Implementation of State Auditor's Recommendations

Audits Released in January 2003 Through December 2004

Special Report to

Senate Budget and Fiscal Review Subcommittee #3—Health and Human Services

February 2005
Report No. 2005-406 S3

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CALIFORNIA STATE AUDITOR

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February 23, 2005 2005-406 S3

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

Dear Governor and Legislative Leaders:

The Bureau of State Audits presents its special report for the Senate Budget and Fiscal Review Subcommittee No. 3—Health and Human Services. 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 Senate Budget and Fiscal Review Subcommittee No. 3—Health and Human Services. 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.

To obtain copies of the complete audit and investigative reports, access the bureau's Web site at **www.bsa.ca.gov/bsa/** or contact the bureau at (916) 445-0255 or TTY (916) 445-0033.

OVERSIGHT OF LONG-TERM CARE PROGRAMS

Opportunities Exist to Streamline State Oversight Activities

REPORT NUMBER 2003-111, APRIL 2004

Departments of Aging, Health Services', and Social Services' responses as of October 2004

Audit Highlights . . .

Our review of the oversight for six long-term care programs noted the following concerns:

- ☑ *The departments of Health Services and Aging duplicate their oversight for the adult day health care program.*
- ☑ *Creating a separate license unique to the program of all-inclusive care for the elderly could streamline oversight.*
- ☑ *Health Services' expanded oversight of the multipurpose senior services program mirrors Aging's efforts.*
- ☑ *Better communication between the departments of Social Services and Aging, respectively, with other entities overseeing the adult day program and the Alzheimer's day care resource centers needs to occur.*

The Joint Legislative Audit Committee (audit committee) asked that we examine the State's oversight structure for the following six long-term care programs that these three departments oversee: adult day health care program, program of all-inclusive care for the elderly, multipurpose senior services program, skilled nursing facilities, adult day program, and Alzheimer's day care resource centers. For each program, the audit committee asked us to identify the agencies that provide oversight and the number of hours each department spends conducting on-site compliance reviews, inspections, and complaint investigations. Also, the audit committee asked us to identify oversight activities that overlap between different departments and determine whether the overlapping activities could be streamlined into a central process. We found opportunities to streamline or improve the oversight efforts for five of the six programs we reviewed, and for three of these programs the opportunities were substantial. For the sixth program—skill nursing facilities—there is little opportunity for the Department of Health Services (Health Services) to alter the scope, number, or frequency of its reviews because the federal government mandates how these reviews are conducted as a condition of federal funding.

Finding #1: Consolidation and coordination are needed to streamline adult day health care oversight.

Health Services and the Department of Aging (Aging) duplicate each other's efforts when they conduct separate licensing and certification onsite reviews to oversee adult day health care centers (health care centers). This duplication occurs because the separate sets of regulations the departments follow when conducting their respective reviews overlap. Moreover, the departments do not conduct a joint review, which could

mitigate the regulatory overlap. In addition, certain Health Services' Medi-Cal field offices conduct separate visits to some health care centers and may find noncompliance with many of the same regulations reviewed during the health care centers' licensing and certification reviews.

To minimize duplication of effort in adult day health care oversight and potentially lessen the resulting burden on health care centers, Health Services should incorporate Aging's certification review into its licensing review, combine the licensing and certification regulations, and coordinate to the extent possible any Medi-Cal field office oversight activities to occur during the licensing and certification reviews. If Health Services determines a statutory change is necessary to implement our recommendation, it should ask the Legislature to consider changing the statutes governing the adult day health care program. We also recommended that Aging work with Health Services to implement this recommendation.

Health Services Action: Partial corrective action taken.

Health Services reports that the Legislature has placed a one-year moratorium on certification reviews while it develops a Medi-Cal waiver for the adult day health care program. Health Services also indicates that it believes there are significant differences in purpose, requirements, timing, and frequency of the licensing and certification reviews that justify separate reviews by the two departments. However, as we noted in our audit, we found that the separate reviews duplicated the departments' efforts and may unnecessarily burden health care centers. While developing the Medi-Cal waiver, Health Services indicates that it will work with Aging to clearly separate the licensing and certification requirements in state regulations. Finally, Health Services indicates that staff from the Medi-Cal field offices have coordinated their visits to health care centers with Health Services and Aging staff to the extent possible. In addition, the Legislature passed Assembly Bill 2816, Chapter 455, Statutes of 2004 (AB 2816), to require the California Health and Human Services Agency to determine by March 1, 2005, the appropriate department to oversee health care centers.

Finding #2: A single license approach could streamline oversight of the program of all-inclusive care for the elderly.

The State's fragmented oversight of the program of all-inclusive care for the elderly (PACE) also could benefit from a more unified approach. In addition to having to comply with federal regulations and a state contract, PACE providers are subject to multiple state licensing regulations that apply to the various services a provider may offer, so they face multiple oversight visits from Health Services. The State could streamline this oversight by allowing a single license that covers all state and federal regulations pertaining to the various PACE services, regardless of the facility providing the services. With a single license, the State could unite its oversight activities more easily based on the requirements established in the license agreement. Such oversight could use a cooperative approach—combining staff who specialize in different areas of the single license—for a comprehensive review of all a PACE provider's facilities during the same time period rather than having many reviews scattered over time. This would relieve the extended burden on PACE providers from a succession of licensing visits to each of their facilities.

The Legislature should consider allowing a single license that authorizes all the long-term care services a PACE provider offers, regardless of the facility that provides the services.

Legislative Action: None.

The Legislature has not taken action on this recommendation as of January 2005.

Finding #3: Health Services' expanded oversight of the multipurpose senior services program overlaps with Aging's role.

Health Services' expanded oversight of the multipurpose senior services program (multipurpose program)—which Aging oversees under Health Services' supervision—now overlaps with Aging's role. After a federal review conducted in 1999, Health Services expanded its oversight role by accompanying Aging's staff on many of their utilization reviews to the local multipurpose program sites. Health Services believes this expanded oversight is needed to respond to federal concerns about inadequate oversight and to ensure that multipurpose program sites use federal funds appropriately. Although Health Services is conducting a pilot process to devise a permanent model for multipurpose program oversight, we believe it should

develop a reasonable rationale for the number of utilization reviews it ultimately decides to attend or, alternatively, assume responsibility for the program itself.

To reduce overlapping efforts between itself and Aging in overseeing the multipurpose program, Health Services should complete its pilot process and develop a reasonable rationale for the percentage of utilization reviews it attends. Alternatively, after evaluating the results of its pilot process, Health Services could assume responsibility for the multipurpose program. We also recommended that Aging work with Health Services to implement this recommendation.

Health Services Action: Corrective action taken.

Health Services indicates that it has completed its pilot process and developed criteria for which site visits it will attend with Aging. After evaluating the results of its pilot process, Health Services also decided that it would not assume responsibility for the multipurpose program.
Further, AB 2816 also required Health Services to determine a percentage of the multipurpose program utilization reviews that it will oversee to provide sufficient oversight of Aging, but small enough to avoid unnecessary duplication of effort between the two departments.

Finding #4: Although oversight of adult day programs does not appear redundant, better communication of oversight concerns could occur.

Because the Department of Social Services (Social Services) limits its oversight of adult day programs, we found no significant overlap in oversight for this program. Regional centers, county mental health departments, and local area agencies on aging (local area agencies) also oversee adult day programs, but they focus primarily on the delivery of services to their clients. Communication about adult day programs takes place between Social Services and the regional centers, but better communication between Social Services and two other departments, Health Services and Aging, would create more efficient oversight for a small number of facilities shared by adult day programs and other long-term care programs we reviewed.

Social Services should better coordinate its oversight efforts with Health Services and Aging for the small number of adult day programs that share facilities with other programs. We also recommended that Health Services work with Social Services to implement this recommendation.

Social Services Action: Pending.

Social Services has identified four adult day program facilities that it has licensed and that also share space with a health care center. Because some clients do not qualify for health care center funding, Social Services is working with Health Services and local health services departments to ensure that no clients will be turned away if the adult day program license is rescinded.

Finding #5: More communication among oversight entities could improve oversight of Alzheimer's centers.

Because most Alzheimer's centers reside in facilities offering other long-term care programs—mostly health care centers and adult day programs—the oversight of Alzheimer's centers could benefit from better coordination among state and local agencies. Alzheimer's centers are under Aging's oversight but are directly overseen by local area agencies, which are government or nonprofit entities under contract with Aging to provide services to seniors. However, there is no formal process to share oversight information between the local area agencies and Health Services, which licenses health care centers, and between the local area agencies and Social Services, which licenses adult day program facilities. In the governor's proposed budget for fiscal year 2004–05, separate funding for the Alzheimer's centers is merged into a block grant that will be provided to the local area agencies. Thus, Alzheimer's centers may continue to exist only to the extent that the local area agencies choose to fund them.

If the Alzheimer's centers remain a separately funded program in fiscal year 2004–05, Aging should work with Health Services and Social Services to share and act on findings from oversight visits. If funding for the Alzheimer's centers is merged into a block grant, the departments and area agencies on aging should share information to the extent that area agencies on aging choose to continue funding Alzheimer's centers. We also recommended that Health Services and Social Services work with Aging to implement this recommendation.

Aging Action: Pending.

Aging indicates that it requested and received a draft memorandum of understanding from Social Services that will serve as a model to guide communication of oversight findings among itself, Social Services, and the area agencies on aging. Aging reports that this draft memorandum of understanding was under review as of October 2004.

CALIFORNIA CHILDREN AND FAMILIES COMMISSIONS

Some County Commissions' Contracting Practices Are Lacking, and Both the State and County Commissions Can Improve Their Efforts to Find Funding Partners and Collect Data on Program Performance

Audit Highlights . . .

Our review of the state and five counties' California Children and Families Commissions funded by Proposition 10 tax revenues revealed the following:

- ☑ *The state commission consistently followed contracting rules applicable to all state agencies, but some county commissions lacked well-defined and documented policies and practices for awarding contracts to service providers.*
- ☑ *To monitor service providers, county commissions require them to submit quarterly progress reports as a condition of receiving payment.*
- ☑ *The county commissions maintained significant fund balances as of June 30, 2003, but have earmarked most of these fund balances for specific purposes.*

continued on next page . . .

REPORT NUMBER 2003-123, JULY 2004

The California Children and Families Commission and various county commissions[1] responses as of September 2004

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the California Children and Families Commission (state commission) and a sample of county commissions. Specifically, the audit committee requested us to review and evaluate the policies and procedures the state commission and a sample of county commissions use to collect, deposit, distribute, and spend Preposition 10 tax revenues. In addition, the audit committee requested that we determine whether county commissions have surplus balances and what they intend to do with these funds. Further, we were to determine the extent to which county commissions have periodic internal or external reviews, such as performance or financial audits, of their operations. Also, we were asked to examine county commissions' level of oversight of service providers, including the nature and extent to which service providers have standards and whether they report their progress to the county commissions. Moreover, the audit committee requested that we identify the amount county commissions spend on administration and travel, and determine whether the percentages spent on these activities are appropriate. We were also asked to determine whether county commissions have sought funding partners to leverage local funds through partnerships. Lastly, the audit committee requested that we evaluate the process county commissions use to select their chairpersons.

[1] El Dorado County, Kern County, Los Angeles County, San Diego County, and Santa Clara County.

- ☑ *Although the state and county commissions acknowledge the importance of funding partners, the commissions have received little funding outside their Proposition 10 tax revenues.*
- ☑ *Some county commissions lack clear policies limiting their administrative spending.*
- ☑ *State and county commissions have only recently begun to evaluate program effectiveness and so far have mainly reported demographic and service output data rather than performance outcomes.*

Finding #1: Not all county commissions follow well-defined policies and procedures when allocating funds.

Two of the county commissions we reviewed maintain insufficient records of their funding practices and one lacks well-defined allocation practices. To gain public credibility and confidence, county commissions should consistently follow self-defined allocation practices that are clear and well documented. In spite of this, some county commissions lack necessary documentation to substantiate their allocation procedures, and one county commission's funding policies are poorly defined. In addition, when well-defined policies do exist, another county commission did not always follow them. Lastly, some county commissions did not disclose to the public the noncompetitive nature of their allocations of funds, which could raise concerns about whether service providers are competent and charge a fair price.

To ensure the appropriate use of program funds and instill public confidence, we recommended that the Kern and Santa Clara county commissions adopt and follow well-defined policies to guide their allocation efforts and maintain sufficient documentation to support their allocation decisions.

First 5 Santa Clara Action: Corrective action taken.

According to First 5 Santa Clara, its commission approved an interim purchasing policy that defines the different methods that First 5 Santa Clara may use to select vendors, service providers, and grantees. First 5 Santa Clara also stated it now documents the selection process used and retains such information in its contract files.

First 5 Kern County: Partial corrective action taken.

First 5 Kern stated that it had compared its contracting policy to that of the county, after which it was modeled, and identified no significant differences. First 5 Kern stated that its contracting policy satisfies all legal requirements, meets the needs of the commission, and it does not intend to make any changes. Concerning maintaining adequate documentation, First 5 Kern stated it has implemented an internal form to document the resolution of any weaknesses identified by the independent evaluation committee during its evaluation of proposals, will clearly disclose to the public the nature of any future funding awards it makes in its minutes, and implemented a rating tool using proposal-specific criteria to evaluate future proposals.

Finding #2: Efforts to obtain funding partners have produced little non-state funding.

The California Children and Families Act of 1998 (Act) grants the state commission and each county commission the authority to apply for gifts, grants, and donations to further a program of early childhood development. Although the state and county commissions acknowledge the important role funding partners can play in addressing early childhood development and sustaining ongoing programs, they have received very little funding from sources other than Proposition 10 tax revenues. For fiscal year 2002–03, only one county commission we reviewed had received any grant funding, which represented less than 1 percent of that commission's total revenue, and the state commission received less than 7 percent of total revenue from contracts and interest on investments.

To address the sustainability of their programs, we recommended that the state and county commissions continue to take action to identify and apply for any available grants, gifts, donations, or other sources of funding.

First 5 Santa Clara Action: Partial corrective action taken

First 5 Santa Clara states it is actively pursuing outside resources and is retaining a consultant to draft a plan to assist it in seeking funding opportunities.

First 5 Kern Action: Partial corrective action taken.

First 5 Kern stated that it would continue to explore opportunities for other sources of funding and mentioned recently receiving a significant monetary award.

First 5 Los Angeles Action: Partial corrective action taken.

First 5 Los Angeles stated it was focused on creating partnerships between the commission and communities, families, and public and private organizations to share the responsibility for mobilizing social and financial capital.

First 5 El Dorado Action: Partial corrective action taken.

First 5 El Dorado stated it had applied for and received a federal grant and will continue to research and apply for additional funding.

First 5 San Diego Action: Partial corrective action taken.

First 5 San Diego stated that the commission had adopted a 20-year financial plan that maintains grant making levels

over the plan's horizon by allocating funds to a sustainability reserve and drawing on those funds to stabilize funding levels as revenues decline. First 5 San Diego also stated it will focus on identifying fund sources that assist the commission to leverage, broaden, and deepen its impact on San Diego's children.

First 5 California Action: Partial corrective action taken.

First 5 California stated it has documented success in receiving significant funding commitments from the community, private and public partners, and state and federal government and will continue its efforts in this area.

Finding #3: Some county commissions lack a clear commitment to limit their administrative spending.

Recognizing that a certain level of funding must be committed to administrative functions, four of the five county commissions we reviewed have expressed a commitment to keep such costs low. For example, in its strategic plan covering the period from fiscal year 2001–02 through fiscal year 2003–04, First 5 Los Angeles promised to spend only 5 percent of its revenues on operational and administrative costs. Additionally, First 5 Kern is limited by county ordinance to spending no more than 8 percent of its annual funding allocation on administrative expenses. Two county commissions, El Dorado and San Diego, neither established an explicit maximum on the amount of administrative costs in their strategic plans nor had a maximum imposed by county ordinance. Moreover, county commissions may not be entirely consistent in the types of costs they consider to be administrative.

Because the Act does not define administrative costs and county commissions define them differently, we developed a working definition in order to compare them. Using our definition, some county commissions spend a larger portion of their revenue or expenses than others on the administration of their programs. However, we recognize that other valid definitions exist.

To demonstrate its commitment to keeping administrative costs low, we recommended that each county commission, which has not already done so, define what constitutes its administrative costs, set a limit on the amount of funding it will spend on such costs, and annually track expenditures against this self-imposed limit.

First 5 Santa Clara Action: Pending.

First 5 Santa Clara stated it is working with the Government Finance Officers Association (association) to develop a standard definition of administrative costs for use by county commissions. First 5 Santa Clara will review the association's recommendations and the recommended limit on the percentage of funding First 5 Santa Clara should spend on administrative costs and will forward this information to the commission for approval.

First 5 Los Angeles Action: Corrective action taken.

First 5 Los Angeles stated that its definition of administrative costs is any costs that are not directly a part of an initiative. All staff salaries and direct operating costs are considered administrative. First 5 Los Angeles stated that its practice is to limit administrative costs to no more than 5 percent of total revenue and 10 percent of total expenses.

First 5 El Dorado Action: Pending.

First 5 El Dorado stated that it would develop and adopt administrative cost policies.

First 5 San Diego Action: Pending.

First 5 San Diego will work with the association to construct and adopt a uniform definition of administrative expenses and budgetary reporting categories for county commissions' financial reporting.

Finding #4: According to outside evaluators, some county commissions' service providers have collected little data on performance outcomes.

County commissions have been gathering data from service providers, but service providers have collected scant performance-based outcome data. While one county commission's outside evaluators have focused only on discussing various aspects of programs and have yet to measure program outcomes, other county commissions' outside evaluators have expressed concerns that service providers are not capturing enough information to reasonably gauge program success.

To ensure that county commissions are basing their funding decisions on outcome-based data, as required by the Act, we recommended that they address the concerns expressed by their outside evaluators to ensure that service providers are collecting these data.

First 5 Santa Clara Action: Partial corrective action taken.

First 5 Santa Clara stated that its staff conducted on-site monitoring and prepared quarterly reports throughout the year. In addition, First 5 Santa Clara stated its consultant conducted interviews with service providers and participants, held focus groups, and surveyed grantees and parents. All of these data collection methods contribute to the development of First 5 Santa Clara's evaluation report, which it will send with its six-month response.

First 5 Kern Action: Partial corrective action taken.

First 5 Kern stated it will continue to address the concerns expressed by its independent evaluator, but asserted that its consultant recently stated that significant progress has been made in meeting objectives. The independent evaluator's annual report identified specific program data that demonstrate that sizable numbers of children up to age 5 and their families are better off than they were. First 5 Kern cited outcomes such as increased cognitive scores and the favorable cost benefit of its immunization and dental care programs as examples of the beneficial affect its funding has had in the county.

First 5 Los Angeles Action: Partial corrective action taken.

First 5 Los Angeles stated it is strongly committed to the outcomes-based funding aspects of the Act, and has developed and implemented an accountability framework that is focused on outcomes. Nevertheless, First 5 Los Angeles stated that it is essential to collect and monitor important process and output data in order to understand the relative contributions of its funded initiatives toward changes in selected indicators. First 5 Los Angeles also stated that it has taken several concrete steps that align its accountability efforts with our recommendations. Specifically, it has adopted a more comprehensive and reliable set of overarching indicators, which it intends to track over the next five years.

First 5 El Dorado Action: Pending.

First 5 El Dorado stated that the staff it hired in June 2004 has extensive experience in data collection and interpretation, and it will continue to use the School Readiness Initiative and the statewide Proposition 10 Evaluation Data System to collect program data.

First 5 San Diego Action: Pending.

First 5 San Diego stated that it will work in partnership with the First 5 Association of California to address the recommendation related to outcome reporting through a joint work group proposed to be established on the issue of statewide evaluation. On the local level, First 5 San Diego stated that it currently evaluates its performance through its achievement of the annual implementation plan, which directly supports First 5 San Diego's long-term strategic plan.

Finding #5: Internal and external reviews of county commission operations fail to adequately address performance.

Reviews of county commission operations do not always give a comprehensive and objective look at performance. Although each county commission we visited undergoes an annual independent financial audit of its operations, following well-established and generally accepted standards, similar reviews of the county commissions' performance are not occurring. Instead, the county commissions' annual reports to the state commission consist primarily of self-generated descriptions of their programs, planning efforts, and funding priorities. These reports lack an objective review of how the county commissions are managing their programs and also lack an assessment of how well county commissions are ensuring that they meet the Act's goals and objectives.

To provide a meaningful assessment of annual performance, we recommended that the state commission require each county commission to conduct an annual audit of its performance prior to any future revenue allocations. Such audits should be objective and should follow guidelines designed to critically assess each county commission's performance.

First 5 California: Pending.

First 5 California stated that it is establishing an ad-hoc working group made up of legislative staff, state and local commissioners, and others to review current evaluation design and annual reporting requirements and to suggest changes and enhancements to clarify and strengthen the reporting of performance outcomes and other program data. Based on the recommendations of this group and a joint county/state working group on technical design issues, First 5 California stated it would develop a request for proposals to secure a new evaluation contract.

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.

DEPARTMENT OF DEVELOPMENTAL SERVICES, PORTERVILLE DEVELOPMENTAL CENTER

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

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

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

Investigative Highlights . . .

Porterville Developmental Center:

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

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

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

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

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

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

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

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

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

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

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

Center and Department Action: Corrective action taken.

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

HEALTH AND HUMAN SERVICES AGENCY DATA CENTER

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

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

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

Investigative Highlights . . .

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

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

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

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

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

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

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

Data Center Action: Partial corrective action taken.

The data center has referred our findings to the Fair Political Practices Commission and the attorney general for evaluation of the alleged violations of conflict-of-interest laws. Further, the data center has provided mandatory in-service training to educate key employees involved in the procurement process and their responsibilities under state laws.

DEPARTMENT OF HEALTH SERVICES

Investigations of Improper Activities by State Employees

ALLEGATION NUMBER I2003-0853 (REPORT I2004-2), SEPTEMBER 2004

Department of Health Services' response as of October 2004

Investigative Highlight . . .

For eight months, one employee regularly used a state vehicle for his 180-mile daily commute.

We investigated and substantiated an allegation that managers and employees at the Department of Health Services (Health Services) regularly used state vehicles for their personal commutes.

Finding: Health Services' employees received a benefit from their misuse of state vehicles.

In an effort to justify a business need for the number of vehicles leased by a Health Services' office (office), the office manager allowed employees under her supervision to use state vehicles for their personal commutes. Nine employees, including the manager, used state vehicles to commute between their homes and the office in violation of state laws and regulations. We determined that as a result of their misuse of state vehicles, office employees received a personal benefit of $12,346. Because the employees received a personal benefit as a result of the manager's decision, it appears that they violated state law prohibiting the use of state resources for personal gain.

Department of Health Services' Action: Corrective action taken.

Health Services agreed with our findings and reported that it conducted a cost/benefit analysis of state vehicle usage and returned four of the 12 vehicles used by the office. Additionally, Health Services reported that office employees no longer use state vehicles for personal use. Further, Health Services reported that it performed a detailed reconciliation of the state vehicle mileage logs with employee time sheets and based on those findings, it will prepare and serve notice of adverse action to the affected employees.

DEPARTMENT OF HEALTH SERVICES

Some of Its Policies and Practices Result in Higher State Costs for the Medical Therapy Program

Audit Highlights . . .

Our review of the Department of Health Services' (department) Medical Therapy Program (MTP) revealed the following:

- ☑ *During fiscal year 2002–03 the department spent $4.6 million more than state law specifically authorizes because it:*
  - *Fully funded certain county positions without the express statutory authority to do so.*
  - *Used a method for sharing the State's Medicaid program, the California Medical Assistance Program (Medi-Cal), payments with counties that resulted in the State incurring a larger portion of MTP costs than specifically authorized in law.*
  - *Did not identify and reap the State's share of Medi-Cal payments made to certain counties for MTP services.*
- ☑ *A majority of MTP claims are denied for Medi-Cal payment due to a child's lack of eligibility.*

continued on next page . . .

REPORT NUMBER 2003-124, AUGUST 2004

Department of Health Services' and Los Angeles County's responses as of October 2004 and November 2004, respectively

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review Department of Health Services' (department) and county billing practices for the Medical Therapy Program (MTP) and evaluate whether such practices minimize the State's costs for MTP services. Based on our review, we found:

Finding #1: The Department of Health Services' authority to fully fund certain county costs is unclear.

The department is required to divide MTP costs equally between the State and counties in accordance with Section 123940 of the Health and Safety Code (Section 123940). However, the department has fully funded the costs of county personnel to coordinate with special education programs in public schools. These coordination activities are required under Chapter 1747, Statutes of 1984 (AB 3632). Although AB 3632 does not require it, the department contends that it has the budget authority to pay 100 percent of county costs for coordinating the delivery of MTP services with special education. Despite the department's practice of fully paying for the additional county costs related to coordinating activities under AB 3632, the department has not received express statutory authority to fund these county activities at a level greater than 50 percent of county costs. In particular, neither provisional language in the budget act nor language in the MTP's implementing statute authorizes a deviation from the requirements of Section 123940. Consequently, the department's legal authority to fully fund these county coordination activities is unclear.

Should the Legislature decide to discontinue fully funding county costs for coordinating the delivery of MTP services with special education, it should consider the impact such a decision might

- ☑ *Lacking federal approval, the department allows Medi-Cal to pay MTP claims without requiring that other health care insurers, if any, pay first.*
- ☑ *Limits on the number of times Medi-Cal will pay for certain therapy procedures are a barrier to obtaining Medi-Cal reimbursement for MTP services and may be overly restrictive for children in the MTP.*
- ☑ *Except for Los Angeles, the counties we visited took reasonable steps to follow up on and correct MTP claims denied for Medi-Cal payment.*
- ☑ *The department identified approximately $24,000 in MTP claims for fiscal year 2003–04 that are covered by the Healthy Families Program, calling into question whether this program will significantly reduce MTP costs in the future.*

have on the State's overall financial obligations related to special education. Specifically, the State receives federal funding each year under the Individuals with Disabilities Education Act. As a condition of receiving this federal funding, the State is prohibited from reducing the amount of state financial support for special education and related services below the level of that support in the preceding fiscal year. Failing to maintain this level of state support may cause the State to face a possible reduction in federal special education funds.

We recommended that the department seek specific statutory authority from the Legislature to fully fund county personnel whose jobs include coordinating the MTP with special education agencies as required by AB 3632. Should the Legislature decide to reduce the State's current funding for these activities, it should consider the implications of such an action on the State's responsibility under the federal Individuals with Disabilities Education Act to maintain a level of funding for special education and related services at least equal to the level of funding the State provided in the preceding fiscal year.

Department Action: None.

The department disagrees with the need to seek more specific legal authority for 100 percent state funding for functions associated with implementing the regulations for AB 3632. The department asserts that AB 3632 is a mandate and the funding has been appropriated for this requirement since fiscal year 1998–99. As a result, the department is taking no action at this time.

The department's assertion that the coordination activities it has fully funded are a state mandate is incorrect. As we indicated on page 49 of the audit report, the Commission on State Mandates (commission) is the authority designated by the Legislature to determine whether a mandate exists. The commission has not determined that a state mandate exists for the MTP coordination activities under AB 3632. Further, the department does not receive an appropriation under the state mandated local programs portion of its annual budget for this purpose.

Finding #2: The department's estimate of the MTP costs counties incur to coordinate with special education may not reflect actual costs.

The department's formula for determining the number of state-funded full-time equivalent positions (FTEs) is divided into two parts. The first part of the formula calculates the number of county FTEs needed for the coordination duties specified in AB 3632. The department inputs the county-reported information on planning areas and therapy units and multiplies it by the number of hours needed annually for liaison duties. The formula assumes 188 hours are necessary per year for coordination activities for each planning area and an additional eight hours per year for each therapy unit. The department also calculates the number of county therapist FTEs needed to participate in special education meetings, using the MTP caseload data each county reports. The department's formula assumes that 85 percent of the children enrolled in the MTP are also receiving services through special education programs and that it takes an MTP representative 0.115 hours per week per child to attend special education team meetings. Although the department developed these workload standards in 1989 to address counties' initial and continuing obligations, staff at the department told us that it has not required county MTPs to complete time studies to validate its workload assumptions.

However, our review revealed that the department's 85 percent estimate is not consistent with the data counties reported to the department. Specifically, in fiscal year 2002–03, counties reported that about 77 percent of children in the MTP were also in special education. In fiscal year 2003–04, this number dropped to 54 percent.

Overall, the department's formula does not result in a reliable estimate of the costs counties incur for coordinating the delivery of MTP services with special education, primarily because the formula is not based on actual data but rather on estimates of needed personnel.

We recommended that the department reevaluate its method for calculating county costs for coordinating the delivery of MTP services with special education services to ensure that amounts reasonably reflect actual county efforts.

Department Action: Pending.

The department agrees to refine the methodology for calculating the reimbursement for individual counties for mandated workload resulting from AB 3632 interagency regulations. The department is in the process of drafting a policy letter to counties that will establish more clear and concise documentation requirements.

Finding #3: The department has not adequately reduced the State's MTP costs based on Medi-Cal revenue to the program.

By law, the State and counties must share MTP costs equally, which also requires equal sharing of MTP revenues that reduce those costs and come from sources other than the State or counties, such as the federal portion of Medi-Cal payments. However, the department's method of reducing state and county MTP costs by the amount of Medi-Cal revenue to the program results in the State paying more than is specifically required under Section 123940. In particular, the State's costs for the MTP were higher than counties' cost by more than $774,000 during fiscal year 2002–03 and more than $1.4 million in the preceding four fiscal years. In order for the State and counties to share equally in the costs of the MTP, the department needs to reduce the State's MTP costs by 75 percent of all Medi-Cal payments a county receives during a quarter—that is, the General Fund portion plus half the federal portion of total Medi-Cal payments.

The department contends that Medi-Cal payments should be viewed as a third-party sources of funds to the program when determining state and county shares of MTP costs; that is, the Medi-Cal payments should be deducted from total MTP costs before determining the State and county share of remaining MTP costs. However, doing so results in the State paying more than half the MTP costs, which is not consistent with Section 123940.

We recommended that the department modify its current method for reducing the State's costs for the MTP to ensure that state costs are reduced by an amount equal to the entire General Fund portion and one-half the federal portion of all Medi-Cal payments made for MTP services.

Department Action: None.

The department's current policy is to deduct all third-party payments, including Medi-Cal, from the cost of services before state and county share of cost is determined. In addition, the department asserts that our recommendation is inconsistent with its current interpretation of Section 14000 et seq. of the Health and Safety Code, which provides for the cost of Medi-Cal services to be shared by the federal and state governments. The department plans to discuss this recommendation in the larger context of the California Performance Review recommendations and will take no action until that time.

The department continues to misinterpret our recommendation by stating it would require counties to pay a share of the State's Medi-Cal costs in the MTP. As noted in Table 1 and Figure 2 of the audit report, we recognize that the State's General Fund and Title XIX federal funds provide approximately equal shares of funding for Medi-Cal payments. However, because the State funds about half of the Medi-Cal payments for MTP services, our recommendation to the department is that it recognize the State's contribution to the MTP through these Medi-Cal payments and reduce the State's costs for the MTP in a way that results in equal costs to the State and counties.

Finding #4: The department did not gather complete data on Medi-Cal payments by county-organized health system (COHS) agencies, resulting in greater costs to the State for the MTP.

Until fiscal year 2003–04, the department did not have a reliable process to collect information on the Medi-Cal payments that COHS agencies make for MTP services. As previously discussed, the department needs this information when it calculates quarterly reimbursements to counties so it can accurately reduce the State's share of MTP costs based on any Medi-Cal payments the counties receive. Because it did not gather all the information related to Medi-Cal payments made by COHS agencies, the department did not reduce the State's MTP costs by a total of approximately $733,000 over the four-year reporting period ending in fiscal year 2002–03, based on data four counties reported to us. The department's failure to obtain complete data on Medi-Cal payments made by COHS agencies for MTP services was particularly detrimental because the department did not reduce the State's costs for any portion of these Medi-Cal payments.

Although the department asserted that it did not know of the Medi-Cal payments made by COHS agencies for county MTPs, it reasonably should have. Specifically, each quarter, the department's Medi-Cal federal fiscal intermediary, Electronic Data Systems Federal Corporation (EDS), sends the department data regarding MTP claims it processed during the quarter and whether the claims were paid or denied. A review of this data could have led the department to question counties about anomalous claims activity. For example, for fiscal year 2002–03, 97 percent and 98 percent of MTP claims submitted to EDS by Santa Barbara and San Mateo counties, respectively, were denied. One of the main reasons these claims were denied was that the patients were enrolled in managed-care plans, and COHS agencies rather than EDS should pay for the services provided to these enrollees. The department asserted that it was the counties' responsibility to report Medi-Cal payments for MTP services made by COHS agencies; however, without having provided specific instructions requesting the counties to report this data, the department's expectation is somewhat questionable.

We recommended that the department require COHS agencies to report to the department all Medi-Cal payments they make to counties for MTP services.

Department Action: Pending.

The department agrees with the intent of our recommendation and is currently drafting a policy letter to the applicable counties. The department plans to instruct counties to bill their COHS agencies to recover the MTP costs of services provided to enrolled clients and outline the procedures for reporting the revenues received from the COHS agencies.

Finding #5: The department applied an overly broad modification to its claims-processing system that increased Medi-Cal payments for MTP services.

Federal law and state Medi-Cal regulations require that if an individual eligible for Medi-Cal has other health care coverage, such as Medicare or private insurance, providers must bill the other health care insurers before billing Medi-Cal. According to the department, the Medi-Cal claims-processing system is designed to ensure that Medi-Cal is the payer of last resort. However, in March 2004, the department implemented a modification to its Medi-Cal claims-processing system, allowing

MTP claims for services to children with other health care coverage to be paid without attempting to bill the other health care insurers first.

The department explained its implementation of this modification based on its interpretation of other federal and state laws. In particular, the department asserts that according to the federal Individuals with Disabilities Education Act, children in special education with therapy identified as a component of an individualized education program are entitled to a "free and appropriate" education. According to the department, billing the child's other health care insurer could result in the family incurring a cost for the therapy, such as a deductible or copayment charged by a private insurance company. Further, state law provides that children receiving MTP services in public schools are exempt from financial eligibility standards and are not required to pay enrollment fees. The department has interpreted these laws to mean that the MTP is a free program and other health care insurers should not be billed for MTP services because of the possible financial burden to the families.

The department's action was reasonable give the federal law regarding children receiving MTP services as part of a special education program. However, because some children enrolled in the MTP are not in a special education program, the department's action was too broad and is not in compliance with state Medi-Cal and federal Medicaid laws. When asked about obtaining federal approval, the department acknowledged it had not obtained approval to modify the system for MTP, asserting that the federal government had denied a similar request in the past.

We recommended that the department obtain federal approval to allow Medi-Cal to pay for MTP services provided to children who are not in special education without checking for the existence of other health care coverage. Otherwise, the department should modify the current Medi-Cal claims processing system to ensure that other available health care insurers are charged before Medi-Cal pays for MTP services provided to children who are not in special education.

Department Action: None.

The department does not believe that obtaining the federal approval described in our recommendation is promising because, on issues similar to this, the federal Centers for Medicare and Medicaid Services (CMS) has advised the department that it would not review a waiver request from the State because of workload considerations. The department maintains that it would not be productive to develop and submit a waiver request to CMS on this issue since CMS would not consider it. Further, the department states that the Medi-Cal claims processing system has no access to a database that would enable the system to determine whether an individual Medi-Cal beneficiary is covered by the Individuals with Disabilities Education Act. The department further believes that the costs of developing such a system would exceed any foreseeable benefit experienced by the nominal increase of federal participation.

However, as we state on pages 31 and 32 of the audit report, not all children in the MTP receive special education services. Therefore, the department is improperly allowing Medi-Cal to pay claims for services to MTP children who are not in special education without first determining whether other available health care plans will pay. Lacking the necessary federal approval to implement its current process, the department needs to take the appropriate steps to comply with federal Medicaid requirements. We note that, as of its October 2004 response to us, the department has not indicated whether it intends to modify its current claims-processing system to ensure compliance with federal Medicaid requirements.

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Finding #6: Frequency limits imposed by the Medi-Cal claims-processing system are a barrier to increased savings to the State and counties for the MTP.

EDS denied more than 42,500 MTP claims, or 6 percent of MTP claims denied for Medi-Cal payment in the period we reviewed, because the number of therapy services provided exceeded that allowed by the Medi-Cal claims-processing system. State regulations limit how frequently Medi-Cal will pay for some therapy services. However, the department admits that some of the current frequency limits may not be appropriate for the MTP. Generally, counties echo this sentiment, contending that the chronic nature of the medical conditions treated in the MTP necessitate more frequent therapy sessions. Our visits to the counties confirmed that many

children in the MTP receive therapy procedures more often than the Medi-Cal claims-processing system permits. Based on data provided by EDS, approximately $280,000 to $1.5 million in Medi-Cal claims were denied due to frequency limits from July 2002 through March 2004. When Medi-Cal does not pay claims for MTP services, the State and counties must pay more for the program because they lose the federal funding available under Medi-Cal.

We recommended that the department evaluate whether the current limits Medi-Cal places on the frequency of certain therapy procedures are appropriate for MTP services. If the department determines that the Medi-Cal frequency limits are inappropriate, it should seek approval to modify these limits accordingly.

Department Action: Pending.

The department agrees that frequency limits on occupational and physical therapy services in the claims payment system should be reevaluated. The department is considering evaluating the appropriateness of authorizing these procedures as Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Supplemental Services and, if deemed appropriate, will implement. The department believes this would override frequency limitations for therapy services provided to CCS clients.

Finding #7: Los Angeles County does not have a process to follow up on individual MTP claims denied for Medi-Cal payment.

Los Angeles County provided services to approximately 29 percent of the MTP caseload statewide according to caseload data counties reported for fiscal year 2002–03. In contrast to the other three counties we visited, Los Angeles does not follow up on individual denied claims. As a result, it may have missed out on $58,000 to $307,000 in Medi-Cal payments from July 2002 through March 2004 because it did not attempt to resolve and resubmit roughly 8,800 MTP claims denied for potentially correctable or preventable errors. For example, 89 percent of the county's denied claims were the result of missing documentation or invalid data on the claim form. The director of the Los Angeles County MTP said that the county assumed responsibility for billing MTP services and discontinued using a billing service in 2001. She also indicated that the county decided at the time not to resubmit individual denied MTP claims because the county did not have the required

knowledgeable staff to follow up on the claims. In addition, the director told us that the county is currently considering the cost-effectiveness of reviewing and resubmitting denied claims.

To maximize Medi-Cal payments for MTP services, we recommended that Los Angeles County and any other counties that do not review MTP claims denied for Medi-Cal payment should attempt to correct and resubmit denied MTP claims when it is cost-effective to do so.

Los Angeles County Action: Pending.

Los Angeles County agrees with our finding and provided us a corrective action plan to implement our recommendation. The county indicates that it is currently identifying denied Medi-Cal claims and analyzing the associated potential revenue. The county states that it intends to determine the cost-effectiveness of resubmitting correctable denied claims by late January 2005.

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.

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.

DEPARTMENT OF HEALTH SERVICES

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

Audit Highlights . . .

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

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

REPORT NUMBER 2002-118, APRIL 2003

Department of Health Services' response as of July 2004

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

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

Health Services has not been able to fill pharmacist positions approved during budget negotiations for fiscal years 2001–02 and 2002–03 to meet increases in its workload and to implement several budget reduction proposals. Additionally, although Health Services contracted with its fiscal intermediary, Electronic Data Systems Federal Corporation (EDS), for the services of five more pharmacists, as of March 2003, it had also been unable to hire the

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

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

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

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

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

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

- Research its ability to use the services of interns.

Health Services' Action: Partial corrective action taken.

In its original response to our recommendation, Health Services indicated that it sent flyers to every pharmacist in the State and placed advertisements in a number of pharmacy publications. After receiving approval from the Department of Personnel Administration to offer pharmacists a recruitment and retention payment of $2,000 per month, Health Services stated that it was able to hire four pharmacists in October 2003. However, as of July 2004, Health Services stated that it still has two vacant pharmacist positions it anticipates filling before the end of September 2004. Health Services is considering listing its pharmacist position as hard-to-fill, which it stated will allow the recruitment and retention pay to become part of a pharmacist's base salary and count toward his or her retirement. Health Services believes this will help its future recruitment efforts and reduce pharmacist turnover. Additionally, Health Services stated it has hired three research analysts to perform drug cost analyses formerly performed by the pharmacists. Finally, Health Services also indicated that its development of an internship position with the University of Pacific (UOP) in Stockton is ongoing and there has been a new staff member assigned by UOP to this activity.

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

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

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

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

Health Services' Action: Corrective action taken.

In October 2003, Health Services indicated that it has increased the number of pharmacists who can negotiate contracts and it is making changes so that it can complete new drug reviews more timely. In November 2004, Health Services provided us a copy of its Medi-Cal Drug Review Policies and Procedures and indicated that these new policies are available on its Web site.

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

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

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

Health Services' Action: Corrective action taken.

In October 2003, Health Services noted that the Legislature revised the law to require it to complete a TCR within 120 days instead of 150 days. Additionally, Health Services plans to complete four TCRs annually. As of November 2004, Health Services stated that it has completed four TCRs including cholesterol-lowering agents, non-sedating antihistamines, angiotensin-converting enzyme (ACE) inhibitors/angiotension

receptor blockers (ARB), and antidepressants. Additionally, Health Services stated that it has two others in progress—proton pump inhibitors and nonsteriodal anti-inflammatory drugs.

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

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

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

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

drug ingredient cost. Health Service reported that, once implemented, the new reimbursement method will provide cost savings of roughly $9 million to the General Fund for fiscal years 2002–03 and 2003–04. However, we again question whether Health Services will achieve these cost savings for several reasons that include its difficulties in hiring pharmacists to implement this new reimbursement method and its lack of a plan to address what action it will take if wholesalers are unwilling to share their pricing data.

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

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

- Finally, AB 442 also added language that prohibits manufacturers from making retroactive adjustments to federal and state rebates owed as a result of revisions to their best

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

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

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

Health Services stated that only one manufacturer expressed an interest in negotiating a contract for generic drug rebates and it hopes to finalize the agreement in October 2004.
Health Services stated that it has provided limited technical assistance to the Department of Justice in the development of Senate Bill 1170 (SB 1170) that creates reporting requirements for drug manufacturers, principal drug labelers, and drug wholesalers; however, this legislation has not yet been enacted. Additionally, as of July 2004, Health Services indicated it has drafted trailer bill language that defines the MAIC for generic drugs and imposes penalties on wholesalers failing to report prices.
In October 2003, Health Services stated that it plans to analyze the cost-effectiveness of a preferred prior authorization list on a drug-by-drug or therapeutic drug category basis. As of May 2004, Health Services indicated that it is in the process of conducting a review of certain drugs for preferred prior authorization status. Health Services completed a review of the drugs used for the treatment of erectile dysfunction and is releasing rebate contracts. Health Services also stated that it is in the process of analyzing the drugs used in the treatment of multiple sclerosis and it intends to have rebate contracts effective in several months.
Finally, Health Services indicated that the center has issued a regulation effective January 1, 2004, that allows manufacturers to make retroactive adjustments to their AMPs or best prices for a three-year period. Further, the center informally indicated that state law prohibiting retroactive rebate adjustments would not supercede the federal rule. Therefore, Health Services is seeking agreement from the center that the State's statute prohibiting any retroactive adjustments of the state supplemental rebates can be made effective by incorporating the State's statute in the language included in the supplemental rebate contract with the manufacturer.

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

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

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

Health Services' Action: Pending.

In its October 2003 response, Health Services indicated that it expected to expand its staff by filling 10 analyst positions and one manager position by December 2004 in anticipation of resolving the backlog of disputes by the end of fiscal year 2004–05. In its July 2004 response, Health Services stated that it has filled the manager's position and is working on filling two analyst positions.

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

Unlike Health Services' Medi-Cal drug program, the AIDS Drug Assistance Program (ADAP) does not have access to a unit rebate amount based on confidential pricing information that would enable it to calculate and bill correctly the federal rebate payments owed by manufacturers. Instead, the ADAP relies on manufacturers to calculate and remit the correct amounts and thus cannot ensure that it has received the full rebate amounts. In 1998, the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services, published a federal register notice that provided the ADAPs in all states with an option to receive the same federal rebates as the Medicaid program and to encourage ADAP's to emulate the Medicaid model.

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

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

We believe that it would benefit the ADAP to take advantage of Health Services' Rebate Accounting and Information System (RAIS) to invoice drug manufacturers and, when the RAIS achieves its projected capability, to calculate interest on amounts owed by manufacturers when they delay in submitting federal rebate payments. In fact, in a letter dated January 2001, the director of the center urged state Medicaid directors to work with the ADAPs in their state to assist in the submission of federal rebate claims to manufacturers within the requirement of the drug pricing confidentiality provisions.

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

Health Services' Action: None.

Health Services indicated that ADAP and the Medi-Cal staff met and discussed the possibility of using RAIS for invoicing ADAP manufacturers. Although both programs agreed that the idea was feasible, they determined that the costs associated with changing systems and adding ADAP to RAIS was prohibitive. However, Health Services stated that ADAP has begun using the most recent unit rebate amount provided by drug manufacturers to more closely estimate rebates owed to it and believes that this has resulted in less than a 1 percent difference between the estimated amount invoiced and the actual rebates owed.

Finally, in its October 2003 response to our recommendations, Health Services stated that it does not plan to seek legislation to assess and collect interest from manufacturers when they delay submitting federal rebates. Specifically, in its July 2004 response, Health Services explained that, based on an analysis of rebates invoiced for calendar year 2003, ADAP continues to be successful in collecting rebate payments due from drug manufacturers in a timely manner. It also indicated that proposing legislation imposing interest penalties on manufacturers for late rebate payments would have limited benefit and implementing the necessary billing system would not be cost-effective.

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

Although the supplemental rebates that Health Services negotiates with brand name drug manufacturers generally ensure that Medi-Cal incurs lower costs for drugs than do other state programs, Health Services does not have procedures to ensure that it accurately tracks the expiration dates of its supplemental rebate contracts and thus has ample time to renegotiate contracts. Our review of Health Services' drug prices found that it restricts its reimbursement to eight brand name drugs because it is generally able to obtain lower net costs for them than for their generic counterparts after applying the supplemental rebates it receives from the manufacturers. However, for the other two drugs we found that the net costs of the brand names were higher than those of the generics because Health Services failed either to renegotiate the contracts or to secure critical contract terms from the manufacturer—errors that we estimated cost Medi-Cal roughly $57,000 in 2002.

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

Health Services stated that it has assigned a pharmacist to monitor the status of contracts and bring to the attention of the pharmacy section management those contracts that will be expiring in the upcoming six months. Management then assigns pharmacist staff to renew or renegotiate the contracts. Health Services also indicated that it has established a review process to ensure that supplemental rebate contracts are appropriately entered into its contract tracking database and RAIS.

Additionally, Health Services noted that if it is unable to complete negotiation for state supplemental rebates, it plans to remove the restriction to allow the use of generic drugs when there is a net cost savings to the State. In October 2003, Health Services indicated that it had begun evaluating the net cost impact of removing the restrictions to use brand name drugs on a case-by-case basis and, as of May 2004, it continues to do so.

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

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

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

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

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

Health Services' Action: None.

In October 2003, Health Services indicated that the 2003 Budget Act includes a 5 percent reimbursement reduction for pharmacies effective January 1, 2003. Health Services believes that this reduction will allow for greater annual savings than deducting copayments from its reimbursement rate and having pharmacists collect the payments from beneficiaries. However, as of November 2004, Health Services is under a preliminary injunction and cannot implement the 5 percent rate cut. It has appealed the injunction and was scheduled to provide oral argument in the 9th Circuit Court of Appeals the week of December 6, 2004. Additionally, Health Services stated that it is evaluating various beneficiary cost-sharing proposals as part of the Medi-Cal redesign effort.

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

Two steps Health Services could take to possibly realize cost savings are adopting "duration of therapy' and "step therapy protocol" edits in its drug utilization review (DUR) program—a mechanism to ensure that prescriptions for covered outpatient drugs are appropriate, medically necessary, and not likely to have adverse medical effects. In 2000, the secretary of the Health and Human Services Agency established a task force to explore drug use and cost control strategies in the Medi-Cal program. One

issue discussed by the task force was the possibility of having Health Services reestablish a hard edit for duration of therapy to control the use of certain drugs that become unnecessary or inappropriate after a specified period—for example, drugs prescribed for specific medical conditions, such as ulcers. In the past, Health Services used a hard edit for duration of therapy but decided to discontinue its use because of the substantial increase in the volume of TARs that its staff had to process as a result of the edit. However, Health Services could not provide us with data to support its claim that the volume of TARs that staff had to process increased substantially because of that particular hard edit. Additionally, task force participants supporting the reestablishment of the edit believed that it would prevent unnecessary prescription refills, reduce inappropriate therapies for certain medical conditions, and possibly reduce costs.

Another hard edit that might be useful in controlling drug costs would require a physician to prescribe a less expensive but therapeutically equivalent drug for a beneficiary who is in the early stages of a particular medical condition. This type of hard edit, called step therapy protocols or accepted treatment guidelines, would recommend starting treatment of a condition with a less expensive drug that has a verified equivalent effect and moving on to a more expensive drug only if the patient is not responding to the first drug. Health Services told us that it had previously considered implementing step therapy protocols, however, it was unable to provide us with data or an analysis evaluating the costs and benefits of altering its process to include step therapy protocols. However, one state that responded to our survey reported that it has achieved cost savings totaling more than $3.1 million for 9,600 claims by implementing step therapy protocols.

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

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

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

Health Services' Action: Pending.

Health Services stated that it has begun using the duration of therapy hard edits for one drug only and there is significant concern related to the effect these edits have on its workload. According to Health Services, it is exploring other processes such as step therapy that would reduce workload and make broader implementation of duration of therapy hard edits possible. Finally, Health Services indicated that it is moving forward with the first DUR hard edit for early refills. However, it has not yet established a firm implementation date.

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

Health Services' retrospective DUR process monitors drug use and cost trends to identify misuses and educational needs. Through this process, Health Services has identified and developed responses to costly Medi-Cal drug patterns. Currently, Health Services' educational program disseminates information only to general audiences periodically and comprises a small number of active and proposed projects that are heavily dependent on the expertise and resources of its DUR board members. Consequently, efforts to educate providers about inappropriate or medically unnecessary drug therapies, and the potential to capture cost savings that may result from changes in drug prescribing and dispensing behavior, are limited.

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

In addition, Health Services' DUR board is responsible for identifying drug therapy problems and recommending the types of interventions that will most effectively improve the quality

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

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

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

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

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

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

Health Services' Action: Pending.

Health Services indicated that it is in the process of filling two research analyst positions created to determine the cost effectiveness of Dear Dr. Letters and any other prescribing education efforts it undertakes as part of its drug expenditure reductions initiatives. Additionally, Health Services stated that it will develop prescriber profiles to create general educational documents for all prescribers and to facilitate its plans to contact prescribers directly to address their prescribing practices. In its May 2004 response, Health Services also indicated that it recently hired research staff and is in the process of hiring a physician to work on this issue.

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

Although many states have implemented disease management programs, which are designed to improve the quality of care for Medicaid populations and ultimately contain costs for both prescription drugs and Medicaid overall, Health Services' progress toward a comprehensive disease management program is minimal. Recently, Health Services has collaborated with the California Pharmacists Association (CPhA) to develop Medi-Cal-specific pilot projects for disease management. The Medi-Cal Pharmacist Care Project was initially proposed in 2000 by the University of Southern California (USC) School of Pharmacy, in cooperation with the CPhA and Health Services, as an effort to establish a framework wherein qualified pharmacists would serve as coordinators of disease management for high-risk Medi-Cal beneficiaries suffering from asthma and diabetes. A second proposal focusing on pharmacist services for hypertension was developed in 2002. The objectives of the proposals are to determine whether a pharmacist-coordinated model of disease management, applied to the Medi-Cal population, can improve health outcomes for beneficiaries.

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

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

Health Services' Action: Pending.

In October 2003, Health Services indicated that CPhA received significant monetary commitments to fund a pilot project. Thus, CPhA is moving forward on a pilot project in the San Diego area that focuses on diabetes and, according to Health Services, one of its pharmacists is providing feedback to CPhA on the pilot project's design. Health Services stated that, if results are positive, it would take the appropriate steps to incorporate the project in the Medi-Cal program. During April 2004, Health Services indicated it met with CPhA to discuss the next steps of the diabetes pilot project. CPhA is preparing a business proposal for Health Services' review, but has not yet provided Health Services with a timeframe.

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

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

Health Services justifies its spending for these optional services with its belief that these drugs are keeping overall drug costs down. According to Health Services, if it did not cover these drug classes—in particular, the cough and cold drugs—its beneficiaries would demand prescription drugs from their physicians to relieve their symptoms, thereby creating a shift to higher-priced drugs that are not optional. Additionally, Health Services told us that other costs, such as Medi-Cal hospitalization costs, might increase because without the optional drugs, some beneficiaries might ultimately require hospitalization. However, Health Services could not provide us

with an analysis to support the net effect that discontinuing to offer the optional drug class would have on increasing drug and hospitalization costs for certain beneficiaries. After conducting such an analysis, Health Service might be able to limit cough and cold drugs to beneficiaries who have asthma or are elderly, and similarly limit or eliminate other categories.

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

Health Services' Action: Pending.

Health Services stated that it analyzed the effect of discontinuing all or a portion of the optional drug categories on Medi-Cal beneficiaries and on drug expenditures. Health Services concluded that the savings would be minimal and the potential for detrimental impact on beneficiaries could be significant. However, the analysis Health Services provided did not calculate the amount of the net savings or loss. Health Services indicated that to perform this type of analysis would require a long-term or a very large retrospective study.

DEPARTMENT OF MENTAL HEALTH

State and Federal Regulations Have Hampered Its Implementation of Legislation Meant to Strengthen the Status of Psychologists at Its Hospitals

REPORT NUMBER 2003-114, JULY 2004

Department of Mental Health response as of September 2004

Audit Highlights . . .

Our review of the Department of Mental Health's (department) implementation of Chapter 717, Statutes of 1998 (Chapter 717), commonly known as Assembly Bill 947, revealed that:

- ☑ *Even though the department has acted to implement Chapter 717 at its four hospitals, a key issue—whether psychologists have the authority to serve as attending clinicians in patient care and treatment—remains unresolved.*
- ☑ *State regulations specifically allow only physicians to order the restraint and seclusion of patients, an action that psychologists contend is within their scope of license.*
- ☑ *No significant change occurred either to psychologists' membership on certain key committees or in the privileges available to them after Chapter 717 was enacted.*

continued on next page . . .

The Joint Legislative Audit Committee requested the Bureau of State Audits to evaluate the Department of Mental Health's (department) status in implementing Assembly Bill 947, which was enacted as Chapter 717, Statues of 1998 (Chapter 717). Specifically, our review found that even though the department has acted to implement Chapter 717 at its four hospitals, a key issue—whether psychologists have the authority to serve as attending clinicians in patient care and treatment—remains unresolved. In addition, state regulations specifically allow only physicians to order the restraint and seclusion of patients, an action that psychologists contend is within their scope of license. Further, no significant changes occurred either to the psychologists' membership on key committees or in the clinical privileges available to them at the department's hospitals after the enactment of Chapter 717. Finally, although California is considered one of the more progressive states with regard to the status of psychologists in state hospitals, some other states' statutes allow more privileges for their psychologists. However, psychologists in these other states are not always performing these activities in practice.

Finding #1: Although the department has attempted to implement Chapter 717, it has not resolved the key issue of whether psychologists have the authority to serve as attending clinicians in patient care and treatment.

The department and its hospitals have taken steps to implement the requirements of Chapter 717 by ensuring that medical staff bylaws (bylaws) at each hospital allow psychologists to be part of the medical staff. Although psychologists are now included on the medical staff at the department's hospitals, they are not allowed to serve as attending clinicians. The department, using

☑ *Although California is considered one of the more progressive states with regard to the status of psychologists in state hospitals, some other states' statutes allow more privileges for their psychologists, but the psychologists are not always performing these activities in practice.*

reports it requested from a psychology subcommittee and its hospital chiefs of staff, issued a special order in January 2003 enumerating 27 activities that psychologists could perform under their scope of license. However, these activities did not include the authority to act as an attending clinician or order the restraint or seclusion of patients. As a result, staff psychologists still contend that the department has not fully implemented Chapter 717. The department's view is that it has implemented the intent of Chapter 717 and has addressed the psychologists' contentions to the extent possible within the framework that governs patient care in its hospitals. Nevertheless, in 2003 the department requested medical staff leadership at its hospitals to develop pilot projects for psychologists to serve as attending clinicians. According to the department, because of differing ideologies the pilot projects were never fully developed. The department is currently attempting to promote solutions to satisfy its psychologists and psychiatrists, legal requirements, and standards of care for its patients.

We recommended that the department work to resolve the continuing issue regarding whether psychologists can serve as attending clinicians in its four hospitals. The department's effort should include providing leadership and guidance to the administrators, psychiatrists, and psychologists at each hospital to find reasonable solutions to satisfy the statutory and regulatory requirements that govern patient care in its hospitals.

Department Action: Pending.

The department drafted a directive to use either attending or co-attending clinician pilot projects for psychologists in its hospitals. It believes these pilot projects will serve as a foundation to move toward resolving the attending clinician issue. In addition, the department began discussions with the Department of Health Services to revise state regulations to reduce barriers to fully implement Chapter 717. The department believes that reducing regulatory barriers will enhance its efforts to allow psychologists to participate in the care of patients as either attending or co-attending clinicians.

Finding #2: Psychologists at the department's four hospitals are generally underrepresented on key committees in proportion to their presence on the medical staff.

Our review of the composition of three key committees—medical executive, credentials, and bylaws—demonstrated that, with few exceptions, the psychiatrists on these committees outnumber the psychologists. In addition, the passage of Chapter 717 in 1998 has had little effect in changing the composition of one of the committees, while psychologist representation was either mixed or improved on the other two. Moreover, we found that, even after the passage of Chapter 717, psychologists are generally underrepresented on key committees in proportion to their presence on the medical staff. For example, while psychologists make up 36 percent of the medical staff at one of the department's hospitals, they hold only 10 percent of the positions on the medical executive committee.

We recommended that to ensure the appropriate level of representation for psychologists on key committees, the department direct its hospitals to annually review the composition of their medical staffs and the proportion of psychologists, psychiatrists, and other medical staff on their medical executive, credentials, and, if applicable, bylaws committees. Each hospital should modify, to the extent possible, the membership of these committees to more closely reflect the composition of its medical staff.

Department Action: Partial corrective action taken.

The department issued in September 2004 a special order that directed its hospitals to conduct reviews and modify, to the extent possible, the membership of their medical executive, credentials, and, if applicable, bylaws committees to more closely reflect the composition of their medical staffs. The department required its hospitals to complete their first reviews by October 31, 2004, and annually thereafter. The hospitals will complete changes in committee composition within their normal voting or appointment process for committee members.

DEPARTMENT OF SOCIAL SERVICES

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

REPORT NUMBER 2002-114, AUGUST 2003

Department of Social Services' response as of August 2004

Audit Highlights . . .

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

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

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

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

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

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

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

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

Department Action: Corrective action taken.

The department reported that it has compiled and is using an Exemption Analyst Resource Manual, which includes detailed desk procedures for exemption analysts. In addition, the department incorporated procedures for reviewing exemption requests in its Evaluator Manual; however, these procedures are pending final approval. The department also reported that it had trained all Community Care Licensing Division staff on these exemption request procedures.

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

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

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

Department Action: Partial corrective action taken.

With the implementation of the clearance before work component, individuals can no longer start work or be present in the facility prior to being cleared. The department states it has also taken steps to ensure that individuals with non-exemptible crimes are notified in a timely manner. Moreover, the department has also reprioritized the work associated with individuals with lesser crimes or infractions, and now gives this work higher priority so that delays do not impede individuals' right to work or licensed facilities' ability to operate efficiently. However, the department did not address how it is ensuring that staff meet established time frames for making exemption decisions.

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

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

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

Department Action: Corrective action taken.

The department stated that it had modified its quality control procedures and these procedures are in place.

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

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

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

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

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

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

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

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

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

Department Action: Corrective action taken.

The department said that it had modified its computer system to allow for better subrap tracking and has completed staff training in the system. In addition, the department has developed and implemented new subrap policies and procedures. Moreover, the department stated that it has

placed a higher priority on cases where individuals have received approval to work in a facility and are later arrested for certain crimes or are convicted of a crime. Finally, the department reported that new regulations requiring criminal record clearances before an applicant begins work ensures that uncleared staff will not be in a facility. For this reason, the promptness of the department's notification to a facility that a criminal history exemption is required becomes less urgent.

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

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

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

Department Action: None.

➲ The department assessed its practices as we recommended, but reported that it believes requiring additional Federal Bureau of Investigation checks would be costly and unnecessary. It indicates that its limited resources will prohibit it from requiring additional Federal Bureau of

Investigation background checks for individuals who become disassociated from a facility and then return to work within two years.

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

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

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

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

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

- Continue to emphasize complaint investigations over other duties and require supervisors to review evidence that facilities took corrective action before signing off on a complaint.
- Require analysts to begin investigating complaints within 10 days of receiving complaints.
- Ensure that analysts follow policies requiring them to refer to the investigations unit any serious allegation within eight hours of receipt.

Department Action: Corrective action taken.

In August 2003, the department reminded its licensing staff of the importance of conducting and completing complaint investigations in a timely manner through a Workload Prioritization memorandum. In addition, during October and November 2003, the department regional office managers led training discussions to emphasize complaint investigations as a top priority. The department also noted that it is making database enhancements to track complaint completion. The database enhancements are scheduled for completion in late 2004. Although it had earlier reported that it would require all supervisors to wait to sign off on complaints until all plans of correction are complete, the department now states that this practice is not appropriate in all cases. Instead, the department is requiring a supervisor sign off on all serious plans of correction prior to staff closing the complaints. The department also cited supervisors' routine review of staff's complaint log book as a way of ensuring plans of correction are complete. The department has changed its evaluator manual to reflect the requirement that licensing field staff issue a citation within 10 days of receipt of the investigative findings.

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

The department is responsible for licensing foster family agencies—private nonprofit corporations that in turn certify adults (certified parents) to operate foster family homes (certified family homes). However, because the department does not

require foster family agencies to request information about applicants' compliance histories, the opportunity exists for certified parents to avoid correcting identified deficiencies.

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

Department Action: Corrective action taken.

The department reported that it had developed and is distributing a self-assessment Technical Assistance Guide for foster family agencies, which provides directions on transfers between foster family agencies and instructs foster family agencies on how to review prior histories and verify the accuracy of certified parents' statements. It also stated that it plans to develop regulations requiring disclosure of prior uncorrected substantiated complaints.

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

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

To ensure that it issues licenses only to qualified individuals, we recommended that the department ensure that analysts follow the department's checklist in collecting and considering

all required licensing information, including, but not limited to, health screening reports, administrator's certification, and necessary background checks.

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

Department Action: Corrective action taken.

The department reported that it completed its review of its licensing processes for its four program areas and during October and November 2003, regional office managers led training discussions on the application process emphasizing the need to obtain required documents prior to licensing a care facility. In November 2003, the department issued a memo to its staff outlining new visit requirements and emphasizing post-licensing visit requirements. The department indicates that licensing program analysts are now meeting the protocols to complete post-licensing visits.

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

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

The Health and Safety code sets out staff development and training requirements for all analysts so they have the skills necessary to properly carry out their duties. Although these requirements are designed to provide information analysts need to stay current with the demands of their jobs, of the 22 analysts we selected who required this level of training during fiscal year 2001–02, 20 had training hours that fell short of statutory

requirements. Without the necessary ongoing training, we question whether analysts are prepared to effectively perform their duties.

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

Department Action: Partial corrective action taken.

The department temporarily suspended its QEP evaluations in offices with severe staffing shortages and reports that it is reimplementing these evaluations as staffing levels improve. The department also stated that is had developed a new training database and instructed staff on its use. Although the department previously said it was developing a training need assessment tool, the status of this tool is unclear.

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

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

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

Department Action: Corrective action taken.

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

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

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

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

Department Action: None.

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

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

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

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

Department Action: Corrective action taken.

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

STATEWIDE FINGERPRINT IMAGING SYSTEM

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

Audit Highlights . . .

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

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

REPORT NUMBER 2001-015, JANUARY 2003

Department of Social Services' response as of December 2003

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

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

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

Social Services' Action: Corrective action taken.

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

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

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

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

Social Services' Action: Corrective action taken.

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

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

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

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

Legislative Action: Legislation proposed.

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

Social Services' Action: Pending.

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

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