudications for their sex offenses are protected from public disclosure under Megan's Law. However, we found omitted from the Megan's Law public information a total of 51 Department of the Youth Authority (Youth Authority) records of juvenile sex offenders tried in adult courts. In 20 cases, Department of Justice (Justice) staff did not mark the records as coming from adult courts; in 31 other cases, Youth Authority or Department of Corrections (Corrections) did not prepare pre-registration or notification forms or Justice did not receive or process them. Without information about *serious* and *high-risk* juvenile sex offenders tried in adult courts and released into communities, California residents have no way of knowing that they are living near these convicted offenders.

In addition to problems with the overall accuracy of the Megan's Law database, we found that Justice does not always prevent the public disclosure of juvenile sex offenders' records. Specifically, Justice erroneously disclosed to the public 42 records for sex

☑ *Although Justice maintains that its primary responsibility is to compile the sex offender data it receives from law enforcement agencies and confinement facilities, it has taken steps to improve the accuracy of the information in the Megan's Law database.*

offenders convicted in juvenile courts, thwarting the additional protection and confidentiality that the Legislature has afforded to juveniles.

To ensure that the records of juvenile sex offenders are properly classified and disclosed to the public, we recommended that Justice do the following:

- Coordinate with the Youth Authority and periodically reconcile its sex offender registry with Youth Authority information.
- Provide training to its staff regarding the proper classification of records, such as flagging juvenile records appropriately for public disclosure.
- Revise its pre-registration process with Youth Authority to include a request for court information, which can be used to properly classify juvenile records.
- Request the Judicial Council to amend its juvenile commitment form to require that Youth Authority send a copy of the form to Justice.

Justice Action: Corrective action taken.

Justice reports that it worked with Youth Authority to develop an automated process for updating juvenile sex offender status in the Violent Crime Information Network (VCIN) with Youth Authority data. Justice implemented this process in November 2003 and uses it to update the VCIN monthly. In May 2004, Justice completed modifications to the process of synchronizing data between Justice and Youth Authority. As a result, a sex offender's status in the VCIN automatically changes from incarcerated to released when the sex offender's record no longer appears in Youth Authority's monthly electronic file. Justice also implemented new procedures and trained its staff to ensure that all juvenile sex offender records are properly classified for purposes of public disclosure. However, according to Justice, the Judicial Council denied its request to amend its juvenile commitment form to allow Youth Authority to provide Justice more detailed court disposition information about juvenile sex offenders.

Finding #2: The Megan's Law database omits some records with inaccurate offense codes.

Of approximately 18,000 records in the VCIN that are classified as "other" and not shown to the public, Justice identified 1,900 records that have offense code 290 rather than the more specific offense codes for which the sex offenders were convicted. Local law enforcement agencies and Justice staff sometimes enter the 290 offense code in reference to the section of the California Penal Code that mandates registration for sex offenders when they are uncertain of the appropriate code, and the VCIN automatically classifies records with this offense code as "other." Records classified as other are not included in the Megan's Law database and thus not disclosed to the public. Justice ultimately determines the proper offense code by researching conviction information, but stated that until recently it has not had the necessary staffing resources to do the work. Justice subsequently updated the offense code for 497 of the 1,900, raising the classification to serious for 351 of them. For most of the remaining 1,403 records, Justice is waiting for responses from other states.

We recommended that Justice continue reviewing records for which it has only the 290 offense code and update the offense codes as appropriate.

Justice Action: Corrective action taken.

Justice continues to review criminal history information to verify that registered sex offenders are properly classified for the purpose of public disclosure in the Megan's Law database. As of August 5, 2004, Justice had completed reviewing the approximate 18,000 sex offenders classified as "other," resulting in the reclassification of 1,431 of these sex offenders to "serious." Justice continues to research records with offense code 290, most of which involve offenses committed out-of-state and require Justice to acquire documentation from the courts in other states.

Finding #3: Some sex offender records continue to indicate the incarcerated status after offenders are discharged from prison or paroled, while others show incarcerated sex offenders as residing in local neighborhoods.

We found that for 582 records in VCIN that indicate the offenders are in prison, there were no records with matching Criminal Information and Identification (CII) numbers on Corrections' list of inmates. A sample of 59 of these revealed that 48 of the offenders

were no longer in prison. Another 1,142 records incorrectly indicate the sex offenders are free when, in fact, they are incarcerated. Additionally, of 2,575 records Justice identified as pending release from prison for more than a year, 1,787 of these offenders had already been released. Because Justice does not review Corrections' monthly list of prison inmates to identify sex offenders who appear on the list one month but not the next, it does not know if Corrections should have completed a form notifying Justice and local law enforcement that it will soon be releasing a sex offender or that one has died, and Justice does not know which offenders require follow-up to determine their true status. Unless Justice corrects these records or these offenders register, their records in the Megan's Law database will continue to incorrectly indicate that they are incarcerated.

We recommended that Justice regularly compare its records showing the incarcerated status with information provided by Corrections to determine which sex offenders are confined and those who are no longer in confinement, continue to work with Corrections to improve this process, and produce exception reports to resolve those records in question. Justice can then update these records appropriately.

Justice Action: Corrective action taken.

Justice modified the program it uses to update the VCIN using Corrections' list of incarcerated sex offenders, so that an offender's incarceration status will be removed from the Megan's Law database when the offender no longer appears on Corrections' list. The offender's status automatically changes to "released" and a violation notice is activated if the offender does not register with local law enforcement as required. Justice is also modifying the VCIN to generate violation notices based on the date of release, rather than on the date of notification, as reported in the pre-release notification documents. Justice anticipates it will complete these changes by the end of January 2004. According to Justice, these changes will significantly reduce future discrepancies between Justice's and Corrections' data.

To the extent possible, Justice and Corrections will pursue other methods for ensuring complete synchronization of sex offender data. For example, in May 2004, Justice implemented new program logic to improve the automated matching of Justice's and Corrections' data. As a result, more than 400 additional records in the VCIN were updated to reflect incarcerated status. However, Justice believes that it would not be practical to generate monthly exception reports as a means of identifying any sex offender records that cannot be properly matched to Corrections' data. It says that the use of such reports would be extremely time-consuming, since it would potentially require the manual research of thousands of possible matches each month.

Finding #4: The Megan's Law database includes hundreds of duplicate records primarily created by personnel who lack adequate training.

We identified 437 records in the Megan's Law database that were obvious duplicates of other database records. Consequently, the public cannot rely on the sex offender information shown in a zip code search to identify the number of offenders in a specific community. The public also cannot rely on the information retrieved from the Megan's Law database in response to a search for a specific sex offender by name, because more than one record can appear for an offender and, without dates on the records, the public cannot determine which record is the most current.

Personnel who update sex offender records create duplicate records because they do not always search for existing records before creating new ones. According to Justice's policies and procedures, when a sex offender registers, personnel updating sex offender records are required to search the database to determine if the offender matches existing records. However, Justice has not provided sufficient training to its personnel and to all local law enforcement agencies that update sex offender records. For example, we found that personnel at one city's police department entered 89 of the 437 duplicate records.

We recommended that Justice periodically analyze its data to identify and eliminate obvious duplicates. As a first step, Justice should review the bureau's analysis identifying obvious duplicate records and eliminate these duplicate records.

Additionally, to ensure that local law enforcement and its own staff update sex offender information appropriately, we recommended that Justice design and implement an appropriate training program.

Justice Action: Partial corrective action taken.

Justice has implemented an improved system for identifying duplicate records in the VCIN through a specially designed data-string search and manual verification process. This search augments the existing process of identifying duplicate records based on a cross match of CII numbers, and has been effective in detecting and eliminating virtually all duplicate errors within a week after they are created.

In addition, by early 2005, Justice plans to implement Live Scan, an electronic fingerprinting technology, allowing local law enforcement agencies to electronically transmit to Justice the offenders' fingerprints with each registration transaction. The fingerprints will be automatically verified for immediate and reliable identity confirmation, which according to Justice, will eliminate duplicate entries.

Also, Justice is continuing to improve its statewide training program on sex offender registration and is developing new training materials, including a comprehensive registration reporting manual and a high-quality video regarding legal aspects. Justice states that final development of these materials has been delayed until fall of 2004 pending the outcome of key legislative proposals that could have a significant impact on reporting and dissemination practices. To the extent resources permit, Justice continues to provide law enforcement training on data entry procedures, with focus on agency-specific reporting problems identified through ongoing analysis of submitted registration data. Justice personnel receive regular training in various aspects of registration processing in order to minimize technical errors that may contribute to data inaccuracy.

Finding #5: The Megan's Law database does not show when sex offenders' records were updated, limiting the information's usefulness to the public.

Because the Megan's Law database does not include the dates of offenders' registrations, the public has no way of distinguishing the records recently updated from those updated long ago, thereby limiting the usefulness of the information. We found that approximately 23,000 records were last updated before April 2002,

and about 14,000 of those were last updated before April 1998. Often, registrants do not comply with annual registration requirements, and many offenders with outdated information are not required to register in California because they may have moved outside the State, been deported or incarcerated, or are deceased. Without information in the Megan's Law database to tell them whether the last update was a week or five years ago, or a specific disclaimer explaining the possibility of outdated data, people viewing the database cannot evaluate the usefulness of the information they read.

We recommended that Justice modify the Megan's Law database to include the date that the registration information was last provided.

Justice Action: Corrective action taken.

Justice has modified the Megan's Law database to include a message indicating if and for how long an offender has been in violation of registration requirements.

Finding #6: The public would be well served by Justice attaching disclaimers to the Megan's Law database.

Even if state and local agencies accurately reported all the information they receive, the Megan's Law database would continue to be incomplete and inaccurate as a result of sex offenders not registering as required or providing inaccurate information when they do register. Currently, Justice includes some disclaimers in the information it provides the public. However, we believe that modifying the existing disclaimers and adding others about potential inaccuracies and errors could help the public better understand and use the data to protect themselves and their families. As of the end of our audit, Justice was in the process of finalizing additional disclaimers that incorporate our suggestions.

We recommended that Justice finalize its disclaimer information and direct law enforcement agencies to provide the disclaimers to the public members who view the Megan's Law database. The disclaimer information should include the following:

- A statement that Justice compiles but does not independently confirm the accuracy of the information it gathers from several sources, including sex offenders who register at law enforcement agencies and custodians who report to Justice when sex offenders are released from confinement

facilities. This statement should advise the viewer that the information can change quickly and that it would not be feasible for California's law enforcement agencies to verify the whereabouts of every sex offender at any given time.

- A statement that the information is intended not to indicate the offenders' risk to the public but to help people form their own assessments of risk.

- A statement that the location information is based on the "last reported location," which may have changed.

- A statement to remind viewers that a fingerprint comparison is necessary to positively identify a sex offender.

Justice Action: Corrective action taken.

Justice developed a comprehensive disclaimer containing the specific elements we recommended and has added this disclaimer to the Megan's Law database in English and 12 other languages.

Finding #7: Justice's review of the Megan's Law data has not been adequate.

State law declares the Legislature's intent that Justice continuously reviews the sex offender information in the Megan's Law database. However, Justice has interpreted this intent language to direct it only to continually review the accuracy of its entry of information, not of the information itself. Our legal counsel agrees with Justice that the intent language is not binding and states that because Justice is responsible for administering the Megan's Law database, it has flexibility in determining how it will fulfill the Legislature's intent that it continually review sex offender data. However, we believe Justice's review has not been adequate because the Megan's Law database is intended for the public's use in safeguarding itself from dangerous sex offenders. According to Justice, because it is only a repository, not the originating source, of much of the Megan's Law information, it is beyond the purview of Justice to ensure that information provided by courts and registering agencies is accurate.

The Associated Press reported in January 2003, based on information provided by Justice, that Justice did not know the whereabouts of 33,296 registered sex offenders because they had not registered annually as required. Subsequently, Justice determined that 663 of the 33,296 sex offenders had, in fact,

registered within the past year. In addition, Justice confirmed that 2,833 sex offenders are living outside the State and 1,360 are deceased. However, Justice received either outdated, incomplete, or no information on the remaining 28,440 sex offenders who did not register.

Justice obtained information on deaths from the Department of Health Services (Health Services), deportations from the Immigration and Naturalization Service (INS)[1], and sex offenders living in other states from the National Law Enforcement Telecommunication Services. However, until 2003, Justice had not requested death information to use for updating sex offenders' records. According to Justice, previously it did not obtain the information from Health Services or the INS because it has no underlying statutory responsibility for seeking out information from these agencies.

We recommended that Justice design and implement a program to check the data as a whole for inconsistencies and periodically reconcile the data with other reliable information. Additionally, we recommended that Justice continue to work with Health Services, the INS, and other public agencies to obtain valuable information and update the sex offenders' records.

Justice Action: Corrective action taken.

Justice has contracted with Health Services and the Social Security Administration to regularly obtain updated death certificate information. It will use this information on an annual basis to update sex offender information in the VCIN. In November 2003, Justice obtained on-line access to INS' deportation files, and regularly reviewed them to identify sex offenders who have been deported. In addition, Justice has begun ongoing analysis of its sex offender database to identify and correct record errors, which includes a series of special searches for key words and unique transaction sequences that may indicate possible data entry errors.

[1] On March 1, 2003, the U.S. Immigration and Naturalization Service became part of the U.S. Department of Homeland Security and changed its name to the Bureau of Citizenship and Immigration Services.

CALIFORNIA MILITARY DEPARTMENT

Improper Payments to Employees

ALLEGATION NUMBER I2002-1069 (REPORT I2004-2), SEPTEMBER 2004

California Military Department response as of July 2004

Investigative Highlight . . .

Over a two-year period, the Military Department paid employees at two of its three training centers $128,400 more than they were entitled to receive.

We investigated and substantiated an allegation that the California Military Department (Military Department) improperly granted employees an increase in pay they were not entitled to receive.

Finding: The Military Department overpaid its employees $128,400.

Between July 1, 2001, and June 30, 2003, 19 employees at two of the Military Department's three training centers received increased pay associated with inmate supervision even though they did not supervise inmates for the minimum number of hours required to receive the pay. For the two years we reviewed, the Military Department paid its employees at two of the training centers approximately $128,400 more than what they were entitled to receive. We were unable to determine to what extent, if any, the Military Department's third training center also improperly granted its employees the increased pay because it was not able to provide supporting documents for 23 of the 24 months we requested. At least 10 of its employees received the pay increase at some time during the two-year period.

Military Department Action: Corrective action taken.

The Military Department agreed with our findings and reported that it has implemented changes to correct the problems identified. Specifically, it reported that it has returned all employees receiving the pay increase to their original pay level and implemented a policy at all three training centers for certifying when employees are eligible for the pay increase. The Military Department also implemented a policy that requires the training centers to maintain employee compensation documentation for two years. Further, the Military Department reported that because its personnel costs for the training centers are reimbursed by the United States Property and Fiscal Officer for California

(USPFO), the State has, in effect, already been reimbursed for the overpayments; thus it will not pursue reimbursement from the employees who improperly received the increased pay. The Military Department provided a copy of our report to the USPFO, which has the authority to recoup or waive the overpayments from the State.

PRISON INDUSTRY AUTHORITY

Although It Has Broad Discretion in Pursuing Its Statutory Purposes, It Could Improve Certain Pricing Practices and Develop Performance Measures

REPORT NUMBER 2004-101, DECEMBER 2004

Youth and Adult Correctional Agency response as of December 2004

Audit Highlights . . .

Our review of the Prison Industry Authority (PIA) revealed the following:

- ☑ *Although state law does not require PIA to offer competitive prices and its prices can differ from those of other vendors, PIA could improve certain pricing practices.*
- ☑ *PIA has not established participation targets for the number of inmates it aims to employ among its various enterprises.*
- ☑ *PIA has not demonstrated adequately whether and in what manner it fulfills its statutory purpose to reduce the operating costs of the California Department of Corrections.*
- ☑ *Although PIA has embarked upon various activities aimed at enhancing the employability of its participants, it has not established targets or performance measures to track participants' post-release success and evaluate its own performance.*

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to identify to the extent possible the total amount the Prison Industry Authority (PIA) has received from its customers for PIA products over the past two fiscal years and to determine, for a sample of items, whether the products are priced above the market. Also, the audit committee requested that we determine to the extent possible PIA's financial impact on the California Department of Corrections (Corrections) and examine PIA's method for measuring its impact on inmates, particularly with regard to their obtaining employment upon release.

Finding #1: PIA lacks accurate product cost figures, does not document its justification for product prices, and lacks policies regarding special or discount pricing.

The Prison Industry Board (board) has established a pricing policy that allows PIA the discretion to establish prices that do not recover production costs, but it generally expects PIA to price each item at a level sufficient to recover the cost of producing the item. To comply with this expectation, PIA must be able to identify product costs accurately. However, according to PIA's acting assistant general manager for financial operations, distributing costs to products consistently and accurately is difficult because PIA's cost allocation methodology still relies primarily on the estimated hours an inmate spends making a product and because these hours can fluctuate significantly in a prison environment. Moreover, until recently PIA did not allocate certain costs, such as distribution, transportation, and administrative support, among its various enterprises, let alone among its individual products. Without accurate product costs, PIA cannot demonstrate that it considers only applicable costs when pricing a particular product in accordance with the board's policy.

In its pricing policy, the board established that PIA must base its prices on a profit margin, cost data, market data for comparable products and prices, and marketing strategies related to the product or service. Additionally, the policy requires PIA to review and update prices periodically to reflect a variety of changes. We expected that PIA would document the analyses it performed to establish and review its prices in order to demonstrate how it applied the specific criteria in the board's pricing policy in practice. However, when we reviewed 19 products for which PIA had adjusted or established the price in fiscal year 2002–03, PIA was unable to provide supporting analyses demonstrating how it arrived at or reviewed the prices for any of these products. Without documenting the analysis that supports each price, PIA cannot demonstrate to the board the consistency of the process it follows when pricing or reviewing the prices of its products and services.

Although PIA has discretion with regard to pricing, we expected it to have established policies regarding special or discount pricing arrangements through which different customers pay different prices for like items. However, after identifying certain products for which PIA charged a different price to different customers in fiscal year 2002–03 and asking PIA for an explanation, we found that there is no written policy regarding such arrangements. Without policies defining the circumstances under which PIA enters into special pricing arrangements or offers discounts, PIA risks the appearance that its pricing practices are unfair.

We recommended that PIA develop a method to allocate administrative support, distribution, and transportation costs directly to its products and services and ensure that, until it does so, its allocation of costs to the various enterprises is as accurate as possible. In addition, we recommended that PIA ensure that it documents the analyses it conducts to establish, change, or review its prices. Finally, PIA should establish policies for entering into special pricing arrangements or offering discounts and ensure that its customers are aware of such opportunities.

PIA Action: Partial corrective action taken.

PIA states that it plans to annually refine its process of allocating distribution, transportation, and central office costs among its enterprises, with the objective of continually improving the accuracy of costs that are allocated to PIA's enterprises and allowing PIA to further refine product costing and pricing strategies as well. PIA also states that in July 2004 a standardized methodology was developed for establishing, changing, and reviewing pricing for standard products and a form for documenting competitive pricing research was also developed. Finally, PIA states that by March 1, 2005, it will formalize and document internal procedures that will include guidelines for offering discounts and other nonstandard pricing strategies to all customers.

Finding #2: PIA has not established inmate participation targets or related enterprise evaluation criteria.

Although one of PIA's statutory purposes is to employ inmates, and the Legislature intended in part that PIA employ inmates in order to reduce inmate idleness and prison violence, PIA has not established participation targets for the number of inmates or percentage of Corrections' institution population PIA aims to employ, either overall or by enterprise. Moreover, although inmates employed in PIA's enterprises contribute toward its ability to be self-supporting, this contribution varies depending on the enterprise. Yet PIA has not established criteria for evaluating each enterprise's combined contribution to PIA's statutory purposes of being self-supporting and employing inmates. Without establishing employment targets and routinely assessing the contribution of each enterprise to profitability as well as inmate employment against criteria, such as profitability per inmate, PIA limits decision makers' ability to assess its overall performance.

We recommended that PIA establish long-range annual employment targets overall, for each enterprise, and as a percentage of Corrections' institution population. PIA should include these targets and annual results in meeting them, as well as explanations when they are not met, in its annual report to the Legislature. In addition, PIA should establish criteria,

such as profitability per inmate, and evaluate its enterprises' contribution toward its statutory purposes of being self-supporting and employing inmates relative to such criteria.

PIA Action: Partial corrective action taken.

PIA states that beginning with fiscal year 2005–06, its annual plan and strategic business plan will include long-range inmate employment targets and its annual report will address the success in meeting these targets. PIA indicates that it has adopted profitability per inmate as an indicator of performance and is considering other appropriate criteria for evaluation purposes.

Finding #3: PIA has not demonstrated adequately whether and in what manner it reduces the operating costs of Corrections.

PIA claims that it provided Corrections $14.1 million in cost savings in fiscal year 2002–03 by offering a correctional work or training program (correctional program) for inmates that Corrections otherwise would have had to fund. However, in PIA's absence, Corrections is neither legally obligated nor was it prepared to reassign all of PIA's participants in fiscal year 2002–03 to programs other than PIA. Further, PIA bases its calculation on the particular correctional program components Corrections sought to expand in a fiscal year 1998–99 unapproved budget change proposal and did not demonstrate that these programs represented the only available correctional program options and associated costs for fiscal year 2002–03. Thus, PIA's approach toward claiming cost savings to Corrections for fiscal year 2002–03 is questionable.

A new bridging education program (bridging program) Corrections initiated in fiscal year 2003–04 provides an additional option for inmates who wish to participate in a correctional program and are eligible to reduce their sentences by one year for each year of participation. As a result, PIA may be able to claim that it provides Corrections a cost savings only for those inmates that Corrections, in PIA's absence, would reassign into the bridging program and incur related costs. The bridging program also will reduce or eliminate the group of inmates whose participation in PIA could result in a cost avoidance to Corrections due to their earning sentence reductions credits at a faster rate. Thus, PIA's ability to claim any cost avoidance in the future with regard to sentence reduction credits its participants earn is impaired significantly.

To the degree PIA estimates cost savings that result from inmates participating in PIA, we recommended that PIA ensure that its analysis considers all the options and associated costs per inmate that Corrections would have available for reassigning PIA's participants into another program in PIA's absence.

PIA Action: Pending.

PIA states that it will implement our recommendation when performing future analyses involving cost savings that result from inmates participating in PIA.

Finding #4: PIA has not established targets or performance measures to track participants' post-release success and evaluate its own performance.

As a result of obtaining data from Corrections and entering into a contract with the Employment Development Department, PIA now has the capability to report on two of the common elements that decision makers use to assess a correctional program—inmates' ability to obtain post-release employment and to avoid returning to prison. However PIA has not established targets or performance measures to track participants' post-release success and evaluate its own performance. Further, PIA currently lacks the necessary data to determine whether the specific training or experience it provides inmates affects the type of job an inmate obtains after release. For instance, one component of PIA's inmate employability program is to offer industry-accredited certifications to inmates. However, PIA presently cannot identify whether the certifications have led to post-release employment in the field in which inmates obtained certification. Despite the challenges of establishing a direct link between PIA's activities and inmates' level of success after release from prison, without measuring and reporting on how inmates who have participated in its enterprises fare after release, PIA cannot provide an adequate perspective on the effectiveness of its pursuit of its statutory purpose to offer inmates the opportunity to develop effective work habits and occupational skills. Moreover, without performance measures or targets, PIA cannot focus its inmate employability efforts on areas that demonstrate success.

We recommended that PIA establish targets against which to measure its participants' post-release success in obtaining employment and not returning to prison. For instance, PIA should compare the post-release success of its participants

to that of participants in other correctional programs, to nonparticipants, or to its own expectations. PIA should also identify whether the specific training or experience inmates obtain leads to employment in a related field. Corrections should assist PIA in obtaining any necessary data for comparison by providing comparable data on other correctional programs to PIA. To further refine and focus on those activities with a demonstrated track record, PIA should also track the individuals participating in unique components of the inmate employability program to determine whether there is a link between the components and inmates' post-release employment, earnings, and returns to prison.

PIA Action: Pending.

PIA states that it is finalizing a contract with an institution of higher education to design and conduct a multi-year research study scheduled to begin in 2005 to measure the impact of PIA on its participants' post-release success. PIA plans to use the study results to determine appropriate standards for establishing targets relative to post-release employment and recidivism. PIA also indicates that it will develop a table similar to the one we recommended to include in its annual report to demonstrate each enterprise's contribution to participants' post-release success. PIA states that it will work with Corrections to compare its impact on post-release employment and recidivism with other correctional programs and nonparticipants. Finally, PIA indicates that by March 1, 2005, it will expand current tracking activities to better assess the impact of discrete elements of the inmate employability program upon post-release employment and recidivism.

CALIFORNIA PUBLIC UTILITIES COMMISSION

It Cannot Ensure That It Spends Railroad Safety Program Fees in Accordance With State Law

REPORT NUMBER 2003-121, MAY 2004

California Public Utilities Commission response as of November 2004

Audit Highlights . . .

Our review of the California Public Utilities Commission (commission) revealed that:

- ☑ *The commission does not have an effective method to track the time its employees spend on railroad safety activities.*
- ☑ *The commission cannot ensure that it charges only allowable travel-related expenses to the Railroad Safety Program.*
- ☑ *Inaccuracies in its cost allocation plan and table have caused the commission to incorrectly charge indirect costs to the Railroad Safety Program.*
- ☑ *Without a system to track direct and indirect costs, the commission cannot establish reliable budgets and set appropriate fees.*

The Joint Legislative Audit Committee requested the Bureau of State Audits to determine whether the California Public Utilities Commission (commission) uses Railroad Safety Program fees according to requirements specified in the California Public Utilities Code. Specifically, we found:

Finding #1: The commission does not have an effective method to track the time its employees spend on railroad safety activities.

The commission uses a timekeeping system that does not track the actual time its employees spend working on railroad safety activities. As a result, some inspectors inconsistently report their hours, and the commission uses estimates to determine the direct labor expenditures of clerical, supervisory, and legal staff who work on activities related to the Railroad Safety Program. In fiscal years 2002–03 and 2003–04, errors in those estimates resulted in overcharges to the Railroad Safety Program. However, the commission did not take sufficient steps to ensure that similar errors would not reoccur. In fact, we found that between July 2003 and February 2004 the commission incorrectly charged the Railroad Safety Program $281,000 for staff in its legal divisions.

The commission has been trying to upgrade its timekeeping system since as early as spring 2002 to allow its employees to record the actual time they spend on projects or activities and to integrate its timekeeping system with its accounting system. However, the commission has experienced delays and does not expect to complete the system upgrades until

September 2004. Thus, it cannot ensure that the fees it collects are spent only on the direct labor charges of Railroad Safety Program employees.

We recommended that the commission should move quickly to fully implement upgrades to its timekeeping system to allow employees to record the actual time they spend on railroad safety activities and to enable the commission to reconcile expenditures to funding sources. We also recommended that the commission should ensure that it determines the effect that incorrectly charging hours for staff in its legal divisions has on the allocation of indirect costs to the Railroad Safety Program and adjust its accounting records for fiscal year 2003–04.

Commission Action: Partial corrective action taken.

The commission indicated that staff in the Information and Management Services Division and the Consumer Protection and Safety Division received training on its timekeeping system in October 2004 and have begun entering data into the system. The commission plans to train staff in its other divisions by December 2004 and estimates that staff in these other divisions will begin entering data into the system by January 2005. Finally, the commission stated that it made the appropriate adjustments to its accounting records.

Finding #2: The commission cannot ensure that it charges only allowable travel-related expenses to the Railroad Safety Program.

Because of weaknesses in its method of processing travel expense claims submitted by railroad safety inspectors, the commission cannot ensure that all travel-related expenses charged to the Railroad Safety Program are allowable.

Specifically, the commission does not always require inspectors to report the proper program cost account codes or the percentage of time they spend traveling for Railroad Safety Program inspections on their travel expense claims. Further, although inspectors' time sheets may indicate time spent on other programs, the commission does not direct its accounting staff to charge costs among programs according to the indicated percentages. Consequently, the commission cannot ensure that only allowable travel-related expenses are charged to the Railroad Safety Program.

We recommended that the commission should establish procedures requiring inspectors to identify the program cost account codes to be charged for their travel expenses on their travel expense claims. Additionally, the commission should require its accounting staff to enter all valid codes shown on the travel expense claim into the accounting system.

Commission Action: Corrective action taken.

The commission indicated that it implemented a process under the guidance of the Consumer Protection and Safety Division's budget control and fiscal officers.

Finding #3: Inaccuracies in its cost allocation plan (plan) and table have caused the commission to incorrectly charge indirect costs to the Railroad Safety Program.

The commission has not established a formal process for periodically reviewing and updating its plan in accordance with state accounting procedures. The plan contains the method of distributing operating expenses or equipment costs that cannot practically be charged directly to the programs that benefit from the accumulated costs. Additionally, the commission does not maintain its accounting system's cost allocation table (table), which contains data that are the basis of the allocation of expenditures and encumbrances in the commission's accounting system, the California State Accounting and Reporting System. Consequently, both the plan and table contained inaccuracies that resulted in the commission improperly charging the Railroad Safety Program for indirect costs. For example, the commission did not change its table to reflect all the unit codes established during its reorganization. Without a formal process for evaluating the accuracy of its plan and table, the commission cannot ensure that it appropriately charges indirect costs to various programs, including the Railroad Safety Program.

We recommended that the commission develop policies and procedures to ensure that it maintains its plan and table for indirect charges in accordance with the State Administrative Manual. Specifically, the commission should periodically review and update its plan and table to ensure that the allocation bases are appropriate. Further, it should ensure that management reviews and approves any changes to the plan.

Commission Action: Partial corrective action taken.

The commission plans to update its fiscal year 2004–05 cost allocation plan and table by January 2005. It also plans to submit the cost allocation plan to its management for review and approval. Thereafter, the commission plans to review its cost allocations annually and/or when changes to its organizational structure require adjustments to the cost allocation factors. Finally, the commission indicated that it adjusted its accounting records for fiscal year 2003–04.

CALIFORNIA PUBLIC UTILITIES COMMISSION

State Law and Regulations Establish Firm Deadlines for Only a Small Number of Its Proceedings

REPORT NUMBER 2003-103, NOVEMBER 2003

California Public Utilities Commission's response as of December 2004

Audit Highlights . . .

Our review of whether the California Public Utilities Commission (commission) promptly resolves formal and informal proceedings found the following:

- ☑ *Few of the 1,602 formal proceedings the commission initiated between January 1, 2000, and June 30, 2003, were subject to statutory deadlines.*
- ☑ *Commission staff provided various reasons for delays, including that the outcomes of some proceedings were dependent on other decisions or investigations or the proceedings were purposely kept open to take up related issues or to manage them in multiple phases.*
- ☑ *Two factors contributed to delays in processing the more informal advice letters, which the commission uses to approve minor requests from utilities: Some had a lower workload priority and some required formal resolution or investigation.*

continued on next page . . .

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits determine whether the California Public Utilities Commission (commission) promptly completes the various types of administrative proceedings it is responsible for conducting. The audit committee asked that we determine how the commission sets priorities in the water, telecommunications, and energy areas when conducting its various types of administrative proceedings. Additionally, we were asked to review staffing levels to assess whether these levels are adequate for the commission to comply with its statutory mandates regarding administrative proceedings. As part of the assessment, we were to consider other studies that may have been performed related to staffing. Finally, the audit committee requested that we identify any timelines contained in law or regulations for the completion of proceedings. We were asked to select a sample of proceedings that exceeded the timelines yet remain unresolved and another sample that exceeded the timelines but were resolved and determine the reasons for delays.

Finding #1: Some proceedings the commission closed promptly that it later reopened appeared to be delayed.

The commission resolved five of 45 proceedings we reviewed within the statutory deadline or guideline, but because its tracking system does not appropriately reflect the resolution of proceedings that are reopened, these proceedings appeared to have been delayed. The commission's system tracks numerous pieces of information about each proceeding, including the title and type of proceeding, when it was opened and closed, and when it was reopened. However, when the commission reopens a proceeding, such as when it considers requests for a rehearing, and then closes the proceeding again, the

Although the commission cited workload and inadequate staffing as contributing to delays in processing its formal proceedings and advice letters, the lack of a workload tracking system hinders its ability to justify staffing needs.

later closing date replaces the initial one. Because only the later closing date is used in measuring how long the commission took to resolve the proceeding, the commission appears to have required more time than it actually did. When we became aware that the closing dates in the tracking system were not always accurate, we reviewed all 70 of the proceedings that had reopen dates and found that the commission resolved 43 within the original deadlines.

We recommended that the commission modify its tracking system to retain the original closing date as well as record its subsequent closing date for those proceedings it reopens.

Commission's Action: Corrective action taken.

The commission indicated that it is now retaining multiple closing dates within its tracking system. Additionally, it plans to further modify the tracking system to perform queries and prepare reports utilizing the retained data.

Finding #2: The commission did not report certain proceedings.

Although the commission tracks and reports to the Legislature whether it has met certain deadlines established in law, it does not report whether it is meeting the 60- and 90-day deadlines for issuing draft decisions. Moreover, it does not adequately track the submission date that would allow it to do so. Specifically, although commission staff provided us with submission dates for rate-setting and quasi-legislative proceedings, two of the 12 submission dates reviewed for accuracy were erroneous. In addition, the commission initially was unable to provide us with submission dates for adjudicatory proceedings. According to the chief administrative law judge (ALJ), the commission based its decision to report only certain deadlines to the Legislature on its belief that the Legislature is most concerned with the portion of these proceedings involving commissioners' actions; therefore, it tracks and reports whether the commissioners have met the 60-day deadline to approve final decisions. However, because ALJs are most often responsible for meeting the 60- and 90-day deadlines to prepare draft decisions, the commission's decision not to report compliance with these deadlines to the Legislature overlooks the portion of the proceedings subject to these deadlines. Therefore, because state law requires the commission to issue draft decisions within either 60 or 90 days of submission, we believe it is important to accurately track all submission dates in order to monitor compliance with these requirements.

To ensure it is complying with the 60- and 90-day deadlines between submission date and filing a draft decision, we recommended that the commission better track its submission dates and monitor whether it is meeting its deadlines.

Commission's Action: Corrective action taken.

The commission stated that it implemented internal work rules to require its ALJs to report submission dates earlier and more accurately. However, the commission did not indicate whether it is using the submission dates to monitor whether it is meeting its deadlines.

Finding #3: The commission did not prepare a work plan access guide annually as required by law.

Although state law requires that the commission develop, publish, and annually update a work plan access guide (work plan), it did not prepare the work plan for 2000 through 2002. Among other things, state law requires the commission to include within the work plan a description of the scheduled rate-making proceedings and other decisions it may consider during the calendar year, information on how the public and ratepayers can gain access to the commission's rate-making process, and information regarding the specific matters to be decided. Ultimately, the commission did prepare a work plan for 2003 that included its criteria for determining regulatory priorities and a list of the 2003 major proceedings. The commission states in its 2003 work plan that it allocates its staff resources for decision making according to a stated set of priorities established by its president.

To ensure it discloses to the public and the Legislature its process for prioritizing its proceedings, we recommended that the commission continue to annually prepare and publicize a work plan, which includes its criteria for prioritizing formal proceedings, as required by law.

Commission's Action: Corrective action taken.

The commission indicated that its current process is to continue to prepare an annual work plan that contains work priorities and criteria for determining priorities.

Finding #4: The commission delayed closing or failed to close advice letters promptly.

Staff promptly reviewed and approved 17 of the telecommunications division's and 10 of the energy division's advice letters, which the commission uses to address minor requests from utilities. However, staff either delayed closing or failed to close these 27 advice letters in the proposal and advice letter (PAL) tracking system. This represents 30 percent of the 90 advice letters we selected for testing. We believe that the high proportion of advice letters in our sample that remain open according to the dates in the PAL tracking system when they are actually closed should be of concern to the commission because it recently began using data recorded in the PAL tracking system to report to the commissioners on the status of advice letters. This type of erroneous data generated by the tracking system could be misleading to the commission and to those to which the commission reports this information.

We recommended that to ensure the information included in the PAL tracking system is accurate for reporting to the commissioners in public meetings on the timeliness of advice letters, the commission should review all advice letters in the system and close those where it is appropriate to do so.

Commission's Action: Partial corrective action taken.

The commission stated that it has revised its internal process and is currently reviewing all open advice letters.

Finding #5: The telecommunications division does not adequately maintain and track its advice letters.

The commission's telecommunications division (telecommunications) lacks a filing system that allows it to store advice letters and the supporting documentation for the letters in a central location. Thus, telecommunications had difficulties locating advice letter files and related supporting documents. Specifically, telecommunications staff required several weeks to locate 60 advice letter files we requested and were ultimately unable to locate six of them. We observed in many instances that advice letters were located at an analyst's desk or piled on tables rather than in a central filing area. Telecommunications staff conceded that maintaining and tracking advice letters has been and continues to be a problem.

In an attempt to address its filing problems, telecommunications has initiated a pilot project that allows utilities to submit advice letters and supporting documents in an electronic format. A program manager indicated that telecommunications intends to maintain electronic copies of the advice letter and supporting documents, which he believes will facilitate their storage and tracking. Although this may eventually prove successful, telecommunications still needs to file and track the advice letters and supporting documents of utilities that currently choose not to file electronically in such a way that it is able to accurately and promptly retrieve them.

Finally, as part of its processing, telecommunications requires utilities to submit a summary sheet with their advice letters. Telecommunications uses this summary sheet to track the advice letter's progress by indicating the differing levels of review and approval it has received. However, staff often could not locate the relevant summary sheet or, when found, it was not fully completed.

We recommended that as part of its new electronic filing process, the commission ensure that the telecommunications division creates an effective centralized filing system for those advice letters and supporting documents not submitted in electronic format. Additionally, for purposes of oversight and external and internal review, the commission should ensure that telecommunications staff consistently complete and retain summary sheets to evidence appropriate approval and review and that telecommunications maintains the summary sheets in its advice letter files.

Commission's Action: Partial corrective action taken.

The commission indicated that on January 5, 2004, it implemented new rules for handling advice letters, which eliminated the paper process. However, it indicated that closed paper advice letters are in temporary bulk storage making it difficult to retrieve them. The commission is considering other options to handle the bulk files, budget permitting, such as microfilming or archiving in a central state location off premises.

Finding #6: The commission lacks a workload tracking system that would allow it to justify its staffing needs.

Although the commission indicated that staffing is a limiting factor in promptly processing its formal proceedings and advice letters, it was unable to provide us with workload analyses to support these contentions. In fact, the Department of Finance (Finance),

in various reports and management letters it prepared between February 1998 and February 2003, reported that the commission lacks a workload tracking system that would allow it to justify its staffing needs. In response to a February 2003 management letter, the commission began to revise its workload tracking system to address Finance's concerns; however, it does not anticipate implementing key phases of the new system until the end of 2003 or the beginning of 2004. Thus, during our audit the commission was unable to provide us any staffing analyses that would allow us to determine whether its staffing levels are adequate to promptly process formal proceedings and advice letters.

We recommended that the commission continue to work with Finance on improving its workload tracking system so that it can justify its staffing needs.

Commission's Action: Partial correct action taken.

The commission stated that it is currently implementing a new workload tracking system, which it plans to begin using with the December 2004 pay period. It also indicated that the new system maintains historical employee position information, which is necessary for accurately determining staffing requirements.

PUBLIC UTILITIES COMMISSION

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

ALLEGATION I2002-753 (REPORT I2003-2), SEPTEMBER 2003

Public Utilities Commission response as of September 2003

We investigated and substantiated that a supervisor with the Public Utilities Commission (PUC) improperly deposited into his personal bank account funds he received from the annual state railroad conference (conference) he oversaw.

Investigative Highlights . . .

A supervisor with the Public Utilities Commission (PUC):

- ☑ *Improperly deposited into his personal bank account $80,759 he received from PUC-sponsored conferences he oversaw during 1999, 2000, and 2001.*
- ☑ *Achieved a profit of $37,542 after paying conference expenses.*
- ☑ *Used $1,408 in funds he received during the 1999 conference to pay for alcohol.*

Finding #1: The supervisor improperly deposited conference funds into his personal bank account.

In violation of state law, the supervisor improperly deposited into his personal bank account at least $80,759 he received as a result of his involvement with the conference. Specifically, between June and August 1999, he deposited $30,056 in checks he received from various individuals or groups of individuals who attended that year's conference. Between May and August 2000, the supervisor deposited into his personal account $8,835, representing a $95 registration fee for as many as 93 individuals. The following year, between July and October 2001, the supervisor deposited $41,868 in his personal account, most of which related to $200 registration fees for more than 130 attendees.

The supervisor maintained that the conference was not a state-sponsored function but rather a joint effort involving various representatives from government, railroad companies, and consulting firms. He reasoned that the State paid only for registration and per diem costs for state-employed attendees and that no one, including his supervisors, indicated that he was handling conference funds inappropriately. Nonetheless, the decision to manage these funds outside the State Treasury is not consistent with state law. The law characterizes funds as public

funds when employees receive them in their official capacity. Documentation such as conference announcements, registration forms, hotel contracts, and check copies clearly demonstrate that these events were advertised as a state conference that the PUC endorsed and that the supervisor acted in his official capacity with the State when he accepted payments related to the conference.

Finding #2: The supervisor profited from his involvement with the state conference.

Because the PUC allowed the supervisor to control conference funds outside of approved state accounts, he was able to retain as much as $37,542 in profits. State law prohibits state employees from engaging in any employment, activity, or enterprise that is clearly inconsistent, incompatible, in conflict with, or inimical to their duties as state officers or employees. Incompatible activities include using state time, facilities, equipment, supplies, and the prestige or influence of the State for one's own private gain or advantage. Our analysis indicates that the supervisor profited by at least $3,725 from the 1999 conference; $3,386 from the 2000 conference; and $30,431 from the 2001 conference.

We asked the supervisor to review our calculations and provide any additional evidence, particularly concerning any conference-related costs that might demonstrate he had not profited from these events. The supervisor insisted that he had lost money each year on the conference and that he had maintained detailed accounting records that proved this until one of his superiors told him that he no longer needed to keep them. After reviewing the accounting records and invoices we obtained from each of the facilities that hosted the conferences, the supervisor stated that he had paid other costs, such as off-site dinners and mailing expenses, that these bills did not reflect. However, he was unable to provide documentation to support any of these additional costs.

Finding #3: The supervisor used funds to pay for alcohol-related expenses.

Of the money the supervisor received and paid for costs associated with the 1999 conference, we identified $1,408 that pertained to alcohol-related expenses. State law prohibits state officers and employees from using state resources for personal enjoyment, private gain, or personal advantage or for an

outside endeavor not related to state business. As we mentioned previously, because state law characterizes the conference funds the supervisor received and deposited as public money, its use to purchase alcohol constitutes a misuse of public funds.

PUC Action: Corrective action taken.

The PUC discontinued the conference and plans to train all staff who may accept money from outside parties on proper record-keeping procedures and fiscal accountability. In addition, the PUC states it does not plan to initiate personnel action against the supervisor until it receives and completes its review of critical documentation. PUC terminated the employee effective February 13, 2004.

OFFICE OF THE SECRETARY OF STATE

Clear and Appropriate Direction Is Lacking in Its Implementation of the Federal Help America Vote Act

REPORT NUMBER 2004-139, DECEMBER 2004

Office of the Secretary of State response as of December 2004

Audit Highlights . . .

Our review of the Office of the Secretary of State's (office) administration of federal Help America Vote Act of 2002 (HAVA) funds revealed the following:

- ☑ *The office's insufficient planning and poor management practices hampered its efforts to implement HAVA provisions promptly.*
- ☑ *The office's disregard for proper controls and its poor oversight of staff and consultants led to questionable uses of HAVA funds.*
- ☑ *The office avoided competitive bidding for many contracts paid with HAVA funds by improperly using a Department of General Services exemption from competitive bidding and by not following the State's procurement policies.*
- ☑ *The office bypassed the Legislature's spending approval authority when it executed consultant contracts and then charged the associated costs to its HAVA administration account.*

continued on next page . . .

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the Office of the Secretary of State's (office) fiscal year 2003–04 budget request and verify that all components of the federal Help America Vote Act of 2002 (HAVA) grants were implemented within the spirit and letter of the law. Specifically, the audit committee asked the bureau to review and evaluate relevant laws, rules, and regulations; to determine whether the office used HAVA funds only for allowable purposes and in accordance with Section 28 of the Budget Act of 2003; and to determine whether the office implemented HAVA in compliance with federal requirements. It also asked the bureau to review and evaluate the office's policies and procedures for administering HAVA funds, including the process of awarding and disbursing those funds, and to determine whether it effectively oversees the use of the funds it awards to ensure that recipients use them only for allowable purposes. The audit revealed the following:

Finding #1: The office's insufficient planning and poor management practices hampered its efforts to implement some HAVA provisions in a timely way.

The office is in danger of failing to meet the deadline for at least one HAVA requirement and other important future implementation milestones because of insufficient planning and other poor management practices. According to its current schedule, it may not fully implement by the January 1, 2006, HAVA deadline a computerized statewide voter registration list that is maintained and administered at the state level. Further, the office could have been more proactive in assisting counties in achieving the successful statewide implementation of other HAVA requirements, such as provisional voting procedures, a free access system, the posting of voter information, and voter identification requirements.

☑ ***The office failed to disburse HAVA funds to counties for the replacement of outdated voting machines within the time frames outlined in its grant application package and county agreements.***

These shortcomings in meeting HAVA deadlines can be traced to the office's incomplete planning for each of the activities it intended to undertake. As a result of this incomplete planning, as of June 30, 2004, the office had spent only $46.6 million of the $81.2 million authorized by the Legislature for fiscal year 2003–04. The lack of implementation plans for various HAVA projects could have been due in part to a lack of project management oversight. According to the office's executive staff, no one individual was assigned the overall responsibility for HAVA implementation. Instead, direction for administering HAVA activities came from many staff in the executive office. Eventually recognizing the need for project management services to implement HAVA successfully, the office solicited proposals from vendors for consulting services in June and then again in October 2004, and gave notice of its intent to award a contract on December 1, 2004.

To ensure that it successfully implements the requirements called for in HAVA, we recommended that the office take the following steps:

- Develop a comprehensive implementation plan that includes all HAVA projects and activities.
- Designate the individuals responsible for coordinating and assuring the overall implementation of the plan.
- Identify and dedicate the resources necessary to carry out the plan and assign roles and responsibilities accordingly.
- Establish timelines and key milestones and monitor to ensure that planned HAVA activities and projects are completed when scheduled and that they meet expectations.

Office Action: Pending.

The office responded that it drafted a preliminary implementation plan that it was in the process of finalizing. It also stated it had identified a member of its HAVA staff who will be supported by the consulting firm and will join a team of managers responsible for implementing all HAVA requirements. Additionally, it stated that it sent to the Department of Finance (Finance) its revised spending plan with details of the proposed distribution of HAVA funds.

Finding #2: The office's disregard for proper controls and its poor oversight of staff and consultants led to questionable uses of HAVA funds.

Because of a lack of proper control and oversight, the office risks having to repay the federal government for costs charged to HAVA funds that either did not have the adequate support or were for questionable activities. The office did not provide many employees with job descriptions that explained their HAVA responsibilities and that could make employees aware of potential conflicts of interest, incompatible activities, and other requirements important in administering federal funds. Moreover, the office's conflict-of-interest code and incompatible activities policy do not prohibit the real or perceived participation in partisan activity by employees or consultants.

Our review of the $1,025,695 in personal service costs the office charged to HAVA funds in fiscal year 2003–04 revealed that the office neither prepared the certifications for its employees that worked full-time on HAVA activities nor instructed its employees to complete monthly time sheets or other activity reports required by federal cost principles to support the personal service costs charged to HAVA funds. Further, two of the five employees we reviewed whose entire salaries were charged to HAVA funds reported attending certain events that did not appear to relate to allowable HAVA activities. Therefore, the office cannot assure that the personal service costs charged to HAVA funds are accurate and allowable.

In addition, the office failed to adequately account for the activities of some consultants it hired to assist in the implementation of HAVA. Of the 169 staff activity reports submitted between December 2003 and September 2004 by the regional outreach consultants it hired, 62 (37 percent) listed one or more activities that had no relationship to HAVA requirements. Some of these consultants reported attending events such as fundraisers and a state delegation meeting for the Democratic National Convention, and indicated they were representing the secretary of state at these events. However, HAVA does not specify these as allowable activities and some appear to be partisan in nature. Although we could not quantify the amounts paid to consultants for these types of activities because the office did not require them to indicate on their invoices the time spent on each one, we question the office's use of HAVA funds to pay for these types of activities.

The office also exercised poor oversight of a law firm's contract to provide legal services relating to HAVA, approving and paying for invoiced services that violated the terms of the contract. The contract stipulated that the law firm's daily charge for services would not exceed $1,200 per day and that the firm would provide services one day a week on an as-needed basis. However, an invoice for payment listed 17 separate days on which the amount the firm charged exceeded the contract's $1,200 per day limit. Moreover, rather than providing services one day a week, the firm billed the office for 22 days in January, 21 days in February, 23 days in March, and five days in the first two weeks of April 2004. Furthermore, the office paid for services rendered before a binding contract was in place, and we found no indication that the former chief counsel reviewed the invoice, even though he was the office's representative for this contract and, therefore, was presumably more familiar with the legal services rendered and the contract's payment terms. Instead, the invoice was reviewed and approved for expedited payment by the chief assistant secretary of state.

In another example of its poor contract oversight, the office hired a consulting firm to perform public outreach within the context of HAVA. The consultant proposed preparing an outreach plan and was asked to identify specific events, people, and opportunities for outreach. Although the office used HAVA funds to pay this consultant $4,750, it was unable to provide us with a plan or any other work products for this contract.

As a result of the failure to provide proper oversight of employees and consultants and the failure to prepare and maintain adequate documents to support the costs charged to HAVA funds, the office is at risk of having the federal government require repayment of some, if not all, of the HAVA funds used to pay for these activities.

To establish or strengthen controls, comply with federal and state laws, and reduce the risk that HAVA funds are spent inappropriately, we recommended that the office take the following actions:

- Develop clear job descriptions for employees working on HAVA activities that include expectations regarding conflicts of interest, incompatible activities, and any other requirements important in administering federal funds.

- Establish and enforce a policy prohibiting partisan activities by employees and consultants hired by the office; periodic staff training and annual certification by all employees that they have read and will comply should be part of this policy.

- Standardize the language used in all consultant contracts to include provisions regarding conflicts of interest and incompatible activities, such as partisan activities.

- Ensure that time charged to HAVA or any other federal program is supported with appropriate documentation, including time sheets and certifications.

- Require that contract managers monitor for the completion of contract services and work products prior to approving invoices for payment.

- Review invoices to assure that charges to be paid with HAVA funds are reasonable and allowable and conform to the terms of the contract.

Office Action: Pending.

The office responded that it communicated, verbally and in writing, the specific roles and responsibilities of staff—including the importance of following appropriate activity and time sheet reporting procedures—and would include in the their final duty statements a clear statement of conflicts of interest, incompatible activities, and other requirements important in administering federal funds. It indicated that it was also collecting model language to develop written rules prohibiting inappropriate partisan activities of employees and consultants, and would establish a program of staff training and annual certification to ensure ongoing compliance. Further, it stated that it standardized the consultant contract language to include conflicts of interest and incompatible activities provisions. Additionally, it indicated that it obtained and was adapting for its use, time sheets and procedures used by other state agencies that receive federal funds. It stated that it also reminded contract managers of the need to ensure completion of contract deliverables before approving payment and was writing detailed procedures for invoice approval. It indicated it had implemented a system where a manager will review contractor deliverables and that no HAVA funds would be disbursed if contract obligations were not met and that this oversight would be shared by its new management consultant.

Finding #3: The office used questionable practices to procure goods and services related to HAVA.

The office bypassed competitive bidding for most HAVA expenditures. It obtained and then inappropriately used a Department of General Services (General Services) exemption from competitive bidding for 46 of the 77 HAVA-expensed contracts. Most of the contracts under this exemption did not have the urgency described in the justification provided to General Services and could have been competitively bid had the office planned better. Further, the scope of work sections for the voter outreach consultant contracts were vague, generally requiring only that the consultant "perform voter and election outreach activities" and did not establish any way to determine whether the consultants' efforts were successful. Further, the office could not provide us with a plan showing what activities these consultants were to complete by any specified deadlines. Also, the office did not adequately ensure that its voter outreach consultants were using their compensated time to educate voters about HAVA-related issues.

Additionally, the office did not follow General Services policies in making California Multiple Award Schedule (CMAS) procurements when it split purchase orders to avoid CMAS procurement limits and competitive bidding requirements on two HAVA-funded projects. Further, for 10 of the 12 HAVA-expensed purchase orders it made using CMAS, the office did not follow recommended policy and obtain comparison quotes from other qualified vendors. The office also did not follow state procurement policies that require informal bids for two of the three non-CMAS commodity purchase orders in our sample that the office issued and paid with HAVA funds. As a result of these non-competitive procurement practices, the State is less sure that the office obtained the best value for the purchases it made with HAVA funds.

To establish or strengthen controls over procurements, we recommended that the office take the following actions:

- Follow competitive bidding requirements to award contracts and restrict the use of exemptions to those occasions that truly justify the need for them.

- When competition is not used to award contracts, establish a process to screen and hire consultants.

- Follow control procedures for the review and approval of contracts to ensure that contracts include a detailed description of the scope of work, specific services and work products, and performance measures.

- Follow General Services policies when using CMAS for contracting needs.

- Comply with state policy for procuring commodities.

Office Action: Pending.

The office responded that it would restrict the use of exemptions from competitive bidding to those occasions that truly justify the need. It also stated it was developing and documenting a process to screen and hire consultants and, in the interim, would award non-competitively bid contracts only if specifically approved by the secretary of state and General Services. Additionally, the office indicated that it established a standard contract review process that requires a detailed scope of work, specific deliverables, and performance measures. Further, it stated that it would comply fully with applicable state procurement policies.

Finding #4: The office spent HAVA funds on activities for which it had no spending authority.

The office bypassed the Legislature's spending approval authority. It inappropriately executed voter outreach contracts valued at $230,400 in fiscal year 2004–05 although it had no spending authority for these activities. Additionally, while deliberations over the office's fiscal year 2004–05 HAVA spending authority were taking place, the consultants that received fiscal year 2004–05 contracts to perform voter outreach work had already begun work and subsequently submitted invoices for their services. To pay for these invoices, the office charged $84,600 in associated contract costs to its HAVA administration account, which was inconsistent with its past practice for paying for such activities.

We recommended that the office prohibit fiscal year 2004–05 expenditures for HAVA activities until it receives spending authority from Finance and the Legislature.

Office Action: Pending.

The office responded that it would make sure that fiscal year 2004–05 funds are not spent or obligated without the appropriate spending authority.

Finding #5: The office unnecessarily delayed grant payments to counties.

The office failed to disburse HAVA funds for replacing voting machines within the time frames outlined in its grant application package, internal procedures, and contracts with counties, causing some to lose interest income they could have used to replace their voting equipment. In a September 2003 application packet, the office said that payment would occur approximately 30 days after a county received written confirmation from the office that its application had been approved and a contract had been executed. Correspondingly, the office's internal accounting procedures outlined the timeline for payment at approximately 30 days for application approval and 30 days for disbursement of funds, for a total of 60 days. However, despite these assurances of prompt payment, the office disbursed voting machine replacement funds an average of 168 days after receiving the application, causing one county to submit a claim for lost interest income.

We recommended that the office disburse federal HAVA funds to counties for voting machine replacement within the time frames set out in its grant application, procedures, and contracts.

Office Action: Pending.

The office responded that once it receives spending authority, it would expeditiously disburse funds to eligible counties that applied for voting machine replacement funds within the time frames set out in the grant application, procedures, and contracts.

STATE BAR OF CALIFORNIA

Although It Reasonably Sets and Manages Mandatory Fees, It Faces Potential Deficits in the Future and Needs to More Strictly Enforce Disciplinary Policies and Procedures

REPORT NUMBER 2002-030, APRIL 2003

The State Bar of California response as of May 2004

Audit Highlights . . .

The State Bar of California (State Bar) continues to make some improvements since our audit in 2001. For example, it:

- ☑ *Made further changes to reduce its backlog of disciplinary cases.*
- ☑ *Continued to ensure that mandatory fees are reasonable and do not support voluntary programs.*

However, the State Bar needs to do the following:

- ☑ *Ensure that policies and procedures for processing disciplinary cases are being followed.*
- ☑ *Monitor its need for an increase in membership fees to avoid a potential deficit in its general fund in the future.*

Chapter 342, Statutes of 1999, directed the State Bar of California (State Bar) to contract with the Bureau of State Audits to conduct a performance audit of the State Bar's operations from January 1, 2002, through December 31, 2002. We found that the State Bar continues to reduce its backlog of disciplinary cases that resulted from its virtual shutdown in 1998. Overall, the State Bar's efforts have significantly decreased the number of cases in its backlog from 1,340 at the end of 2000 to 401 at the end of 2002. In addition, the State Bar continues to ensure that dues for members are reasonable and are not used to support voluntary functions. However, deficiencies similar to those identified by the State Bar's staff in its 2000 internal random review of disciplinary cases continue to be an issue. Moreover, the State Bar's financial forecast indicates that if fees remain at its current level, the State Bar could face a deficit in its general fund at the end of 2005.

Finding #1: The State Bar has made significant progress in decreasing its backlog of disciplinary cases.

Since our 2001 audit, the State Bar has continued its efforts to decrease its backlog of disciplinary cases. For example, it created a backlog team in its enforcement unit. The backlog team, composed generally of the most experienced investigators, focused exclusively on the backlog cases. The overall goal for 2002 was to have a backlog of no more than 400 cases. The State Bar's efforts significantly decreased the number of cases in its backlog from 1,340 at the end of 2000 to 401 at the end of 2002. According to a backlog reduction report prepared by its staff, the State Bar is currently focusing on not allowing the backlog to increase beyond 400 in 2003. Further, it maintains an "aspirational goal" of reducing the backlog to 250 by the end of

2003, but the report stated that the State Bar's ability to achieve that goal has been negatively impacted by budget constraints and other external factors.

We recommended that the State Bar continue its efforts to reduce its current backlog.

State Bar Action: Partial corrective action taken.

The State Bar reported that it is continuing its efforts to reduce the backlog. In May 2004, it reported that as of April 2004 the backlog count was 604. Although the backlog number is higher than the goal of 400, the State Bar stated it is working on bringing the backlog number back to the 250-400 range by the end of the year. As of May 2004, the State Bar plans office-wide to transfer two investigations per investigator to the backlog team to assist in reducing the backlog. In addition, it transferred an investigator position from the Los Angeles office to the San Francisco office to assist in lowering the number of cases that "roll-in" to backlog in the San Francisco office.

Finding #2: The State Bar needs to strictly enforce its policies and procedures when processing complaints.

The State Bar's internal random review process indicates that staff do not always follow policies and procedures when processing complaints. Specifically, in 2002, the State Bar identified some of the same type of deficiencies as reported in its random review in 2000. Its two reviews in 2002 identified staff's failure to enter information into the computer database, poor record keeping and file maintenance, and not sending closing letters to complainants or respondents. Because State Bar staff did not always provide proper record keeping and file maintenance, the reviewers sometimes found it difficult to determine if a case had been appropriately handled. However, the reviewers found that the areas of concern were not generally significant enough to have an adverse effect on the overall disposition of a case. To address some of these issues, the State Bar conducted group and individual training, and it issued a training bulletin to remind staff of the policies and procedures.

We recommended that the State Bar require that each file contain a checklist of important steps in the process and potential documents to ensure that employees follow policies and procedures for processing cases. Each applicable item should

be checked off as it is performed or received. An employee's supervisor should be responsible for reviewing the checklists to ensure their use. In addition, the State Bar should conduct spot checks of current cases that are being closed. Responsible staff should be required to resolve any issues concerning files determined to be noncompliant.

State Bar Action: Partial corrective action taken.

The State Bar reported that it has implemented the use of checklists to ensure important steps are taken and necessary documents are contained in the complaint files. It also is continuing the implementation of a computer verification system. With automation complete for the Intake Unit, computer verification for the Investigations and Trials units will be completed with the installment of the new graphical user interface for the systems. In addition, beginning November 2003 supervising attorneys have been spot-checking closures every month to verify that files include closing letters and detailed closing memos. The State Bar also continues to employ the internal random review process twice a year for the appropriateness of file resolutions. In addition, it continues to utilize the second-look process to ensure that resolutions are appropriate. The second-look process is in place for complainants who ask for review of the closure of their complaint.

Finding #3: Cost recoveries for the State Bar's client security fund and disciplinary activities continue to be low.

Since our 2001 audit, the State Bar's cost recovery rates improved slightly, although the rates remain low. Specifically, the Client Security Fund cost recovery rates increased from 2.5 percent in 2000 to 10.9 percent in 2002. A similar increase occurred in the cost recovery rates from the disciplinary process. In 2002, these amounts increased from 28.8 percent to 36.4 percent. Because cost recoveries are still low, the State Bar used more of its membership fees to subsidize support for its Client Security Fund and disciplinary process than it might otherwise need to.

The State Bar believes that other recovery methods, such as the State's offset program, may not be feasible. One cost recovery method that may be available is the collection of money debts under the California Enforcement of Judgments Law. However, according to the executive director, the State Bar's position is that state statutes explicitly define the specific circumstances

and methods by which it is to impose and collect its disciplinary costs, and thus the Legislature has implicitly excluded other methods more generally provided in the law.

When our audit report was issued in April 2003, the executive director told us that the State Bar was seeking a legislative amendment, similar to statutory language applicable to costs imposed in disciplinary proceedings of the Department of Consumer Affairs, to help it strengthen its collection enforcement authority. Because existing state law does not explicitly state that the State Bar can use the methods provided in the Enforcement of Judgments Law, the State Bar believes it needs statutory language that states it can do so. This language would provide the State Bar independent authority to pursue legal action for these costs.

We recommended that the State Bar pursue a legislative amendment that would help it strengthen its enforcement authority over collections related to client security and disciplinary costs.

State Bar Action: Corrective action taken.

The State Bar reported that in 2003 it was successful in obtaining amendments to sections 6086(a) and 6140.5(d) of the Business and Professions Code to provide that orders of the California Supreme Court or the State Bar Court imposing disciplinary costs or reimbursements to the Client Security Fund may be enforceable as money judgments. These changes in the law granted to the State Bar inherent authority to pursue civil remedies in the superior courts distinct from its reinstatement proceedings. The State Bar created a working group to establish the processes necessary to implement these new statutes. The State Bar reported that the unique nature of its proceedings posed several procedural and logistical issues. For example, it required consultations with other state agencies with similar statutory authority to collect administrative awards as money judgments in the superior courts. The State Bar also reported that proposed changes to the California Rules of Court and to the Rules of Procedures of the State Bar have been drafted and are awaiting further action pending completion of the 90-day public comment period. In addition, it is reviewing with staff of the Supreme Court and Judicial Council other provisions of the California Rules of Court to determine if any other amendments will be necessary.

Finding #4: Although it continues to ensure that mandatory fees are reasonable and do not support voluntary programs, the State Bar faces potential deficits in the future.

For the year 2002, the State Bar's financial records for the general fund indicate that it charged a reasonable level of fees. The general fund's revenues of $46.4 million exceeded its expenses by $2.5 million. However, because the board of governors approved transfers to other funds of $5.9 million, its general fund balance declined from $6.6 million in 2001 to $3.3 million in 2002. A financial forecast prepared by the State Bar predicts that in 2003 through 2007, if membership fees remain at $390 a year, general fund expenses will exceed its revenues. Although the State Bar's general fund balance is expected to decrease as a result of its expenses increasing faster than its revenues, a deficit is not expected to occur until the end of 2005 because of the newly created Public Protection Reserve Fund. As of January 1, 2001, the State Bar established this fund to provide a hedge against the unexpected and to assure continuity of its disciplinary system and other essential public protection programs. However, if State Bar expenses continue to exceed its revenues, a deficit in the combined available balance for the general fund and Public Protection Reserve Fund is anticipated by the end of 2005 that will continue to grow through 2007.

We recommended that the State Bar continue to monitor for the necessity of a fee increase to ensure that mandatory fees are set at a reasonable level to meet its operational needs.

State Bar Action: Partial corrective action taken.

The State Bar reported that in September 2003 the governor signed Assembly Bill 1708 (AB 1708) that authorizes the State Bar to collect up to $390 in annual membership fees for 2004. This one-year authorization maintained the same fee level that has been in effect since 2001. The State Bar also reported that AB 1708 amended an existing statute to restrict eligibility for member fee scaling when it showed that there were members with income in six figures who nonetheless scaled and reduced their 2004 payments on grounds that this income was not from the practice of law. The State Bar initially forecast that changes to the scaling provision would

generate $1.1 million in additional revenue. However, the amount was $450,000—less than had been anticipated. The State Bar performed a random audit of 100 members who scaled their 2003 fee and found that 9 percent of the sample either would not submit a copy of their tax return or were found to be not eligible to scale their fee, and therefore paid their 2003 fee in full. The State Bar is proposing that its board of governors authorize another more expansive audit of members who have scaled in 2004 to determine if there still exists a significant number of members who may be abusing the scaling provisions. Also, in deference to the State's current dire fiscal condition, the State Bar is currently seeking a one-year fee bill that would maintain mandatory dues at $390 for the 2005 billing year.

STATE CONTROLLER'S OFFICE

Does Not Always Ensure the Safekeeping, Prompt Distribution, and Collection of Unclaimed Property

Audit Highlights . . .

Our review of the State Controller's Office (controller), Bureau of Unclaimed Property (bureau), revealed the following:

- ☑ *The bureau's computerized Unclaimed Property System lacks sufficient controls to prevent unauthorized changes, and the duplication of account data, potentially resulting in the payment of fraudulent or duplicate claims.*
- ☑ *The bureau's manual tracking of securities is unreliable and the bureau is inconsistent in how quickly it sells securities.*
- ☑ *The bureau excludes more than $7.1 million in unclaimed property from its Web site.*
- ☑ *The bureau does not consistently review and distribute claims in a reasonable amount of time.*
- ☑ *The bureau does not ensure that it receives all of the reported contents of safe deposit boxes.*
- ☑ *The controller's Financial-related Audits Bureau did not pursue an estimated $6.7 million in unclaimed property from one holder.*

REPORT NUMBER 2002-122, JUNE 2003

State Controller's Office response as of June 2004

The Joint Legislative Audit Committee (audit committee) requested that we evaluate the process used by the State Controller's Office (controller) Bureau of Unclaimed Property (bureau) for identifying unclaimed property from corporations, business associations, financial institutions, insurance companies, and other holders. Further, the audit committee asked us to determine whether the bureau distributes unclaimed property to eligible recipients accurately and in a timely manner. We were also asked to evaluate the bureau's process of safeguarding unclaimed property in its custody. Lastly, we were to determine whether the bureau evaluates claimant satisfaction, is responsive to complaints, and has a process in place to identify and implement corrective action.

Finding #1: Inaccurate data contained in the bureau's property system has resulted in the payment of fraudulent and duplicate claims.

The bureau relies on its computerized Unclaimed Property System (property system) to track unclaimed property escheated to the State by persons and businesses holding unclaimed property (holders) and to disclose that the controller has the unclaimed property. However, the property system is not sufficiently reliable. Our primary concern is that the controller has not implemented controls to prevent bureau employees from making unauthorized changes to the system, despite knowing about this problem for eight months. Further, the property system does not generate reports that would reveal when unauthorized changes are made and by whom. These flaws allowed two student assistants to conspire to modify owner names in the data and allowed their accomplices to fraudulently claim some of the property.

Prior to 2002, the property system lacked effective controls to prevent duplicate data from being loaded into the property system. Although the controller took action to correct this weakness, as of May 6, 2003, the bureau had not yet removed all of the duplicate data from its property system. While the Information Systems Division reports it has taken action to prevent payments on properties listed on the duplicate reports, some of the properties are still on the bureau's Web site. Individuals using the Web site to determine whether the controller has their property may inadvertently conclude that they are owed more than the actual amount.

The bureau does not reconcile the total amount remitted for each holder report to the total of all the individual accounts loaded into the property system by that report. This may result in claimants not receiving funds to which they are legally entitled. In addition, the bureau's staff manually entered nearly 6,700 holder reports directly into the property system due to problems with a holder's electronically submitted reports. In doing so, the bureau bypassed most of the automatic system checks that could have identified errors in the data, such as checking for duplicate information. The bureau has established a procedure to verify the data in these records as claims come in, but it does not intend to verify all of the data entered directly into the property system.

To increase the reliability of the data in the property system, the bureau should do the following:

- Implement the programming changes necessary to ensure that employees cannot make unauthorized and unmonitored changes to the property system.

- Remove all duplicate account data from the property system.

- Ensure that both current and newly hired staff review unclaimed property accounts entered manually when claims are filed against the property to determine the accuracy of the data.

To ensure the accuracy of the data loaded into the property system, the bureau should require its staff to reconcile the total amount remitted by each holder to the total of all the individual records in the property system for that report.

Controller's Action: Corrective action taken.

The controller modified its property system to limit on-line property updates and to generate audit reports that allow supervisory review of any such on-line transactions. Additionally, the controller developed a plan to delete all the duplicate reports from the system, including modifying the property system to prevent the duplicate properties from appearing on the bureau's Web site.
Furthermore, the controller conducted training classes to ensure that all staff continues to adhere to current procedures for verification of claims filed for properties on the reports entered manually. The controller retrained staff on proper procedures for holder overpayments. Additionally, the controller made the necessary programming changes to fix system problems, including the development of a periodic report to identify any out of balance reports.

Finding #2: The bureau may incorrectly bill holders for interest penalties.

Inaccuracies in the property system may result in the incorrect billing of holders for interest penalties from which they should be exempt under the controller's amnesty program. Beginning in 2000, holders were allowed amnesty for their past failures to report unclaimed property on or before November 1, 1999, and were exempted from paying an interest penalty. However, the bureau did not include an amnesty indicator in the property system for all qualifying holder reports, and the controller has not modified its program that calculates interest penalties to exclude holder reports that were granted amnesty. The controller will have to correct both problems to avoid inappropriately billing the holders that it granted amnesty.

To prevent the billing of penalties for late reporting to holders granted amnesty, the controller should do the following:

- Identify reports covered by the amnesty program that do not currently have an amnesty indicator and add it.

- Modify its program that generates bills for interest penalties to exclude those reports with an amnesty indicator.

Controller's Action: Corrective action taken.

The controller reconciled all amnesty reports in the tracking system and the unclaimed property system. Further, the controller reviewed interest billings previously issued to verify that no erroneous billings were issued for approved amnesty reports. Additionally, the controller modified its procedures to ensure that all interest billings are reviewed and that no amnesty reports are incorrectly billed for interest. Lastly, the controller developed a plan for programming changes to prevent generating interest billings for approved amnesty reports.

Finding #3: Although holder reports must be processed in order to account for property escheated to the State, thousands of holder reports await processing.

To allow for the tracking and eventual disbursement of unclaimed property, the bureau must process the holder reports by loading the detailed owner data into the property system. Although the bureau must complete this process to be able to disclose on its Web site that it has the owner's property, to pay claims, to bill holders for interest due on late filings, and to reconcile the amounts reported by the holders to the amounts actually remitted by the holders, it told us that, as of June 5, 2003, it had not uploaded more than 8,500 holder reports, some as far back as 1996. More than 4,500 of these reports are less than one year old and are not considered a backlog.

During discussions with the bureau, we learned that two conditions contributed to its backlog of holder reports:

- Electronic reports in unreadable formats.
- Large increases in the number of holder reports submitted.

To enable the bureau to upload data reported in formats that it cannot access, it should do the following:

- Continue its efforts to contact the holders and request that they resubmit the owner data in the current reporting format.
- Consider contracting with an outside entity to read the remaining reports or to convert them into a usable format.

To allow for the timely notification to owners that the State has their property and the prompt billing of interest penalties, the bureau should ensure that it uploads holder reports within 12 months of receipt.

Controller's Action: Corrective action taken.

The controller completed its analysis of the backlogged reports and contacted the holders as necessary for any reports that need to be submitted in a different form. Further, the controller developed alternatives for reading or converting any remaining reports, including options to contract with an outside firm, if necessary, to read or convert the data. Also, the controller has developed a plan to process reports within a year of receipt.

In September 2003, the controller implemented a plan to liquidate the holder report backlog and to process holder reports within a year, with the exception of problem reports. The controller's efforts have significantly reduced the backlog from approximately 9,000 at the high point, to 2,894, as of May 31, 2004. The controller's liquidation efforts will continue, and it expects further reductions.

Finding #4: The bureau's tracking of securities in its custody needs improvement.

Because the bureau cannot use the computerized property system to track changes in securities, it tracks these manually, increasing the probability of error and the number of staff needed to accommodate the workload. We found that the bureau's manual tracking of securities is unreliable and that the bureau is inconsistent in how quickly it sells securities. Moreover, because the bureau tracks securities by company name rather than by individual owner, when corporate actions such as stock splits result in the issuance of additional securities, the bureau does not consistently associate the new securities with the original securities. This results in securities for the same owner being sold on different dates for different prices, further complicating the bureau's reconciliation process, increasing both the potential for errors and the risk of allegations that the bureau has mismanaged owners' assets.

To eliminate the bureau's manual tracking of securities and dispel any impressions that it exercises judgment in deciding when is the best time to sell securities, thereby reducing the potential for errors, eliminating unnecessary work, and reducing the potential

for litigation against the State, the controller should seek legislation to require it to sell securities immediately upon receipt. To ensure that the holders remit all of the reported securities, the bureau should compare the shares received to the shares reported by the holders, using the holder report summary sheets.

Alternatively, the controller should consider having holders deliver duplicates of the securities they have transferred into the controller's name to a specified broker authorized to accept them on the State's behalf. The controller should instruct and give the broker authorization to sell the securities immediately upon receipt. This may also require legislation. Additionally, the bureau should immediately sell all securities already in its custody.

If the bureau is unable to sell securities immediately upon receipt, it should do the following:

- Reconcile the securities remitted to the securities reported within one month of the receipt of the securities, for securities not already in its custody.

- Modify the property system to allow it to track all changes to securities, including the effective dates, receipts, sales, disbursements, and corporate actions, on an owner-by-owner basis. The bureau should ensure that it updates the property system to account for securities currently tracked in its manual ledgers. This process should be automated to allocate changes in the number of securities to the affected accounts with minimal human intervention.

- Sell all securities related to a particular account within two years of the initial receipt, regardless of corporate actions. Additionally, the property system should be modified to generate a monthly report to alert the bureau to securities approaching the two-year deadline for sale, regardless of the timing of corporate actions.

In either case, the bureau should do the following:

- Review all of its manual ledgers to ensure that it has accurately recorded all corporate actions, receipts, sales, and disbursements of securities. Once this review is complete, the bureau should discontinue the use of its manual ledgers.

- Complete its reconciliation of the securities remitted to the securities reported for all securities not previously reconciled.

Legislative Action: None.

Although the controller did not seek legislation to require it to sell securities immediately upon receipt, as discussed in the following paragraph it did address the issue internally.

Controller's Action: Corrective action taken.

The controller directed staff to immediately sell securities received with holder reports. Further, the controller developed a plan to accelerate the sale of securities currently in house. Additionally, the controller reviewed options to streamline the process of escheating securities to facilitate the more immediate sale of securities. Future contracts with third-party contractors include a requirement that securities be delivered to the controller-contracted broker for immediate sale. The controller created standardized procedures for making entries into the security ledgers to improve consistency of entries in the ledgers, including a quality review of the entries. Additionally, the controller developed a plan to improve the timeliness of reconciling the remitted securities to reported securities.

Finding #5: Property belonging to governmental agencies and some private entities are excluded from the bureau's Web site.

We also found that the bureau excludes a large amount of unclaimed property reported to it for federal and state departments, local governments, schools and school districts, other states, and some private entities from its Web site. As of April 30, 2003, the bureau held more than $7.1 million in unclaimed property for various entities that it has not posted on its Web site. Even if the entities check the Web site to see if the State has some of their property, they would erroneously conclude that it does not.

To fully inform all entities that it has their unclaimed property in its possession, the bureau should do the following:

- Discontinue excluding any properties from its Web site.
- When it receives unclaimed property belonging to any governmental entity, notify that entity. If it does not receive sufficient information to determine which governmental entity the property belongs to, it should seek additional information from the holder.

Controller's Action: Corrective action taken.

The controller issued instructions to holders in writing and through the Web site of their responsibilities to notify owners prior to the escheatment of accounts. Additionally, the controller discontinued its practice of excluding government properties from its Web site. Further, the controller developed a plan to notify government agencies of potential unclaimed properties in excess of $1,000 on an annual basis and simplified the process for transferring property to them.

Finding #6: The bureau does not approve and distribute claims in a timely manner.

The Unclaimed Property Law (law) requires the bureau to consider each claim for the return of property within 90 days after it is filed and to provide written notice to the person claiming the property (claimant) if the claim is denied. Although the law does not specifically require the bureau to approve or deny claims within 90 days, we believe that once the claimant has provided all required documentation, 90 days is a reasonable amount of time for the bureau to either approve or deny the claim. However, the bureau does not consistently do so. Claims for securities generally take longer to review and to distribute to the claimant than claims for most other types of property. Lastly, although the bureau has received numerous complaints regarding the timely distribution of claims, it has not streamlined the claim distribution process.

To ensure that it distributes assets to bona fide claimants in a timely manner, the bureau should do the following:

- Review all claims and either approve or deny them within 90 days of receipt.
- Distribute assets on approved claims within 30 days of approval.

Controller's Action: Corrective action taken.

The controller identified means of streamlining the approval of claims by increasing the threshold for applying its streamlined claim approval process from $1,000 to $5,000. Additionally, the controller created a new unit to process unclaimed property claims from heirfinders and investigators.

Finding #7: The bureau does not compare the contents of safe deposit boxes it receives to the holder-prepared inventories.

To determine the adequacy of the bureau's safekeeping of the contents of safe deposit boxes, we reviewed a sample of 32 safe deposit boxes. We expected that the bureau's inventories would conform materially to the holders' inventories; however, we found that the bureau does not reconcile the holders' inventories to its own inventories or to the boxes' contents to ensure that it has received all of the property listed. Instead, the bureau creates its own inventories from the contents actually received and usually disregards the holder inventories. The bureau's process of creating its own inventories results in unnecessary work and does not ensure that it has received all of the reported contents of the safe deposit boxes. If the bureau compared the contents received to the contents reported by the holder, it would be able to identify any missing property and take prompt action to request that the holder either explain the difference or remit the missing property. Doing so would reduce its liability for items that were not remitted by the holder.

To ensure that it has properly accounted for all of the owners' properties, the bureau should develop a standard inventory form for holders to use to report the contents of safe deposit boxes and for the bureau to use to verify that it has received all of the reported contents from the holders. This standard form should include a section for the bureau to indicate its receipt of all of the reported contents, the date of review, and any follow-up required for contents that were reported but not remitted by the holder.

Controller's Action: Corrective action taken.

The controller developed and implemented a standard inventory form for use by financial institutions when sending safe deposit box contents. The controller will use the new form to reconcile the receipt of items, and it also posted the form and instructions to its Web site.

Finding #8: Although state law allows the bureau to auction the contents of safe deposit boxes, it did not auction property for almost two years.

The law allows the bureau to sell the contents of safe deposit boxes in its custody to the highest bidder at public sale, including sales via the Internet. Although the bureau is not required to sell the contents of safe deposit boxes, failure to do so results in

higher costs to the State to store and safeguard those contents. The floor of the bureau's vault is crowded with the safe deposit box contents it has received from holders but has not sent to storage, and its shelves are overflowing with binders and the bagged contents of safe deposit boxes. We found that the bureau had not conducted an auction for almost two years, resulting in the overcrowding of its safe deposit box vault with the contents of safe deposit boxes that it has received from holders.

To reduce the overcrowding in its safe deposit box vault, the bureau should conduct an auction of the contents of safe deposit boxes at least monthly.

Controller's Action: Corrective action taken.

The controller completed a pilot project for conducting on-line Internet auctions of safe deposit box contents. Further, the controller implemented an on-going on-line auction using new procedures and system updates to verify that sale proceeds are received for all items sold. The controller explored the need for additional space for secured storage of the safe deposit contents to reduce the overcrowding. The controller completed its Request for Proposal with a public auctioneer, which conducted a public auction of unclaimed property. Additionally, the controller created new procedures to verify and reconcile public auction proceeds to the actual hammer price from the auction. In February 2004, the controller also implemented programming changes to allow it to post the proceeds of unclaimed property auctions to the owner's account. This change includes new procedures and system updates and provides a more accurate method of maintaining auction proceed records.

Finding #9: The controller does not ensure the collection of all unclaimed property.

The controller's Financial-related Audits Bureau (audit bureau) does not always fully pursue unclaimed property that its auditors have a reasonable basis for believing should be remitted to the State. Specifically, we found that even though its auditors estimated in January 2002 that one holder failed to remit $6.7 million beginning as far back as 1978, the audit bureau did not move forward to substantiate or invalidate the estimated findings. After we brought this to the controller's attention, the audit bureau reopened the examination of the holder. Assuming that the audit bureau substantiates the $6.7 million and the

holder remits the funds on June 30, 2003, the estimated interest penalty would be nearly $8.2 million, resulting in the potential collection of more than $14.9 million. By not exercising due diligence in pursuing the collection of unclaimed property that there is a reasonable basis to believe should have been remitted, the controller is not fulfilling its responsibility to reunite owners with their lost or forgotten property.

To ensure that it collects all unclaimed property, the controller should complete its examination of estimated unclaimed property that its auditors have a reasonable basis for believing should be remitted to the State. Further, the bureau should ensure that it bills and collects the applicable interest penalties based upon the results of the audit bureau's examination.

Controller's Action: Pending.

The controller's examination of the holder is in progress. Further, the controller is attempting to obtain access to information that will help it substantiate or invalidate the estimated unclaimed property. After the controller completes the examination, it plans to bill the holder for any additional audit findings.

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

Investigations of Improper Activities by State Employees, July 2003 Through December 2003

ALLEGATION I2003-0836 (REPORT I2004-1), MARCH 2004

California Unemployment Insurance Appeals Board response as of January 2004

Investigative Highlight . . .

The Appeals Board violated state law when it agreed to allow an employee to work as a contractor as long as she performed work on her own time.

We investigated and substantiated an allegation that the California Unemployment Insurance Appeals Board (Appeals Board) improperly contracted with one of its employees.

Finding: In violation of state law, the Appeals Board paid one of its employees $13,579 for interpreting and translating services she provided between September 2002 and July 2003.

In 1998 an Appeals Board official notified other board officials that employees were not allowed to enter into contracts with the Appeals Board. Nevertheless, the employee sought and received permission from her superiors to work as a contractor as long as she performed the work on her own time. The employee's manager told us he had not received the 1998 notification and was unaware of the prohibition. However, officials are expected to be aware of the laws they are charged with administering.

Appeals Board Action: Corrective action taken.

The Appeals Board told the employee she would no longer be able to contract with the State. It also stated that it was apparent the situation occurred because the employee's manager was not aware that employees were prohibited from contracting with the State. This prohibition is now covered in the Appeals Board's mandatory ethics training program. In addition, the executive director met with the manager to review office procedures and provided him with a counseling memorandum regarding the specific breach of rules.

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 August 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: Pending.

The board states that it has a goal to obtain independent legal counsel during fiscal year 2004–05 to assist it in developing new policy and direction for the department. The board recognizes that corrective actions associated with external audits can provide it with the means to develop meaningful policy changes for the department.

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: Pending.

The board passed a policy on July 18, 2003, to establish the need for independent counsel. Although the board added a retired attorney to the select committee on policies and procedures, it states budgetary issues have prevented it from obtaining its own independent counsel to assist in all areas where it needs legal advice.

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: Pending.

The board states that it is currently developing a training manual that will include procedures for reviewing and conducting appeals.

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: None.

Currently, the board receives calls from veterans interested in becoming board members and it redirects these veterans to the governor's appointment office. Further, the board reports that it and the governor's office are working together to appoint new members.

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: Pending.

The board states, with the exception of ethics training, it does not have funding to provide formal training for board members. However, it does have plans to provide new board members with an orientation of the department's functions. Further, the board states that it is currently developing a training manual that will include specific details on policy making, duties and procedures for conducting appeals, department operations, requirements of the Bagley-Keene open meeting act, and requirements of the Health Insurance Portability and Accountability Act.

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: Partial corrective action taken.

The department reports that it has recently developed a five-year strategic plan that contains goals, objectives, and action plans that address our recommendations. Further, the department states that it will continue to address the items raised by our recommendations, as many will be "on-going" for many years. Also, the department acknowledges the importance of continuing the life and disability programs without incurring any financial hardships to the loan program, and indicates that premiums will remain stable through February 1, 2008, under the current policy.

SEX OFFENDER PLACEMENT

Departments That Are Responsible for Placing Sex Offenders Face Challenges, and Some Need to Better Monitor Their Costs

Audit Highlights . . .

Our review of the departments of Developmental Services (Developmental Services), the Youth Authority (Youth Authority), and Mental Health (Mental Health) processes and related costs for releasing sex offenders into the local community revealed:

- ☑ *Developmental Services cannot identify the total number of individuals it serves who are registered sex offenders, or the related costs, and is not required to do so.*
- ☑ *Youth Authority's out-of-home placement standards do not conform to laws and regulations otherwise governing housing facilities. In addition, it cannot track the cost of housing sex offenders in the community because of an inadequate billing system.*
- ☑ *Only three sexually violent predators (SVPs) have been released to Mental Health's Forensic Conditional Release Program, but procuring housing for SVPs may continue to be difficult, and the program has proven costly.*

continued on next page . . .

REPORT NUMBER 2004-111, DECEMBER 2004

Departments of Developmental Services, the Youth Authority from Youth and Adult Correctional Agency, and Mental Health responses as of December 2004

The Joint Legislative Audit Committee (audit committee) asked us to review the process and costs of the departments of Developmental Services (Developmental Services), the Youth Authority (Youth Authority), and Mental Health (Mental Health) for placing sex offenders in local communities. Specifically, the audit committee asked us to review the three departments' policies and procedures for identifying, evaluating, and placing sex offenders in local communities. It also asked us to review the contracts these departments have with homes used to house sex offenders and to identify the placement costs that each department incurred for the last three fiscal years. Finally, the audit committee asked us to evaluate the relationship between regional centers' housing agents and homeowners for a sample of placements made through Developmental Services during the last fiscal year. For purposes of our audit, we defined a sex offender as follows: At Developmental Services, these are consumers who are required to register as sex offenders under the Penal Code, Section 290; at the Youth Authority, this population includes youthful offenders eligible for placement in its Sex Offender Treatment Program; at Mental Health, this population includes SVPs as defined by the Welfare and Institutions Code, Section 6600. We found that:

Finding #1: Various laws complicate the treatment of sex offenders by Developmental Services.

Developmental Services cannot identify the total number of its consumers who are sex offenders and is not required to do so. Specifically, the Lanterman Developmental Disabilities Services Act does not require that consumers provide criminal histories,

In addition, the State currently has no process to measure how successful the SVP component of this program is or to determine how to improve it.

such as prior sex offenses, when accessing services provided through regional centers. Furthermore, the law only allows the California Attorney General (attorney general) to provide Developmental Services the criminal histories of its potential consumers in very limited circumstances. That same law generally prohibits law enforcement agencies and others from sharing this information with Developmental Services or the regional centers. Because Developmental Services cannot always identify the registered sex offenders in its consumer population, it cannot isolate the costs associated with placing them in local communities. Developmental Services also may not be able to identify and assist consumers with specific services and supports needed to address the behaviors related to his or her sex conviction. When regional centers identify consumers who are sex offenders, they face barriers in placing them in local communities. For example, one community's protest caused Developmental Services to postpone a regional center's implementation of the community placement plan for a small group of consumers in that community.

To most appropriately provide services and supports to its consumers, we recommended that Developmental Services consider seeking legislation to enable it and the regional centers to identify those consumers who are sex offenders by obtaining criminal history information from the attorney general. If the Legislature chooses not to allow access to criminal history information, Developmental Services should seek to modify its laws and regulations governing the individual program plan process to include a question that asks potential consumers if they must register as sex offenders.

Developmental Services Action: Pending.

Developmental Services agreed that a mechanism should be in place to facilitate regional centers' ability to identify those of its consumers who are required to register as sex offenders under Penal Code, Section 290. It stated that this information would enhance the regional center's ability to assist those consumers in complying with related laws and also to assess the appropriate type and level of services and supports that the person needs. To that end, Developmental Services reported that it will immediately begin exploring options, in collaboration with the Association of Regional Center Agencies, that address the need to obtain sufficient information to meet the legal requirements for consumers who fall under Penal Code, Section 290. It also stated that such options would include

a review of the individual program planning process by which regional centers have the ability to solicit information to ensure that consumers receive services and supports appropriate to their needs and to protect consumers from situations that may not be in their best interest.

Legislative Action: Unknown.

Finding #2: The Youth Authority has problems with placement and monitoring of sex offenders, as well as with contracting.

The Youth Authority's standards to assure that basic and specialized needs of the parolees are met do not conform to laws and regulations otherwise governing housing facilities. Because parole agents do not always complete evaluations and inspection of these homes, the safety of the parolees may be in jeopardy. For example, parole offices failed to perform background checks of owners, operators, and employees for 12 of the 14 homes that we reviewed. Also, parole offices do not always follow procedures for supervising parolees who are sex offenders, making it difficult for parole agents to promptly identify whether these youths need more intensive monitoring. Specifically, the Youth Authority could not provide documentation to demonstrate that parole agents held case conferences for nine of the 60 paroled sex offenders in our sample. Moreover, according to our review, parole agents were up to 96 working days late in documenting the case conferences for 36 of the sex offenders.

In addition, the Youth Authority's contracts with homes do not contain some of the elements of a valid contract. For example, the contracts do not specify the term for the performance or completion of the services, nor do they clearly describe the level of service the homes must provide. Moreover, the Youth Authority could not justify the rates it pays to homes. Further, the Youth Authority has not adequately designed and implemented a billing system to track housing costs for youthful offenders. Finally, although the Youth Authority has a conflict-of-interest code meant to avoid potential conflicts of interest, it does not ensure that all of its supervising parole agents and those employees who perform the duties of the supervising parole agents file statements of economic interests.

To assure that at a minimum it meets the basic and specialized needs as well as safety of sex offenders who are on parole, we recommended that the Youth Authority address the deficiencies in its out-of-home placement standards and modify its regulations

accordingly. It should also conduct periodic reviews of a sample of the parolees' case files to ensure parole agents' compliance with its supervising procedures. In addition, to ensure that its contracting process meets state requirements, we recommended that the Youth Authority seek guidance from the departments of General Services (General Services) and Finance (Finance).

To ensure that it can accurately identify the costs associated with housing sex offenders in the community, we recommended that the Youth Authority identify and correct erroneous data in its billing system, implement controls and procedures to ensure the completeness and accuracy of the records, and reconcile the invoices in its billing system with the payments in its accounting records. To ensure that the Youth Authority places paroled sex offenders in group homes that provide the most adequate services for the least amount of money, we recommended that it conduct a study of out-of-home placement rates paid by each of its parole offices and ensure that the rates set are commensurate with the services the homes provide. Finally, to ensure that it avoids potential conflicts of interest, the Youth Authority should ensure that all supervising parole agents and employees who are performing duties similar to those of the supervising parole agents file a statement of economic interests.

Youth Authority Action: Pending.

The Youth Authority agreed with our recommendations and has assigned a project coordinator to oversee various groups that will have responsibility for addressing the deficiencies noted in our report. For example, the Youth Authority stated that a work group has been established to address the deficiencies in its out-of-home placement standards and to modify its regulations. This work group has been instructed to include specific input from the Department of Social Services, Community Care Licensing, and the Department of Alcohol and Drug Programs on their respective standards and licensing requirements. In addition, the Youth Authority stated that it would devise a plan for getting back into compliance with regard to conducting case conferences. The Youth Authority also reported that it has assigned the deputy director of Administrative Services the task of coordinating a meeting with General Services and Finance to ensure that its contract process is consistent with state law and its own policies. Further, the Youth authority stated that a workgroup will address the issue of the appropriate tracking of costs associated with housing sex offenders and will review the billing, contracting,

and payment process. The Youth Authority stated that it will assign a staff person to conduct a study of its out-of-home placement rates and to chair a workgroup to ensure that its rates are commensurate with the services the homes provide. Finally, the Youth Authority reported that its personnel office is in the process of establishing a checklist to ensure that statements of economic interest are filed when an employee assumes or leaves office. The Youth Authority stated that it also revised its conflict-of-interest code to include positions for employees who are performing duties similar to supervising parole agents. The revision is scheduled to take effect in October 2005. In the interim, the Youth Authority stated that it would request all parole agents with supervisory responsibilities to complete statements of economic interests.

Finding #3: Mental Health should improve fiscal oversight of the Forensic Conditional Release Program, and the State lacks a process to measure its success.

Superior courts at the county level play a major role in the release of sexually violent predators (SVPs) to Mental Health's Forensic Conditional Release Program (Conditional Release Program) and retain jurisdiction over these individuals throughout the course of the program. Once an SVP resides in a secure facility for at least one year, he or she is eligible to petition the court to enter the Conditional Release Program. Although few SVPs qualify for the program (only three since the program's inception in 1995), procuring housing for them may continue to be difficult, and Mental Health needs to improve its fiscal oversight. For example, it lacks adequate procedures to monitor Conditional Release Program costs. According to the former chief of Mental Health's Forensic Services Branch, due to budget cuts it no longer has an auditor position available to perform audits and detailed reviews of costs. In addition, Mental Health does not adhere to its policies and procedures designed to reduce program costs. For example, it does not presently ensure that SVPs apply for other available financial resources such as food stamps and Social Security income. Finally, the State currently has no process to measure how successful its Sex Offender Commitment Program is (the Conditional Release Program is its fifth treatment phase in this program) or to determine how to improve it.

To ensure that contractors adhere to the terms and conditions in its contracts, we recommended that Mental Health either reinstate the auditor position or designate available staff to fulfill

the audit functions. In addition, Mental Health should follow through on its policy to reduce costs associated with the SVP component of the Conditional Release Program.

To enable the State to measure the success of the SVP component of the Conditional Release Program, we recommended that the Legislature consider directing Mental Health to conduct an evaluation of the program.

Mental Health Action: Partial corrective action taken.

Mental Health stated that although it will need to receive new funding to reinstate positions eliminated through past budget reductions, it will use Conditional Release Program operations staff to review invoices and supporting documentation prior to making a payment. However, Mental Health did not address fully its efforts to ensure that contractors adhere to the contract terms and conditions for the SVP component of the Conditional Release Program. Specifically, although Mental Health plans to review invoices and supporting documentation prior to making payments to its contractors, as the State Contracting Manual requires, it fails to address adequately the steps it will take to fulfill the audit functions we described in our audit report. Specifically, Mental Health does not indicate if it will seek funding for the auditor position nor does it outline the specific audit steps its Conditional Release Program staff will undertake. Thus, we look forward to Mental Health's subsequent responses relating to this audit issue.

In response to our recommendation that Mental Health should follow through on its policy to reduce costs associated with the SVP component of the Conditional Release Program, Mental Health reported that it will update the Conditional Release Program policies and procedures manual to specify the right to cancel contracts if circumstances cause the service or product to be no longer needed. In addition, Mental Health stated that one contractor enacted procedures to ensure that SVPs are made aware of and follow through with the need to pursue all other sources of support before they receive life support funds. This contractor also added language to its standard terms and conditions stating that the amounts received

by SVPs in the Conditional Release Program as life support funds must be repaid by the SVP. Mental Health also stated that it will update the policies and procedures manual to specify that the amount an SVP receives in life support funds to pay the cost of housing will be evaluated and determined separately from the amount received to pay the cost of other items such as food and clothing.

Legislative Action: Unknown.