Implementation of State Auditor's Recommendations

Audits Released in January 2003 Through December 2004

Special Report to

Senate Budget and Fiscal Review Subcommittee #5—Public Safety, Labor, and Veterans Affairs

February 2005
Report No. 2005-406 S5

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CALIFORNIA STATE AUDITOR

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February 23, 2005 2005-406 S5

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. 5—Public Safety, Labor, and Veterans Affairs. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations.

This information is also available in a special report that is organized by policy areas that generally correspond to the Assembly and Senate standing committees. This special policy area report includes appendices that summarize recommendations that warrant legislative consideration and monetary benefits that auditees could realize if they implemented our recommendations. This special policy area report is available on our Web site at www.bsa.ca.gov/bsa/reports/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. 5—Public Safety, Labor, and Veterans Affairs. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the left-hand margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

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

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

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

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

REPORT NUMBER 2004-105, OCTOBER 2004

California Department of Corrections' response as of December 2004

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

Department Action: Pending.

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

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

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

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

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

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

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

We also recommended that the department should:

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

Department Action: Pending.

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

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

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

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

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

Department Action: Pending.

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

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

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

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

Department Action: Pending.

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

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

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

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

Department Action: Pending.

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

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

Department Action: Pending.

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

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

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

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

Department Action: Pending.

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

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

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

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

Department Action: Pending.

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

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2003-125, JULY 2004

California Department of Corrections' response as of February 2005

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

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

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

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

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

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

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Corrections Action: Pending.

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

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

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

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

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

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

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

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

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

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

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

Corrections Action: Pending.

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

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

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

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

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

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

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

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

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

Corrections Action: Pending.

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

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2003-117, APRIL 2004

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

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

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

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

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

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

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

Department Action: Pending.

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

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

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

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

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

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

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

Department Action: Pending.

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

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

DEPARTMENT OF CORRECTIONS

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

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

Department of Corrections' response as of December 2004

Investigative Highlights . . .

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

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

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

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

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

Audit Highlights . . .

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

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

REPORT NUMBER 2003-130, MARCH 2004

California Department of Corrections' response as of September 2004

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

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

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

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

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

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

Legislative Action: Unknown.

Department Action: Pending.

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

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

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

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

Legislative Action: Unknown.

Department Action: Pending.

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

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

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

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

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

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

Legislative Action: Unknown.

TERRORISM READINESS

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2002-117, JULY 2003

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

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

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

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

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

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

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

OES/OHS Action: Corrective action taken.

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

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

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

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

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

OES Action: Corrective action taken.

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

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

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

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

OES Action: Corrective action taken.

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

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

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

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

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

OES Action: Corrective action taken.

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

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

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

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

OES/OHS Action: Pending.

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

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

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

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

OHS/OHS Action: Pending.

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

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

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

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

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

National Guard Action: Corrective action taken.

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

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

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

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

National Guard Action: Corrective action taken.

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

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

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

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

National Guard Action: Corrective action taken.

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

GOVERNOR'S OFFICE OF EMERGENCY SERVICES

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

REPORT NUMBER 2002-113, JULY 2003

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

Audit Highlights . . .

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

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

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

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

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

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

OES Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

OES Action: Partial corrective action taken.

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

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

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

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

OES Action: Partial corrective action taken.

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

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

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

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

OES Action: Corrective action taken.

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

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

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

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

OES Action: None.

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

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

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

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

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

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

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

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

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

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

OES Action: Partial corrective action taken.

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

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

FRANCHISE TAX BOARD

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

Audit Highlights . . .

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

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

REPORT NUMBER 2003-131, MAY 2004

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

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

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

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

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

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

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

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

Industrial Relations Action: None.

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

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

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

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

Board Action: Corrective action taken.

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

Industrial Relations Action: Pending.

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

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

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

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

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

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

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

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

Board Action: Partial corrective action taken.

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

Industrial Relations Action: Pending.

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

WORKERS' COMPENSATION FRAUD

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2002-018, APRIL 2004

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

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

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

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

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

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

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

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

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

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

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

Insurance Action: Pending.

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

Fraud Commission Action: None.

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

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

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

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

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

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

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

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

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

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

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

Insurance Action: Pending.

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

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

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

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

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

Fraud Commission Action: None.

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

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

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

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

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

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

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

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

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

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

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

Insurance Action: Partial corrective action taken.

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

Insurance Action: Pending.

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

Insurance Action: Corrective action taken.

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

Fraud Commission Action: None.

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

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

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

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

Insurance Action: Pending.

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

Fraud Commission Action: None.

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

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

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

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

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

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

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

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

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

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

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

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

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

Insurance Action: Partial corrective action taken.

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

Insurance Action: Pending.

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

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

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

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

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

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

Insurance Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

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

Insurance Action: Pending.

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

Insurance Action: Partial corrective action taken.

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

Legislative Action: Corrective action taken.

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

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

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

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

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

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

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

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

Industrial Relations Action: Partial corrective action taken.

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

Industrial Relations Action: None.

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

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

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

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

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

Industrial Relations Action: None.

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

CALIFORNIA'S WORKERS' COMPENSATION PROGRAM

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

REPORT NUMBER 2003-108.2, JANUARY 2004

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

Audit Highlights . . .

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

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

continued on next page . . .

The Joint Legislative Audit Committee (audit committee) requested that we review the medical costs related to the workers' compensation insurance system and the extent to which the payment structure has resulted in unacceptably high reimbursement rates. As the audit committee requested, in August 2003 the Bureau of State Audits released a report of the workers' compensation medical payment system, titled *California's Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care*. To address the audit committee's request that we focus on payments for workers' compensation medical services that hospitals and surgical centers provided and insurance companies (insurers) paid for, we relied on medical payment data from the State Compensation Insurance Fund (State Fund), which paid more for than a quarter of the medical costs related to California's insured employers in 2002. However, State Fund was not able to provide us with all the information we sought in order to analyze facility fees paid to surgical centers and pharmaceutical payments. Therefore, we were unable to present this information in our August 2003 report. As a result, we presented our analysis of payment data in this follow-up report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Department Action: Partially implemented.

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

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

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

CALIFORNIA'S WORKERS' COMPENSATION PROGRAM

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

Audit Highlights . . .

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

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

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REPORT NUMBER 2003-108.1, AUGUST 2003

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

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

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

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

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

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

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

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

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

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

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

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

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

Industrial Relations' Action: Corrective action taken.

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

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

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

Legislative Action: Legislation passed.

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

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

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

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

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

We recommended that the administrative director, in coordination with the medical council, should adopt a standardized set of treatment utilization guidelines, based on clinical evidence, to deter over- or underutilization of physician services and other professional medical services and products. The administrative director should consider, to the extent possible, adopting treatment guidelines that are developed by independent entities and that are updated with adequate frequency to reflect advancing technology and changes in professional practice. If the administrative director adopts treatment guidelines developed by the medical council, he should take the steps necessary to ensure that those guidelines are developed without the appearance of undue influence from any group that participates in the State's workers' compensation system.

Industrial Relations' Action: Partial corrective action taken.

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

Legislative Action: Legislation passed.

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

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

A primary cause of the lack of effective utilization controls is that under the current law, utilization reviews are usually not admissible as evidence in judicial proceedings to resolve disputes between medical providers and claims administrators. To be admissible as evidence, a decision reached through a utilization review would need to be supported by a report from a physician

performing an examination of the injured worker—a level of review not typically used by insurers and claims administrators when approving payment for treatment. Therefore, utilization reviews prepared by claims administrators have no weight in judicial proceedings.

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

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

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

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

Industrial Relations' Action: Partial corrective action taken.

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

Legislative Action: Legislation passed.

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

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

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

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

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

We recommended that when determining the future structure of the workers' compensation medical payment system, the administrative director should consider the costs and practicalities of maintaining such a complex system and

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

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

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

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

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

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

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

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

Industrial Relations' Action: Corrective action taken.

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

Legislative Action: Legislation passed.

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

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

The division does not currently have a data collection system that will allow it to perform the necessary research to monitor the effect of policy decisions on the quality and availability of care to injured workers. Although legislation that took effect in 1993 mandated the development of a data collection system, the Workers' Compensation Information System (WCIS) is still incomplete. According to the division, intense opposition to data collection from insurers, a shortage of knowledgeable and experienced staff, and technical difficulties in installing the proper hardware and software infrastructure have delayed the implementation of the WCIS. The division still has not identified a projected completion date for the system.

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

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

Now that the division's budget contains employer user fees and a spending augmentation the administrative director asserts is needed to complete the division's WCIS, we recommended

that the administrative director should place the WCIS implementation project on a timeline to facilitate its completion as quickly as possible. In addition, the administrative director should exercise the authority necessary to ensure that the data collected in the WCIS will provide the information needed to adequately monitor medical costs and services.

Industrial Relations' Action: Partial corrective action taken.

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

DEPARTMENT OF INDUSTRIAL RELATIONS

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

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

Department of Industrial Relations response as of April 2003

Investigative Highlight . . .

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

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

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

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

Department Action: Corrective action taken.

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

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

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

Department Action: Corrective action taken.

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

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

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

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

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

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

Department Action: Partial corrective action taken.

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

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

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

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

PRISON INDUSTRY AUTHORITY

Although It Has Broad Discretion in Pursuing Its Statutory Purposes, It Could Improve Certain Pricing Practices and Develop Performance Measures

REPORT NUMBER 2004-101, DECEMBER 2004

Youth and Adult Correctional Agency response as of December 2004

Audit Highlights . . .

Our review of the Prison Industry Authority (PIA) revealed the following:

- ☑ *Although state law does not require PIA to offer competitive prices and its prices can differ from those of other vendors, PIA could improve certain pricing practices.*
- ☑ *PIA has not established participation targets for the number of inmates it aims to employ among its various enterprises.*
- ☑ *PIA has not demonstrated adequately whether and in what manner it fulfills its statutory purpose to reduce the operating costs of the California Department of Corrections.*
- ☑ *Although PIA has embarked upon various activities aimed at enhancing the employability of its participants, it has not established targets or performance measures to track participants' post-release success and evaluate its own performance.*

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to identify to the extent possible the total amount the Prison Industry Authority (PIA) has received from its customers for PIA products over the past two fiscal years and to determine, for a sample of items, whether the products are priced above the market. Also, the audit committee requested that we determine to the extent possible PIA's financial impact on the California Department of Corrections (Corrections) and examine PIA's method for measuring its impact on inmates, particularly with regard to their obtaining employment upon release.

Finding #1: PIA lacks accurate product cost figures, does not document its justification for product prices, and lacks policies regarding special or discount pricing.

The Prison Industry Board (board) has established a pricing policy that allows PIA the discretion to establish prices that do not recover production costs, but it generally expects PIA to price each item at a level sufficient to recover the cost of producing the item. To comply with this expectation, PIA must be able to identify product costs accurately. However, according to PIA's acting assistant general manager for financial operations, distributing costs to products consistently and accurately is difficult because PIA's cost allocation methodology still relies primarily on the estimated hours an inmate spends making a product and because these hours can fluctuate significantly in a prison environment. Moreover, until recently PIA did not allocate certain costs, such as distribution, transportation, and administrative support, among its various enterprises, let alone among its individual products. Without accurate product costs, PIA cannot demonstrate that it considers only applicable costs when pricing a particular product in accordance with the board's policy.

In its pricing policy, the board established that PIA must base its prices on a profit margin, cost data, market data for comparable products and prices, and marketing strategies related to the product or service. Additionally, the policy requires PIA to review and update prices periodically to reflect a variety of changes. We expected that PIA would document the analyses it performed to establish and review its prices in order to demonstrate how it applied the specific criteria in the board's pricing policy in practice. However, when we reviewed 19 products for which PIA had adjusted or established the price in fiscal year 2002–03, PIA was unable to provide supporting analyses demonstrating how it arrived at or reviewed the prices for any of these products. Without documenting the analysis that supports each price, PIA cannot demonstrate to the board the consistency of the process it follows when pricing or reviewing the prices of its products and services.

Although PIA has discretion with regard to pricing, we expected it to have established policies regarding special or discount pricing arrangements through which different customers pay different prices for like items. However, after identifying certain products for which PIA charged a different price to different customers in fiscal year 2002–03 and asking PIA for an explanation, we found that there is no written policy regarding such arrangements. Without policies defining the circumstances under which PIA enters into special pricing arrangements or offers discounts, PIA risks the appearance that its pricing practices are unfair.

We recommended that PIA develop a method to allocate administrative support, distribution, and transportation costs directly to its products and services and ensure that, until it does so, its allocation of costs to the various enterprises is as accurate as possible. In addition, we recommended that PIA ensure that it documents the analyses it conducts to establish, change, or review its prices. Finally, PIA should establish policies for entering into special pricing arrangements or offering discounts and ensure that its customers are aware of such opportunities.

PIA Action: Partial corrective action taken.

PIA states that it plans to annually refine its process of allocating distribution, transportation, and central office costs among its enterprises, with the objective of continually improving the accuracy of costs that are allocated to PIA's enterprises and allowing PIA to further refine product costing and pricing strategies as well. PIA also states that in July 2004 a standardized methodology was developed for establishing, changing, and reviewing pricing for standard products and a form for documenting competitive pricing research was also developed. Finally, PIA states that by March 1, 2005, it will formalize and document internal procedures that will include guidelines for offering discounts and other nonstandard pricing strategies to all customers.

Finding #2: PIA has not established inmate participation targets or related enterprise evaluation criteria.

Although one of PIA's statutory purposes is to employ inmates, and the Legislature intended in part that PIA employ inmates in order to reduce inmate idleness and prison violence, PIA has not established participation targets for the number of inmates or percentage of Corrections' institution population PIA aims to employ, either overall or by enterprise. Moreover, although inmates employed in PIA's enterprises contribute toward its ability to be self-supporting, this contribution varies depending on the enterprise. Yet PIA has not established criteria for evaluating each enterprise's combined contribution to PIA's statutory purposes of being self-supporting and employing inmates. Without establishing employment targets and routinely assessing the contribution of each enterprise to profitability as well as inmate employment against criteria, such as profitability per inmate, PIA limits decision makers' ability to assess its overall performance.

We recommended that PIA establish long-range annual employment targets overall, for each enterprise, and as a percentage of Corrections' institution population. PIA should include these targets and annual results in meeting them, as well as explanations when they are not met, in its annual report to the Legislature. In addition, PIA should establish criteria,

such as profitability per inmate, and evaluate its enterprises' contribution toward its statutory purposes of being self-supporting and employing inmates relative to such criteria.

PIA Action: Partial corrective action taken.

PIA states that beginning with fiscal year 2005–06, its annual plan and strategic business plan will include long-range inmate employment targets and its annual report will address the success in meeting these targets. PIA indicates that it has adopted profitability per inmate as an indicator of performance and is considering other appropriate criteria for evaluation purposes.

Finding #3: PIA has not demonstrated adequately whether and in what manner it reduces the operating costs of Corrections.

PIA claims that it provided Corrections $14.1 million in cost savings in fiscal year 2002–03 by offering a correctional work or training program (correctional program) for inmates that Corrections otherwise would have had to fund. However, in PIA's absence, Corrections is neither legally obligated nor was it prepared to reassign all of PIA's participants in fiscal year 2002–03 to programs other than PIA. Further, PIA bases its calculation on the particular correctional program components Corrections sought to expand in a fiscal year 1998–99 unapproved budget change proposal and did not demonstrate that these programs represented the only available correctional program options and associated costs for fiscal year 2002–03. Thus, PIA's approach toward claiming cost savings to Corrections for fiscal year 2002–03 is questionable.

A new bridging education program (bridging program) Corrections initiated in fiscal year 2003–04 provides an additional option for inmates who wish to participate in a correctional program and are eligible to reduce their sentences by one year for each year of participation. As a result, PIA may be able to claim that it provides Corrections a cost savings only for those inmates that Corrections, in PIA's absence, would reassign into the bridging program and incur related costs. The bridging program also will reduce or eliminate the group of inmates whose participation in PIA could result in a cost avoidance to Corrections due to their earning sentence reductions credits at a faster rate. Thus, PIA's ability to claim any cost avoidance in the future with regard to sentence reduction credits its participants earn is impaired significantly.

To the degree PIA estimates cost savings that result from inmates participating in PIA, we recommended that PIA ensure that its analysis considers all the options and associated costs per inmate that Corrections would have available for reassigning PIA's participants into another program in PIA's absence.

PIA Action: Pending.

PIA states that it will implement our recommendation when performing future analyses involving cost savings that result from inmates participating in PIA.

Finding #4: PIA has not established targets or performance measures to track participants' post-release success and evaluate its own performance.

As a result of obtaining data from Corrections and entering into a contract with the Employment Development Department, PIA now has the capability to report on two of the common elements that decision makers use to assess a correctional program—inmates' ability to obtain post-release employment and to avoid returning to prison. However PIA has not established targets or performance measures to track participants' post-release success and evaluate its own performance. Further, PIA currently lacks the necessary data to determine whether the specific training or experience it provides inmates affects the type of job an inmate obtains after release. For instance, one component of PIA's inmate employability program is to offer industry-accredited certifications to inmates. However, PIA presently cannot identify whether the certifications have led to post-release employment in the field in which inmates obtained certification. Despite the challenges of establishing a direct link between PIA's activities and inmates' level of success after release from prison, without measuring and reporting on how inmates who have participated in its enterprises fare after release, PIA cannot provide an adequate perspective on the effectiveness of its pursuit of its statutory purpose to offer inmates the opportunity to develop effective work habits and occupational skills. Moreover, without performance measures or targets, PIA cannot focus its inmate employability efforts on areas that demonstrate success.

We recommended that PIA establish targets against which to measure its participants' post-release success in obtaining employment and not returning to prison. For instance, PIA should compare the post-release success of its participants

to that of participants in other correctional programs, to nonparticipants, or to its own expectations. PIA should also identify whether the specific training or experience inmates obtain leads to employment in a related field. Corrections should assist PIA in obtaining any necessary data for comparison by providing comparable data on other correctional programs to PIA. To further refine and focus on those activities with a demonstrated track record, PIA should also track the individuals participating in unique components of the inmate employability program to determine whether there is a link between the components and inmates' post-release employment, earnings, and returns to prison.

PIA Action: Pending.

PIA states that it is finalizing a contract with an institution of higher education to design and conduct a multi-year research study scheduled to begin in 2005 to measure the impact of PIA on its participants' post-release success. PIA plans to use the study results to determine appropriate standards for establishing targets relative to post-release employment and recidivism. PIA also indicates that it will develop a table similar to the one we recommended to include in its annual report to demonstrate each enterprise's contribution to participants' post-release success. PIA states that it will work with Corrections to compare its impact on post-release employment and recidivism with other correctional programs and nonparticipants. Finally, PIA indicates that by March 1, 2005, it will expand current tracking activities to better assess the impact of discrete elements of the inmate employability program upon post-release employment and recidivism.

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

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

ALLEGATION I2003-0836 (REPORT I2004-1), MARCH 2004

California Unemployment Insurance Appeals Board response as of January 2004

Investigative Highlight . . .

The Appeals Board violated state law when it agreed to allow an employee to work as a contractor as long as she performed work on her own time.

We investigated and substantiated an allegation that the California Unemployment Insurance Appeals Board (Appeals Board) improperly contracted with one of its employees.

Finding: In violation of state law, the Appeals Board paid one of its employees $13,579 for interpreting and translating services she provided between September 2002 and July 2003.

In 1998 an Appeals Board official notified other board officials that employees were not allowed to enter into contracts with the Appeals Board. Nevertheless, the employee sought and received permission from her superiors to work as a contractor as long as she performed the work on her own time. The employee's manager told us he had not received the 1998 notification and was unaware of the prohibition. However, officials are expected to be aware of the laws they are charged with administering.

Appeals Board Action: Corrective action taken.

The Appeals Board told the employee she would no longer be able to contract with the State. It also stated that it was apparent the situation occurred because the employee's manager was not aware that employees were prohibited from contracting with the State. This prohibition is now covered in the Appeals Board's mandatory ethics training program. In addition, the executive director met with the manager to review office procedures and provided him with a counseling memorandum regarding the specific breach of rules.

CALIFORNIA UNEMPLOYMENT INSURANCE APPEALS BOARD

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

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

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

Investigative Highlights . . .

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

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

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

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

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

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

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

Agency Action: Partial corrective action taken.

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

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

CALIFORNIA VETERANS BOARD

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

Audit Highlights . . .

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

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

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

REPORT NUMBER 2002-120, JUNE 2003

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

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

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

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

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

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

Board Action: Pending.

The board states that it has a goal to obtain independent legal counsel during fiscal year 2004–05 to assist it in developing new policy and direction for the department. The board recognizes that corrective actions associated with external audits can provide it with the means to develop meaningful policy changes for the department.

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

Despite the board's important responsibilities for making policy and ruling on veterans' appeals of services that the department has denied, the board does not have an independent counsel it requires to minimize the legal risks of its actions. Instead, the board relies on the department's legal staff for advice. Although they are probably knowledgeable on these laws, the department's legal staff are not the appropriate advisors for the board on policies under consideration because the board's policies govern the department. Further, the board's rulings on veterans' appeals should have an independent and fair consideration of the department's actions and the veterans' rights to services. Currently, the board must rely on the department's legal staff for advice on appeals, a practice that introduces questions of fairness and impartiality on appeal decisions.

We recommended that to improve the board's ability to independently make decisions on policies and appeals, and to reduce the legal risk created by its present practices, the

board should establish a policy to obtain the services of an independent counsel to assist with its policy-making and appeal responsibilities.

Board Action: Pending.

The board passed a policy on July 18, 2003, to establish the need for independent counsel. Although the board added a retired attorney to the select committee on policies and procedures, it states budgetary issues have prevented it from obtaining its own independent counsel to assist in all areas where it needs legal advice.

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

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

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

Board Action: Pending.

The board states that it is currently developing a training manual that will include procedures for reviewing and conducting appeals.

Finding #4: With a reduced membership, the board may lack the expertise the Legislature intended and may be unable to hold meetings.

The board's effectiveness has been hindered over the past few years because is has rarely comprised the seven members authorized by the Military and Veterans Code. The governor appoints board members and five board members must have expertise in a particular area required by law. Without these expert members, the board might be limited in its understanding of departmental issues and veterans' appeals. Additionally, its reduced membership could prevent it from meeting the quorum of four required by board policy to conduct business.

To assist the governor in promptly appointing members to fill both the current and future vacancies, we recommended that the board proactively identify possible board members when vacancies occur.

Board Action: None.

Currently, the board receives calls from veterans interested in becoming board members and it redirects these veterans to the governor's appointment office. Further, the board reports that it and the governor's office are working together to appoint new members.

Finding #5: To be an effective oversight and policy-making body, the board needs to adequately train its members.

Contributing to the board's deficiencies as a policy-making and oversight body is the fact that members receive no formal training regarding the laws and regulations controlling veterans' affairs; board policies, duties, and authority, including how to conduct appeals; departmental operations; state laws regarding open meetings; and state laws regarding the privacy of medical information. Insufficient training may have caused the board

to violate state open-meeting laws and possibly resulted in two instances of the board discussing veterans' confidential medical records in public board sessions.

To enable board members to perform their oversight functions effectively, we recommended that the board provide ongoing training to its members in topics related to their responsibilities.

Board Action: Pending.

The board states, with the exception of ethics training, it does not have funding to provide formal training for board members. However, it does have plans to provide new board members with an orientation of the department's functions. Further, the board states that it is currently developing a training manual that will include specific details on policy making, duties and procedures for conducting appeals, department operations, requirements of the Bagley-Keene open meeting act, and requirements of the Health Insurance Portability and Accountability Act.

Finding #6: Despite implementing many recommendations we made in previous audits, the department has not sufficiently addressed an important issue for the Cal-Vet program.

The board's weak policy-making deprives a problem-prone department of needed assistance in improving on weaknesses documented in reviews by the bureau and other oversight agencies. Our follow-up on recommendations we made to the department in two previous audits revealed that the department has implemented eight of the 14 recommendations we could reasonably expect the board to address. However, the department has not given sufficient attention to a key recommendation regarding the long-term viability of the Cal-Vet program, the department's loan program that helps veterans purchase farms or homes. As mentioned in our previous audits, unless there is a change in federal tax laws, fewer and fewer veterans will benefit from the Cal-Vet program because federal tax restrictions have limited eligibility for loans backed by the bonds that supply the majority of the program's funding. Despite two previous unsuccessful efforts, the department is attempting to change federal tax laws to make more veterans eligible for the Cal-Vet program. However, the department has not performed sufficient contingency planning for the potential reduction in the Cal-Vet program's funding should its efforts fail again.

To ensure effective and efficient operations, the department should continue to address the recommendation of our prior audits, especially the recommendations regarding the long-term viability of the Cal-Vet program.

Department Action: Partial corrective action taken.

The department reports that it has recently developed a five-year strategic plan that contains goals, objectives, and action plans that address our recommendations. Further, the department states that it will continue to address the items raised by our recommendations, as many will be "on-going" for many years. Also, the department acknowledges the importance of continuing the life and disability programs without incurring any financial hardships to the loan program, and indicates that premiums will remain stable through February 1, 2008, under the current policy.

SEX OFFENDER PLACEMENT

Departments That Are Responsible for Placing Sex Offenders Face Challenges, and Some Need to Better Monitor Their Costs

Audit Highlights . . .

Our review of the departments of Developmental Services (Developmental Services), the Youth Authority (Youth Authority), and Mental Health (Mental Health) processes and related costs for releasing sex offenders into the local community revealed:

- ☑ *Developmental Services cannot identify the total number of individuals it serves who are registered sex offenders, or the related costs, and is not required to do so.*
- ☑ *Youth Authority's out-of-home placement standards do not conform to laws and regulations otherwise governing housing facilities. In addition, it cannot track the cost of housing sex offenders in the community because of an inadequate billing system.*
- ☑ *Only three sexually violent predators (SVPs) have been released to Mental Health's Forensic Conditional Release Program, but procuring housing for SVPs may continue to be difficult, and the program has proven costly.*

continued on next page . . .

REPORT NUMBER 2004-111, DECEMBER 2004

Departments of Developmental Services, the Youth Authority from Youth and Adult Correctional Agency, and Mental Health responses as of December 2004

The Joint Legislative Audit Committee (audit committee) asked us to review the process and costs of the departments of Developmental Services (Developmental Services), the Youth Authority (Youth Authority), and Mental Health (Mental Health) for placing sex offenders in local communities. Specifically, the audit committee asked us to review the three departments' policies and procedures for identifying, evaluating, and placing sex offenders in local communities. It also asked us to review the contracts these departments have with homes used to house sex offenders and to identify the placement costs that each department incurred for the last three fiscal years. Finally, the audit committee asked us to evaluate the relationship between regional centers' housing agents and homeowners for a sample of placements made through Developmental Services during the last fiscal year. For purposes of our audit, we defined a sex offender as follows: At Developmental Services, these are consumers who are required to register as sex offenders under the Penal Code, Section 290; at the Youth Authority, this population includes youthful offenders eligible for placement in its Sex Offender Treatment Program; at Mental Health, this population includes SVPs as defined by the Welfare and Institutions Code, Section 6600. We found that:

Finding #1: Various laws complicate the treatment of sex offenders by Developmental Services.

Developmental Services cannot identify the total number of its consumers who are sex offenders and is not required to do so. Specifically, the Lanterman Developmental Disabilities Services Act does not require that consumers provide criminal histories,

In addition, the State currently has no process to measure how successful the SVP component of this program is or to determine how to improve it.

such as prior sex offenses, when accessing services provided through regional centers. Furthermore, the law only allows the California Attorney General (attorney general) to provide Developmental Services the criminal histories of its potential consumers in very limited circumstances. That same law generally prohibits law enforcement agencies and others from sharing this information with Developmental Services or the regional centers. Because Developmental Services cannot always identify the registered sex offenders in its consumer population, it cannot isolate the costs associated with placing them in local communities. Developmental Services also may not be able to identify and assist consumers with specific services and supports needed to address the behaviors related to his or her sex conviction. When regional centers identify consumers who are sex offenders, they face barriers in placing them in local communities. For example, one community's protest caused Developmental Services to postpone a regional center's implementation of the community placement plan for a small group of consumers in that community.

To most appropriately provide services and supports to its consumers, we recommended that Developmental Services consider seeking legislation to enable it and the regional centers to identify those consumers who are sex offenders by obtaining criminal history information from the attorney general. If the Legislature chooses not to allow access to criminal history information, Developmental Services should seek to modify its laws and regulations governing the individual program plan process to include a question that asks potential consumers if they must register as sex offenders.

Developmental Services Action: Pending.

Developmental Services agreed that a mechanism should be in place to facilitate regional centers' ability to identify those of its consumers who are required to register as sex offenders under Penal Code, Section 290. It stated that this information would enhance the regional center's ability to assist those consumers in complying with related laws and also to assess the appropriate type and level of services and supports that the person needs. To that end, Developmental Services reported that it will immediately begin exploring options, in collaboration with the Association of Regional Center Agencies, that address the need to obtain sufficient information to meet the legal requirements for consumers who fall under Penal Code, Section 290. It also stated that such options would include

a review of the individual program planning process by which regional centers have the ability to solicit information to ensure that consumers receive services and supports appropriate to their needs and to protect consumers from situations that may not be in their best interest.

Legislative Action: Unknown.

Finding #2: The Youth Authority has problems with placement and monitoring of sex offenders, as well as with contracting.

The Youth Authority's standards to assure that basic and specialized needs of the parolees are met do not conform to laws and regulations otherwise governing housing facilities. Because parole agents do not always complete evaluations and inspection of these homes, the safety of the parolees may be in jeopardy. For example, parole offices failed to perform background checks of owners, operators, and employees for 12 of the 14 homes that we reviewed. Also, parole offices do not always follow procedures for supervising parolees who are sex offenders, making it difficult for parole agents to promptly identify whether these youths need more intensive monitoring. Specifically, the Youth Authority could not provide documentation to demonstrate that parole agents held case conferences for nine of the 60 paroled sex offenders in our sample. Moreover, according to our review, parole agents were up to 96 working days late in documenting the case conferences for 36 of the sex offenders.

In addition, the Youth Authority's contracts with homes do not contain some of the elements of a valid contract. For example, the contracts do not specify the term for the performance or completion of the services, nor do they clearly describe the level of service the homes must provide. Moreover, the Youth Authority could not justify the rates it pays to homes. Further, the Youth Authority has not adequately designed and implemented a billing system to track housing costs for youthful offenders. Finally, although the Youth Authority has a conflict-of-interest code meant to avoid potential conflicts of interest, it does not ensure that all of its supervising parole agents and those employees who perform the duties of the supervising parole agents file statements of economic interests.

To assure that at a minimum it meets the basic and specialized needs as well as safety of sex offenders who are on parole, we recommended that the Youth Authority address the deficiencies in its out-of-home placement standards and modify its regulations

accordingly. It should also conduct periodic reviews of a sample of the parolees' case files to ensure parole agents' compliance with its supervising procedures. In addition, to ensure that its contracting process meets state requirements, we recommended that the Youth Authority seek guidance from the departments of General Services (General Services) and Finance (Finance).

To ensure that it can accurately identify the costs associated with housing sex offenders in the community, we recommended that the Youth Authority identify and correct erroneous data in its billing system, implement controls and procedures to ensure the completeness and accuracy of the records, and reconcile the invoices in its billing system with the payments in its accounting records. To ensure that the Youth Authority places paroled sex offenders in group homes that provide the most adequate services for the least amount of money, we recommended that it conduct a study of out-of-home placement rates paid by each of its parole offices and ensure that the rates set are commensurate with the services the homes provide. Finally, to ensure that it avoids potential conflicts of interest, the Youth Authority should ensure that all supervising parole agents and employees who are performing duties similar to those of the supervising parole agents file a statement of economic interests.

Youth Authority Action: Pending.

The Youth Authority agreed with our recommendations and has assigned a project coordinator to oversee various groups that will have responsibility for addressing the deficiencies noted in our report. For example, the Youth Authority stated that a work group has been established to address the deficiencies in its out-of-home placement standards and to modify its regulations. This work group has been instructed to include specific input from the Department of Social Services, Community Care Licensing, and the Department of Alcohol and Drug Programs on their respective standards and licensing requirements. In addition, the Youth Authority stated that it would devise a plan for getting back into compliance with regard to conducting case conferences. The Youth Authority also reported that it has assigned the deputy director of Administrative Services the task of coordinating a meeting with General Services and Finance to ensure that its contract process is consistent with state law and its own policies. Further, the Youth authority stated that a workgroup will address the issue of the appropriate tracking of costs associated with housing sex offenders and will review the billing, contracting,

and payment process. The Youth Authority stated that it will assign a staff person to conduct a study of its out-of-home placement rates and to chair a workgroup to ensure that its rates are commensurate with the services the homes provide. Finally, the Youth Authority reported that its personnel office is in the process of establishing a checklist to ensure that statements of economic interest are filed when an employee assumes or leaves office. The Youth Authority stated that it also revised its conflict-of-interest code to include positions for employees who are performing duties similar to supervising parole agents. The revision is scheduled to take effect in October 2005. In the interim, the Youth Authority stated that it would request all parole agents with supervisory responsibilities to complete statements of economic interests.

Finding #3: Mental Health should improve fiscal oversight of the Forensic Conditional Release Program, and the State lacks a process to measure its success.

Superior courts at the county level play a major role in the release of sexually violent predators (SVPs) to Mental Health's Forensic Conditional Release Program (Conditional Release Program) and retain jurisdiction over these individuals throughout the course of the program. Once an SVP resides in a secure facility for at least one year, he or she is eligible to petition the court to enter the Conditional Release Program. Although few SVPs qualify for the program (only three since the program's inception in 1995), procuring housing for them may continue to be difficult, and Mental Health needs to improve its fiscal oversight. For example, it lacks adequate procedures to monitor Conditional Release Program costs. According to the former chief of Mental Health's Forensic Services Branch, due to budget cuts it no longer has an auditor position available to perform audits and detailed reviews of costs. In addition, Mental Health does not adhere to its policies and procedures designed to reduce program costs. For example, it does not presently ensure that SVPs apply for other available financial resources such as food stamps and Social Security income. Finally, the State currently has no process to measure how successful its Sex Offender Commitment Program is (the Conditional Release Program is its fifth treatment phase in this program) or to determine how to improve it.

To ensure that contractors adhere to the terms and conditions in its contracts, we recommended that Mental Health either reinstate the auditor position or designate available staff to fulfill

the audit functions. In addition, Mental Health should follow through on its policy to reduce costs associated with the SVP component of the Conditional Release Program.

To enable the State to measure the success of the SVP component of the Conditional Release Program, we recommended that the Legislature consider directing Mental Health to conduct an evaluation of the program.

Mental Health Action: Partial corrective action taken.

Mental Health stated that although it will need to receive new funding to reinstate positions eliminated through past budget reductions, it will use Conditional Release Program operations staff to review invoices and supporting documentation prior to making a payment. However, Mental Health did not address fully its efforts to ensure that contractors adhere to the contract terms and conditions for the SVP component of the Conditional Release Program. Specifically, although Mental Health plans to review invoices and supporting documentation prior to making payments to its contractors, as the State Contracting Manual requires, it fails to address adequately the steps it will take to fulfill the audit functions we described in our audit report. Specifically, Mental Health does not indicate if it will seek funding for the auditor position nor does it outline the specific audit steps its Conditional Release Program staff will undertake. Thus, we look forward to Mental Health's subsequent responses relating to this audit issue.

In response to our recommendation that Mental Health should follow through on its policy to reduce costs associated with the SVP component of the Conditional Release Program, Mental Health reported that it will update the Conditional Release Program policies and procedures manual to specify the right to cancel contracts if circumstances cause the service or product to be no longer needed. In addition, Mental Health stated that one contractor enacted procedures to ensure that SVPs are made aware of and follow through with the need to pursue all other sources of support before they receive life support funds. This contractor also added language to its standard terms and conditions stating that the amounts received

by SVPs in the Conditional Release Program as life support funds must be repaid by the SVP. Mental Health also stated that it will update the policies and procedures manual to specify that the amount an SVP receives in life support funds to pay the cost of housing will be evaluated and determined separately from the amount received to pay the cost of other items such as food and clothing.

Legislative Action: Unknown.