Implementation of State Auditor's Recommendations

Audits Released in January 2004 Through December 2005

Special Report to

*Assembly Budget Subcommittee #4—
State Administration*

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INTRODUCTION

This report summarizes the major findings and recommendations from audit and investigative reports we issued from January 2004 through December 2005, that relate to agencies and departments under the purview of the Assembly Budget Subcommittee No. 4—State Administration. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the left-hand margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

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

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

Unless otherwise noted, we have not performed any type of review or validation of the corrective actions reported by the auditees. All corrective actions noted in this report were based on responses received by our office as of January 11, 2006.

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STATE ATHLETIC COMMISSION

The Current Boxers' Pension Plan Benefits Only a Few and Is Poorly Administered

Audit Highlights . . .

Our review of the State Athletic Commission (commission) and the boxers' pension plan revealed that:

- ☑ ***Under the current plan only four boxers per year are vesting.***
- ☑ ***The current plan will likely give an average 55-year-old vested boxer a pension benefit of $170 per month, while the original plan would have paid $98 per month.***
- ☑ ***During the four-year period from 2001 through 2004, payments for pension plan administration costs were six times greater than the amount of benefits paid to boxers.***
- ☑ ***Since the inception of the current plan, the commission met the minimum funding requirement in only one out of nine years.***
- ☑ ***Poor administration of the pension plan resulted in untimely recording of pension contributions, inaccurate reporting of boxers' eligibility status, and incorrect account balances.***

REPORT NUMBER 2004-134, JULY 2005

State Athletic Commission's response as of September 2005

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the State Athletic commission's (commission) pension plan operations. Specifically, the audit committee was interested in the condition of the current plan, the best course of action to ensure its long-term viability, how much is being spent on administrative expenses, and whether the statutory requirements for pension contributions and benefit distributions are being met. In doing so, we noted the following findings:

Finding #1: Although potentially more generous than the original plan, the current pension plan benefits even fewer boxers.

Combining both the defined benefit plan (original plan) and the defined contribution plan (current plan), only 14 percent of licensed boxers have vested as of December 31, 2003, and account balances for most vested boxers are small. Under the current plan, which began in May 1996, only four boxers per year are vesting compared to 37 boxers per year vesting under the original plan. If the current vesting trend continues, the remaining number of vested boxers will plateau at below 80 in 2036. Although vested boxers currently approaching retirement age are likely to receive more benefits than the original plan guaranteed, pension amounts will still be minimal. The current plan will likely give an average 55-year-old vested boxer a pension benefit of $170 per month, while the original plan would have paid $98 per month. From 2001 to 2004, benefit payments to boxers totaled $36,000 while the payments to administer the plan were six times higher.

We recommended that the Legislature may want to reconsider the need for a pension plan for retired professional boxers since so few boxers annually meet the current criteria of a professional

boxer. If the Legislature decides to continue the boxers' pension plan, we recommended that the commission could consider eliminating the break in service requirement and/or reducing from four to three the number of calendar years that a boxer must fight, if it believes the current vesting criteria is excluding professional boxers for which the pension plan was intended. Further, the commission should mail an annual pension statement to all vested boxers to increase the likelihood that vested boxers are locatable for benefit distribution after they turn age 55.

Commission's Action: Partial corrective action taken.

In order to ensure that the pension plan provides benefits to the professional boxers that were intended, by December 2005, the executive officer expected to complete his review of alternative vesting criteria that would give consideration to a boxer's age (i.e., actual age, number of years boxing, total actual number of rounds fought, number of times knocked out, number of times suspended, etc.). To increase the likelihood that vested boxers are locatable after they turn age 55, the commission plans to send each boxer an annual statement regardless of activity status. For any annual statements that are returned as undeliverable, it will re-send the statement to any secondary address that may be available.

Finding #2: The commission has many problems with its day-to-day administration of the boxers' pension plan.

The boxers' account balances of $3.39 million could have been higher had the commission fully exercised its legal authority to maximize contributions to the current plan. Although the commission increased the ticket assessment to 88 cents per ticket in July 1999, it only met the target in one of nine years and has undercollected by a total of $300,000. Additionally, the commission performs its administrative duties related to the boxers' pension fund slowly and inaccurately. We found problems with untimely depositing of incoming checks to the Department of Consumer Affairs' (Consumer Affairs) bank account, remittances of pension contributions to the boxers' pension fund, and production of accurate eligible round and purse information; missing boxing contest documents needed to support contribution allocations to boxers; and various errors in determining boxers' eligibility and allocation of amounts to boxers' accounts. As a result, the recording of pension contributions were delayed, boxers' eligibility status were inaccurate and their respective account balances were incorrect. Moreover, the commission needs to periodically review boxers' eligibility status and account balances to ensure that the pension plan administrator correctly determines boxers' eligibility and account balances.

To maximize pension fund assets, we recommended that the commission should raise the ticket assessment to meet targeted pension contributions as required by law and promptly remit pension contributions from Consumer Affairs' bank account to the boxers' pension fund. To ensure receipts are deposited in a timely manner, we recommended the commission should implement the corrective action proposed by the acting executive officer to Consumer Affairs related to ensuring timely deposit

of checks. Additionally, the commission should require promoters to remit pension fund contributions on checks separate from other boxing show fees so that deposits of checks and subsequent remittances to the boxers' pension fund are not delayed. To ensure boxers' information concerning eligibility status and pension account balances are accurate, the commission should retain all official documents from each boxing contest. Further, the commission should immediately work with the pension plan administrator to correct errors related to boxers' eligibility status and account balances. Lastly, the commission should periodically review a sample of newly vested and pending boxers, and verify their eligibility status and pension account balances.

Commission's Action: Partial corrective action taken.

The commission is considering various alternatives to meet the funding target, including negotiating with tribal governments to collect contributions from fights on tribal lands, redirecting some broadcast revenues to the pension fund, and raising the per ticket assessment to $1.25. The commission has taken steps to ensure that previously collected pension contributions have been deposited in the pension fund and that future collections are deposited in the pension fund in a timely manner. One of these steps is directing promoters to remit checks for pension contributions separate from checks related to show fees. In order to ensure eligibility information is being retained, the commission is creating a checklist of all documents that are required to be retained in its files. The commission is in the process of completing its research related to correcting errors in boxers' eligibility status and account balances and anticipated it would finish this review by October 2005.

PHARMACEUTICALS

State Departments That Purchase Prescription Drugs Can Further Refine Their Cost Savings Strategies

Audit Highlights . . .

Our review of the State's procurement and reimbursement practices as they relate to the purchase of drugs for or by state departments revealed the following:

- ☑ ***Although the Department of General Services (General Services) generally got the best prices for the drug ingredient cost because of up-front discounts, it had the highest state cost after considering rebates, dispensing fees, co-payments, and third-party payments.***
- ☑ ***The Department of Health Services' net drug ingredient cost and state cost are lower than General Services and the California Public Employees' Retirement System's (CalPERS) because it receives substantial federal Medicaid program and state supplemental rebates.***
- ☑ ***Although CalPERS receives rebates through entities it contracts with to provide pharmacy services to its members, it cannot directly verify it is receiving all of the rebates to which it is entitled.***

continued on next page . . .

REPORT NUMBER 2004-033, MAY 2005

California Public Employees' Retirement System and the Department of General Services' responses from the State and Consumer Services Agency, and the Department of Health Services' response from the Health and Human Services Agency as of November 2005

Chapter 938, Statutes of 2004, required the Bureau of State Audits (bureau) to report to the Legislature on the State's procurement and reimbursement practices as they relate to the purchase of drugs for or by state departments, including, but not limited to, the departments of Mental Health, Corrections, the Youth Authority (Youth Authority), Developmental Services, Health Services (Health Services), and the California Public Employees' Retirement System (CalPERS). Specifically, the statutes required the bureau to review a representative sample of the State's procurement and reimbursement of drugs to determine whether it is receiving the best value for the drugs it purchases. The statutes also required the bureau to compare, to the extent possible, the State's cost to those of other appropriate entities such as the federal government, Canadian government, and private payers. Finally, the bureau was required to determine whether the State's procurement and reimbursement practices result in savings from strategies such as negotiated discounts, rebates, and contracts with multistate purchasing organizations, and whether the State's strategies result in the lowest possible costs. The bureau examined the purchasing strategies of the three primary departments that contract for prescription drugs—the Department of General Services (General Services), Health Services, and CalPERS. We found that:

Finding #1: In some instances, CalPERS cannot directly verify that it is receiving all of the rebates to which it is entitled.

Negotiating drug rebates is one tool available to reduce drug expenditures. Drug manufacturers typically offer rebates based on the extent to which health care plans influence their

☑ *In our comparison of 57 prescription drug costs across the three state departments and select U.S. and Canadian governmental entities, the Canadian entities got the lowest prices about 58 percent of the time. However, federal law strictly limits the importation of prescription drugs through the Food, Drug, and Cosmetic Act whose stringent requirements generally exclude any drugs made for foreign markets.*

products' market share. Although CalPERS does not directly contract with drug manufacturers, it receives rebates from some entities it contracts with for pharmaceutical services. In some instances CalPERS receives rebates under a pass-through method. In the pass-through method, the entity negotiates rebates and contracts with pharmaceutical manufacturers so that rebate payments between the manufacturer and the entity are based on historical and prospective pharmacy utilization data for all of the members of the health care plan that the entity administers. The entity then collects and passes through to plan sponsors, such as CalPERS, either a percentage or the entire amount of the rebates earned by the sponsors based on their member utilization.

Typically, these entities prohibit CalPERS from having access to any information that would cause them to breach the terms of any contract with the pharmaceutical manufacturers to which they are a party. Because CalPERS does not have access to the entities' rebate contracts with the manufacturers, CalPERS cannot directly verify that it is receiving all of the rebates to which it is entitled. According to CalPERS, this rebate practice between the entity and the manufacturer is an industry practice and is not unique to it. CalPERS intends to continue to pursue greater disclosure requirements in future contracts with its contracting entities.

We recommended that the Legislature consider enacting legislation that would allow CalPERS to obtain relevant documentation to ensure that it is receiving all rebates to which it is entitled to lower the prescription drug cost of the health benefits program established by the Public Employees' Medical and Hospital Care Act. Additonally, CalPERS should continue to explore various contract negotiation methods that would yield more rebates for the drugs it purchases and that would allow it to achieve greater disclosure requirements to verify that it is receiving all of the rebates to which it is entitled.

Legislative Action: Unknown.

CalPERS' Action: Partial corrective action taken.

CalPERS reports that the providers for two of its HMO plans will furnish rebate information as part of the financial statements that they regularly provide to it. CalPERS also stated the provider of another of its HMOs considers rebates proprietary and confidential, and the provider does not

identify rebates in its financial statements. However, a recent pharmacy carve-out analysis, conducted by a consultant for pharmacy claims from May 2003 through April 2004, confirmed that this HMO's management of the pharmacy benefit is the most cost-effective of CalPERS' health plans. CalPERS stated that it will continue to assess this HMO's performance and management as part of its recurring rate analysis. CalPERS also reports that it released a pharmacy benefits manager request for proposals for its self-funded PPO plans in May 2005 that specifically asked bidders to complete a financial questionnaire and furnish data on pass-through retail pricing, mail service pricing, administrative fees, rebates, and account profit and loss statements. CalPERS believes that this request for proposals represents a significant step forward in achieving greater disclosure and accountability.

Finding #2: General Services is in the early stages of its direct negotiations with manufacturers and aims to increase its ability to reduce the net ingredient cost of prescription drugs.

Although rebates typically decreased the cost of prescription drugs for Health Services and CalPERS, General Services' net ingredient costs, drug ingredient cost minus any rebates or additional discounts, for the drugs in our sample are about the same as its costs for the drugs before any discounts or rebates. General Services says this is because it is still in the early stages of its direct negotiations with manufacturers to achieve reduced drug costs. Currently, departments purchasing drugs through General Services can obtain rebates only for one drug product class, a rebate General Services obtained through contract negotiation efforts. For that one drug product class, state agencies received at least $1.5 million in rebates for their purchases in fiscal year 2003–04.

To ensure that state departments purchasing drugs through General Services' contracts are obtaining the lowest possible drug prices, we recommended that General Services seek more opportunities for departments to receive rebates by securing more rebate contracts with manufacturers.

General Services' Action: Partial corrective action taken.

General Services reports that to obtain the best and lowest drug price, its primary strategy continues to be to negotiate price discounts upfront with the manufacturer. However, General Services notes that if rebates result in the State obtaining the best and lowest prices, they have been and will continue to be pursued.

Finding #3: Although General Services has made progress, it still needs to negotiate more contracts with drug manufacturers.

In a January 2002 report, *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements*, the bureau recommended that General Services increase its efforts to solicit bids from drug manufacturers to obtain more drug prices on contract. At that time, General Services had about 850 drugs on contract, but during most of fiscal year 2003–04 had

only 665 drugs on contract. General Services states that because of limited resources, it is focusing on negotiating contracts with manufacturers of high-cost drugs. However, opportunities still exist for General Services to increase the amount of purchases made under contract with drug companies.

We recommended that General Services continue its efforts to obtain more drug prices on contract by working with its contractor to negotiate new and renegotiate existing contracts with certain manufacturers.

General Services' Action: Partial corrective action taken.

General Services reports that its strategic sourcing contractor and its partners are providing support to General Services in its efforts to negotiate and renegotiate contracts with drug manufacturers. Specifically, the contractor is assisting General Services in its negotiations with two manufacturers that could provide atypical antipsychotic category of drugs, which make up approximately 30 percent of annual drug costs. The contractor is also being used, as needed, to assist in the renegotiation of two existing contracts within the same category of drugs that both expire during calendar year 2006.

In addition, General Services reports that it has pursued the negotiation of contracts with manufacturers of gastrointestinal and anticonvulsant classes of drugs that are widely used by the State. It recently issued a request for proposals for one of these drug classes, and is currently in the process of evaluating responses. For the other class of drugs, General Services has recently entered into discussions with a high volume manufacturer of that drug, and at the request of the manufacturer, is currently gathering data on the usage of that drug. Upon completion of that activity, General Services states that it will enter into contract negotiations to achieve better pricing, including, if feasible, the provision for obtaining rebates.

Finding #4: General Services was not able to demonstrate that it fully analyzed how to improve its procurement process.

General Services was unable to provide documentation demonstrating that it addressed another recommendation in our January 2002 report: that it fully analyze measures to improve its procurement process, such as joining the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) or contracting directly with a group-purchasing organization. General Services does contract with the alliance, but that contract covers only 16 percent of the drug purchases state departments made. With state departments purchasing almost half their prescription drugs at the prime vendor's price, General Services stands to reap benefits for the State by figuring out additional ways to procure prescription drugs.

General Services recognizes that it can do more to ensure that its strategies result in the lowest possible cost to the State. In September 2004, General Services hired a contractor to analyze state spending and identify opportunities to generate savings. General Services

stated that, as resources become available, it intends to solicit bids to contract directly with a group-purchasing organization to determine if additional savings can be realized beyond the savings generated by the alliance.

We recommended that General Services follow through on its plan to solicit bids to contract directly with a group-purchasing organization to determine if additional savings can be realized. However, in doing so it should thoroughly analyze its ability to secure broader coverage of the drugs state departments purchase by joining MMCAP. The analysis should include the availability of current noncontract drugs from each organization being considered and the savings that could result from spending less administrative time trying to secure additional contracts directly with drug manufacturers.

General Services' Action: Partial corrective action taken.

General Services has determined that an alternative method of accessing a group-purchasing organization should be assessed as soon as feasible. It reports that this assessment will include an analysis of the benefits of joining the cooperative purchasing arrangement used by MMCAP. General Services recently started its analytical work to determine if additional savings could be obtained by directly contracting with a group-purchasing organization. If the analysis determines that additional savings can be realized, General Services will develop and issue a request for proposals for a new method of accessing a group-purchasing organization. General Services expects that a request for proposals, if warranted, will be issued during calendar year 2006.

Finding #5: General Services has not fully considered how to identify and mitigate obstacles to enforcing its statewide formulary.

In our January 2002 report, the bureau recommended that General Services fully consider and try to mitigate all obstacles that could prevent the successful development of a statewide formulary, such as departments not strictly enforcing such a formulary at their institutions. A drug formulary is a list of drugs and other information representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of specific conditions. A main purpose of a formulary is to create competition among manufacturers of similar drugs when the clinical uses are roughly equal. However, the success of a statewide formulary and the State's ability to create enough competition to negotiate lower drug prices for certain products depends on how well state departments adhere to the formulary when they prescribe drugs. Although General Services has developed a statewide formulary, it has not identified the obstacles to enforcing it. General Services has not required departments to adopt a policy requiring strict adherence to the statewide formulary and does not monitor departments' adherence to the formulary. General Services does not believe its role is to enforce the formulary, but the goals of a statewide formulary in reducing drug costs cannot be realized without such enforcement.

We recommended that General Services facilitate the Common Drug Formulary Committee and Pharmacy Advisory Board's development of guidelines, policies, and procedures relating to the departments' adherence to the statewide formulary and ensure that departments formalize their plans for compliance.

General Services' Action: Partial corrective action taken.

General Services reports that at the Common Drug Formulary Committees' August 2005 and October 2005 meetings, preliminary discussions were held on our recommended actions related to the need for written guidelines, plans, policies, and procedures governing the administration and enforcement of the statewide formulary. The committee approved the formulary during the October meeting, which will allow additional resources to be focused on administrative and enforcement issues in the future. According to General Services, the Pharmacy Advisory Board will meet in January 2006 to approve the statewide formulary, and at that meeting, a discussion will be held on the steps to be taken to ensure the adequate and effective administration and enforcement of the formulary.

Finding #6: General Services does not have information concerning non-prime vendor drug purchases made by departments required to participate in its bulk purchasing program.

Although state law requires specific state departments to purchase drugs through General Services, our survey of various departments indicates they are not always doing so. Specifically, California Government Code requires the departments of Corrections, Developmental Services, Youth Authority, and Mental Health to participate in General Services' bulk purchasing program. In addition, California Public Contract Code requires that all state departments purchasing drugs totaling more than $100 must purchase them through General Services. California State University, the University of California, and some entities within the California Department of Veterans' Affairs are exempt from this requirement. Although we found that departments generally purchase most drugs through General Services' contract with its prime vendor, they also purchase drugs through other vendors.

Nine state entities purchased prescription drugs using General Services' prime vendor, but each of these entities also purchased drugs from non-prime vendor sources during fiscal year 2003–04. For example, although the Youth Authority purchased drugs from the prime vendor costing roughly $1.8 million, it also purchased drugs costing almost $451,000 through other vendors. Seven of the nine entities we surveyed purchased 20 percent to 100 percent of their drugs through non-prime vendor sources. General Services stated that it did not have insight into the amounts and kinds of drugs that entities were purchasing through other sources and therefore has not analyzed these purchases.

In order to make more informed decisions concerning the operation of its prescription drugs bulk-purchasing program and to be able to expand the program to include those prescription drugs that best serve the needs of state departments, we recommended that General Services ask those departments that are otherwise required to participate in the bulk purchasing program to notify General Services of the volume, type, and price of prescription drugs they purchase outside of the bulk purchasing program.

General Services' Action: Corrective action taken.

General Services reports that it now requires those departments that must participate in the bulk-purchasing program to provide detailed information on drugs purchased outside of the program. This information will aid General Services' pharmaceutical and acquisitions staff in making decisions about the bulk-purchasing program.

Finding #7: Health Services needs to improve the accuracy of its pharmacy reimbursement claim data.

Our review found that Health Services sometimes uses incorrect information when paying pharmacies. In several instances Health Services' payments to pharmacies were based on outdated or incorrect information. Health Services receives updates from a pricing clearinghouse and changes its prices monthly. One factor that Health Services uses to determine the appropriate drug price for a claim is the date of service. Specifically, Health Services uses this date to query its pricing file and identify the price in effect during the date of service on the claim. However, Health Services holds the price updates it receives from its primary reference source until the subsequent month because its budgetary authority only allows for monthly updates. Additionally, Health Services did not update its prices to reflect the elimination of the direct pricing method, which was the price listed by Health Services' primary or secondary reference source or the principal labeler's catalog for 11 specified pharmaceutical companies. Despite state law eliminating this method as of December 1, 2002, Health Services continued to use it during fiscal year 2003–04 to reimburse pharmacies. Health Services stated that the system change error related to the direct pricing method occurred prior to the July 2003 implementation of its fiscal intermediary's Integrated Testing Unit, which is responsible for performing comprehensive tests of system changes to prevent program errors. Health Services also incorrectly calculated drug prices. Although Health Services began corrective action after we brought the issues to its attention, its analyses to quantify the full extent and dollar impact of these errors was not complete as of April 2005.

To ensure that it reimburses pharmacies the appropriate amounts for prescription drug claims, we recommended that Health Services analyze the cost-effectiveness of increasing the frequency of its pricing updates. If this analysis shows that it would be cost-effective to conduct more frequent updates, Health Services should seek budgetary authority to do so. Health Services should also identify prescription drug claims paid using the direct pricing method, determine the appropriate price for these claims, and make the necessary corrections. In addition, we recommended that Health Services ensure that the fiscal

intermediary's Integrated Testing Unit removes future outdated pricing methods promptly. Finally, Health Services should ensure that its fiscal intermediary's Integrated Testing Unit verifies that, in the future, drug prices in the pricing file are calculated correctly before authorizing their use for processing claims.

Health Services' Action: Corrective action taken.

Health Services reports that a budget health trailer bill amended the Welfare and Institutions Code to increase the frequency of drug price updates to weekly instead of monthly. Health Services has implemented this change through manual updates until system changes are made to enable an automated process. Health Services expects to implement these system changes in January 2006. In addition, Health Services determined that using the direct pricing method, which was eliminated by state law effective December 1, 2002, caused it to overpay 457,368 claims for a total of $2.9 million, and to underpay 199,380 claims by more than $450,000. Therefore, Health Services reports that its total net recoupment will be approximately $2.5 million for the period of December 1, 2002, through June 30, 2005. Finally, Health Services has implemented safeguards within the fiscal intermediary's Integrated Testing Unit to assure that these types of errors in the formulary file will not occur on future system changes.

CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

It Relied Heavily on Blue Shield of California's Exclusive Provider Network Analysis, an Analysis That Is Reasonable in Approach but Includes Some Questionable Elements and Possibly Overstates Estimated Savings

Audit Highlights . . .

Our review of the decision by the California Public Employees' Retirement System (CalPERS) board of administration (board) in May 2004 to approve an exclusive provider network for CalPERS members in the Blue Shield of California (Blue Shield) health maintenance organization (HMO) found the following:

- ☑ ***Our consultants found that many components of Blue Shield's analysis appear reasonable but some questionable elements exist such as using claim data from non-CalPERS sources.***
- ☑ ***Blue Shield's original savings estimate did not incorporate a health system's financial terms that were expected to produce substantial savings in 2005 only if the board did not adopt the exclusive provider network.***
- ☑ ***Blue Shield's estimate of $31.4 million in savings does not take into consideration the impact of members leaving its HMO provider network and joining other health-care plans.***

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REPORT NUMBER 2004-123, MARCH 2005

California Public Employees' Retirement System's response as of September 2005

The Joint Legislative Audit Committee requested the Bureau of State Audits to examine the California Public Employees' Retirement System (CalPERS) decision to discontinue contracting with certain hospitals through the Blue Shield of California (Blue Shield) health maintenance organization (HMO) provider network. Our consultants found that many components of Blue Shield's analysis appear reasonable but some questionable elements exist such as using claim data from non-CalPERS sources. In addition, Blue Shield's original savings estimate did not incorporate a health system's financial terms that were expected to produce substantial savings in 2005 only if the board did not adopt the exclusive provider network. Also, Blue Shield's estimate of $31.4 million in savings does not take into consideration the impact of members leaving its HMO provider network and joining other health care plans. Further, Blue Shield did not adequately address a recommendation to investigate differences in emergency room assumptions for one health system. According to our consultant, Blue Shield's hospital savings estimate of $20.6 million could drop to only $8.9 million if the model-review actuary's assumptions were used. Moreover, the CalPERS board, health benefits committee (committee), and health benefits branch staff relied primarily on Blue Shield's summary of its analyses and its presentations in deciding to approve the exclusive provider network. Although a model-review actuary was hired to, among other things, review Blue Shield's cost savings projections, he was unable to express an opinion on the savings estimate of $36.3 million related to the 38 hospitals;

- ☑ *Blue Shield did not adequately address a recommendation to investigate differences in emergency room assumptions for one health system. According to our consultant, Blue Shield's hospital savings estimate of $20.6 million could drop to only $8.9 million if the model-review actuary's assumptions were used.*
- ☑ *The CalPERS board, health benefits committee, and health benefits branch staff relied primarily on Blue Shield's summary of its analyses and its presentations in deciding to approve the exclusive provider network.*
- ☑ *Although a model-review actuary was hired to, among other things, review Blue Shield's cost savings projections, he was unable to express an opinion on the savings estimate of $36.3 million related to the 38 hospitals; thus, his report could not provide a credible basis for the CalPERS board to evaluate the savings estimate.*
- ☑ *In one instance, our consultant found that Blue Shield deviated from its original criteria for excluding hospitals from the network.*

thus, his report could not provide a credible basis for the CalPERS board to evaluate the savings estimate. Finally, in one instance, our consultant found that Blue Shield deviated from its original criteria for excluding hospitals from the network.

Finding #1: CalPERS relied primarily on Blue Shield's summary of its analyses and presentations in making the decision to exclude hospitals.

A provision of the contract between CalPERS and Blue Shield specifies that Blue Shield cannot disclose information to CalPERS that would cause it to breach the terms of any contract to which it is a party. According to Blue Shield, the terms of the contract between it and providers in its network specifically prohibit the disclosure of certain information, including rates of payment. Consequently, CalPERS health benefits branch staff did not have access to hospital rates, nor could they review Blue Shield's cost model. As a result, CalPERS was unable to verify the accuracy of Blue Shield's cost comparison data.

We recommended that the Legislature consider enacting legislation that would allow CalPERS, during its contract negotiation process, to obtain relevant documentation supporting any analyses it will use to make decisions that materially affect the members of the health benefits program established by the Public Employees' Medical and Hospital Care Act.

Legislative Action: Unknown.

Finding #2: CalPERS did not fully consider all of the findings and recommendations made by the actuary hired to perform a third-party review prior to approving the exclusive provider network.

CalPERS health benefits branch staff directed Blue Shield to hire an independent actuary (model-review actuary) to conduct a third-party review to resolve differences between Blue Shield's and a health system's analyses. Blue Shield's contract with the model-review actuary also required him to review the cost savings projections for the exclusive provider network. The model-review actuary issued his final report to Blue Shield and CalPERS in April 2004, which contained numerous findings and recommendations. Although the board and committee discussed Blue Shield's savings estimate in meetings held before the board voted to approve the exclusive provider network in May 2004, our review of the transcripts found that they did not

discuss all of the model-review actuary's findings and recommendations or the impact of the findings and recommendations on the CalPERS board's decision. Without fully addressing all of the concerns raised by the model-review actuary, CalPERS had no assurance from an independent source that Blue Shield's savings estimate, as well as other aspects of its model, were accurate.

We recommended that, to ensure its decisions are in the best interests of CalPERS members, CalPERS should require its health benefits branch staff to evaluate fully the findings and recommendations of third-party reviews and present their results to the board and committee.

CalPERS' Action: Corrective action taken.

CalPERS stated that, effective September 1, 2005, it implemented procedures to formalize its criteria for analyzing and reporting on third-party reviews. These procedures require CalPERS' management to designate a staff Third-party Review Coordinator to oversee reviews. The procedures also require the coordinator to monitor, evaluate, and report to CalPERS' management the outcomes and efficacy of analyses performed in third-party reviews, including any deficiencies or limitations. Finally, the procedures require CalPERS' management to ensure that the coordinator reviews, approves, and presents all findings to the board and its committees.

CalPERS further stated that its third-party review procedures address the bureau's concerns in the audit report. Specifically, CalPERS stated that the procedures provide a clear statement of work, a thorough review of work by staff and management, documentation, and clear channels of communication of the results of the review to CalPERS' management and the board.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

The Intermediate Sanction Programs Lacked Performance Benchmarks and Were Plagued With Implementation Problems

Audit Highlights . . .

Our review of the California Department of Corrections and Rehabilitation's (department) intermediate sanction programs for parole violators revealed the following:

- ☑ ***Although the department had data regarding parole violators in the programs, it did not analyze the data or establish benchmarks that it could measure the programs' results against.***
- ☑ ***The department's savings were substantially less than anticipated because its savings estimates were based on unrealistic expectations and the programs were implemented late.***
- ☑ ***To minimize the risk to public safety, less dangerous parole violators were placed in the intermediate sanction programs; however, a small percentage of parole violators were convicted of new crimes during the time they otherwise would have been in prison.***
- ☑ ***Although implementation of the intermediate sanction programs was planned for January 1, 2004, the implementation was delayed due to labor negotiations, a department leadership change, and unanticipated contracting problems.***

REPORT NUMBER 2005-111, NOVEMBER 2005

California Department of Corrections and Rehabilitation response as of November 2005

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review how the California Department of Corrections and Rehabilitation (department) handles parole violators under its New Parole Model policy. Specifically, the audit committee requested that we assess the steps used and the extent to which the department has implemented and monitored its new parole policy, focusing on the intermediate sanction programs, including electronic monitoring, substance abuse treatment control units, and community detention houses. In addition, the audit committee asked us to determine whether the department had established performance measures to measure the efficacy of its parole policy in lowering the recidivism rate.

On April 11, 2005, shortly after the audit committee approved the audit, the department secretary terminated the department's use of the intermediate sanction programs as an alternative to parole revocation and return to prison. The programs we were asked to audit had been operating for 14 months or less when they were canceled, so the data available for our analysis were limited.

Finding #1: The department could have established benchmarks and evaluated the intermediate sanction programs against them, but did not.

Although the department's Division of Adult Parole Operations (parole division) had gathered data about the intermediate sanction programs, it did not analyze the data to evaluate the programs' impact on public safety. In addition, the parole

division did not establish benchmarks, such as acceptable return to custody rates for participants that it could measure the program against. Monitoring the programs' impact on public safety against established benchmarks would have provided information relevant to the secretary's decision to terminate the programs, such as whether the percentages of parolees in the programs who were convicted of new crimes or who committed parole violations when they otherwise would have been in prison were within acceptable limits. In addition, had the parole division established benchmarks for what it considered success, such as a minimum number of parole violators completing the programs, and analyzed the available data—similar to what we did for our report—the secretary could have used the analyses in deciding whether terminating the intermediate sanction programs was the best choice. Finally, by defining benchmarks before implementing the programs, the parole division could have determined whether it needed additional data to measure against the established benchmarks.

When planning future intermediate sanction programs, the parole division should decide on appropriate benchmarks for monitoring performance, identify the data it will need to measure performance against those benchmarks, and ensure that reliable data collection mechanisms are in place before a program is implemented. After implementing a new intermediate sanction program, the parole division should analyze the data it has collected and, if relevant, use the data in its existing databases to monitor and evaluate the program's effectiveness on an ongoing basis.

Department's Action: Pending.

The department agrees with our recommendations and indicates that it has designed the new In Custody Drug Treatment and the Electronic In-Home Detention programs to fit with evidence-based research to reduce recidivism. However, the department recognizes some limitations exist in the ability of its databases to provide and compile relevant information, but to the extent that the databases can provide useful information for analysis, it will continue to use them for that purpose in a more systematic manner.

Finding #2: Late implementation and unrealistic expectations prevented the intermediate sanction programs from achieving desired savings.

For various reasons, none of the intermediate sanction programs were implemented by January 1, 2004, as planned, so parole violators could not be placed in the programs as early as had been intended. Compounding the delayed implementation was the parole division's unrealistic expectation that the programs would be fully occupied by the first date of implementation. The parole division also did not take into account that there would be a ramping-up period during which occupancy in the programs would increase gradually, but instead, assumed full capacity from the beginning.

The parole division did not evaluate the data it had about the Halfway Back and Substance Abuse Treatment Control Units (SATCU) programs, so it was unable to calculate the savings achieved by the programs. It was apparent, however, that the savings were substantially less than anticipated because of the delays in implementing the programs and placing parole violators in them. Using the parole division's estimates and data about the programs and the participants, we estimated that for the 5,742 parole violators placed in the programs by December 31, 2004—2,567 in the SATCU program and 3,175 in the Halfway Back program—the department saved $14.5 million—$7.4 million and $7.1 million, respectively. The savings equates to an average $1.2 million per month over a 12-month period, far short of the average $8.4 million per month it would have had to save to achieve its planned savings of $50.2 million for fiscal year 2003–04 and $100.5 million for fiscal year 2004–05.

We recommended that the parole division should ensure the savings estimates developed during program planning are based on reasonable assumptions, and if those assumptions change, update the savings estimates promptly.

Department's Action: Pending.

The department concurs with our recommendation and indicates it will ensure that any discussions with legislative staff or other researchers includes reasonable projections or estimates, and that it updates and reassesses projected savings in a timely manner.

Finding #3: The parole division could have established a performance baseline and used it to analyze the effect the intermediate sanction programs had on parolee behavior, but did not.

The parole division hoped that parole violators would benefit from services they received while in the SATCU and Halfway Back programs to help them integrate back into society and successfully complete their parole terms, resulting in a lower recidivism rate. Although the tradeoff may be difficult, achieving the desired benefits of using intermediate sanctions in lieu of returning eligible parole violators to prison requires a willingness to accept the additional risks associated with keeping individuals who are proven to be uncooperative in the community. The parole division minimized the risk to public safety by placing less-dangerous parole violators in the programs. However, depending on the program, this supervision or strict control occurred for between 30 days and an average of 45 days, which is significantly less than the average 153 days a parolee would have stayed in prison for parole violations.

Based on our data analysis, of the 2,567 parole violators placed in the SATCU program and 3,175 parole violators placed in the Halfway Back program by December 31, 2004, 128 (5 percent) and 114 (4 percent), respectively, were returned to prison for new convictions during the time they otherwise would have been in prison. Notwithstanding the significance of those crimes to their victims, the percentage of parolees participating in the two programs who were convicted of new crimes is small.

An additional 1,732 parole violators placed in the Halfway Back and SATCU programs were returned to prison for committing parole violations during that time. However, the parole division had no benchmarks to determine whether these results were acceptable.

The parole division should consider analyzing the effect programs have had on parolee behavior and should use the knowledge it gains from the analyses to make future intermediate sanction programs more effective. The analysis should include the benefits of adding features to make these programs more effective.

Department's Action: Pending.

The department agrees with our recommendation but points out that analyzing the effects programs have had on parolee behavior is a lengthy and sophisticated process that requires the expertise of professionally trained researchers. Nonetheless, the department states that it will begin identifying benchmarks and processes to collect data to measure performance against those benchmarks.

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

Investigations of Improper Activities by State Employees, January 2005 Through June 2005

INVESTIGATIONS I2004-0649; I2004-0681; I2004-0789 (REPORT I2005-2), SEPTEMBER 2005

Investigative Highlight . . .

Department of Corrections and Rehabilitation failed to account for 10,980 hours of union leave time at a cost to the State of $395,256.

California Department of Corrections and Rehabiliation's response as of November 2005

We investigated and substantiated allegations that the California Department of Corrections and Rehabilitation (Corrections) did not track the total number of hours available in a rank-and-file release time bank (time bank) composed of leave hours that union members donated.

Finding: Corrections failed to adequately account for time-bank hours.

Corrections lacked an adequate system of internal accounting and administrative controls over the number of hours in the time bank used by Peace Office Association members which allowed Peace Officer Association members to take release time without Corrections knowing whether the time-bank balance was sufficient to cover the anticipated leave.

We identified three employee representatives whom Corrections released for a combined total of 10,980 hours between May 2003 and April 2005, which cost the State $395,256, to perform duties for the Peace Officers Association and who were suppose to have this time charged against the time bank.

Corrections indicated that in the latter part of 2004, it began generating management reports that included information on time-bank use and donations and that it is analyzing this information to better assess the overall impact of such union-leave activities. Although we acknowledge that Corrections has considerably improved its monitoring of the time bank's activity, it still failed to account for a significant amount of time-bank hours used. Further, in the management

reports that it used to assess current time-bank activity, Corrections did not correctly account for the hours that the three representatives used. Such errors underscore the need for Corrections to perform its own accounting to ensure that requests for time-bank use are charged against its balance and are sufficiently funded by employee leave donations.

Corrections' Action: Partial corrective action taken.

Corrections reported that it is continually evaluating the impact time-bank activity is having on department operations and plans to discuss such issues during its 2006 contract negotiations with the Peace Officers Association. Further, it reported that it has updated policies and tracking codes pertaining to union leave to more effectively capture the time being used by unions. However, Corrections has not demonstrated that it has established and kept track of time-bank balances so that it can be assured that the time bank has sufficient balances to cover leave requests. Further, Corrections has yet to ensure that its current method of accounting for time-bank activity accurately reflects all of the time-bank hours used, which indicates a serious flaw in Corrections' tracking system.

CALIFORNIA DEPARTMENT OF CORRECTIONS

It Needs to Better Ensure Against Conflicts of Interest and to Improve Its Inmate Population Projections

REPORT NUMBER 2005-105 SEPTEMBER 2005

Audit Highlights . . .

Our review of the California Department of Corrections' (department) processing of two no-bid community correctional facility (CCF) contracts and its projections of inmate populations revealed the following:

- ☑ ***Although one CCF contract was never executed, actions taken by two of the contractor's employees who formerly worked for the department may have violated conflict-of-interest laws.***
- ☑ ***The department does not ensure that retired annuitants in designated positions file statements of economic interests.***
- ☑ ***The department, the facility owner, and the potential contractor all incurred costs before the department received approval to proceed with a no-bid contract.***
- ☑ ***Information the department relied upon to determine the need for the no-bid contracts appears accurate.***

continued on next page . . .

California Department of Corrections and Rehabilitation's response as of November 2005

The California Department of Corrections' (department) fiscal year 2003–04 budget did not include funds to continue the contracts for three private community correctional facilities (CCF). However, in 2004 the department experienced a large unexpected increase in inmate population because parole reform programs were not carried out and because new inmate admissions from counties increased. Since prior population projections had generally projected a stable population through 2009, the department did not expect this large increase. To respond to this situation, the department put thousands of added beds into use, some located in "overcrowding" areas—temporary beds placed in areas that are more difficult to secure, such as gymnasiums and dayrooms. In summer 2004, the Youth and Adult Correctional Agency and the department decided to reactivate two of the closed CCFs, McFarland and Mesa Verde, using one-year, no-bid contracts, while initiating a competitive bidding process for a longer-term solution.

The department's Population Projections Unit (projections unit) generates population projections for time frames that span six fiscal years, monitors and reports on the quality of the projections, and explains inconsistencies between actual and projected populations. The annual population projections correspond with the State's budget cycle and drive the department's annual budget request. The department prepares its budget request using the fall population projection and submits this request to the Department of Finance (Finance) for use in preparing the Governor's Budget. It revises its budget request based on the spring population projection and submits the revision to Finance for inclusion in the May revision of the

- ☑ *The department's inmate population projections are useful for budgeting, but have limited value for longer-range planning, such as determining when to build additional facilities.*
- ☑ *Because certain practices increase the subjectivity of the department's projections and no documentation of the projection process exists, our statistical expert could not establish the validity of the projection process.*

Governor's Budget. The department also uses these projections to assess the ability of its facilities to house the inmate population over a six-year timeline.

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits evaluate the process the department used to negotiate and enter into two no-bid contracts for private prison facilities to determine whether its policies and procedures are consistent with and adhere to current laws and regulations, particularly in relation to conflict-of-interest rules. In addition, the audit committee asked us to analyze information the department used in its decision to enter into the two no-bid contracts to determine whether such information was accurate and reliable, to analyze the reasonableness and consistency of its method of tracking and projecting inmate population, and to assess the validity of any cost savings it identified.

Finding #1: The department began incurring costs related to the Mesa Verde contract prior to receiving appropriate approval.

Before awarding a contract without competition, the department must obtain the approval of General Services. Also, as part of the contract award process, after General Services' approval of the request justifying an exemption from competitive bidding, the department operations manual requires contracts to be forwarded to the contractor for signature. This was the process the department used in executing the McFarland contract. However, it sent the Mesa Verde contract to the contractor for signature before obtaining General Services' approval of its justification for exemption. The department later rescinded its request for exemption because of a decline in inmate population and because of conflict-of-interest concerns. It did notify the contractor by letter that the contract was not fully approved or in effect until General Services gave its final approval. Nevertheless, the department, the facility owner, and the potential contractor all incurred costs before receiving approval from General Services.

We recommend that, to strengthen controls over its processing of no-bid contracts, the department wait until all proper authorities have approved the no-bid contract justification request before sending a contract to a contractor for signature or signing the contract itself.

Department's Action: None.

The department states that its normal contracting procedures comply with this recommendation. However, it further states that when timing is critical for procuring essential services, obtaining the contractor's signature in advance helps to expedite the process, but does not, in any way, execute the contract.

Finding #2: Although the department has controls in place to identify conflicts of interest, a conflict may have existed with the unexecuted Mesa Verde contract.

Despite conflict-of-interest disclosure requirements in the contract, Civigenics—the Mesa Verde contractor—did not disclose that two of its employees had worked for the department within the past year. As of July 2005, these same two Civigenics employees were also listed as current retired annuitants available to work at the department. According to Civigenics officials, the company hired one former high-ranking department employee to develop a strategic plan and the other to help with the reactivation of Mesa Verde. The employment of the two individuals by both the department and Civigenics created potential conflicts of interest that, had the contract been fully executed, could have rendered it void. Moreover, certain contacts between these two individuals and the department during the contract formation process raise the possibility that conflict-of-interest laws were violated even though the contract was never fully executed.

We recommended that the department require key contractor staff to complete statements of economic interests (statements).

Department's Action: Pending.

The department states it will meet with the Office of Legal Affairs (OLA) to revisit the legal issues of imposing a mandatory requirement that all key contractor staff complete a Statement of Economic Interests form. The department further states that previously, OLA had advised it that requiring all key contractor staff to complete a Form 700—Statement of Economic Interests may be too over-inclusive without legal basis to do so, but added that the department may be able to use a form that mirrored the Form 700.

Finding #3: The department can improve its collection and review of required disclosure forms.

State law requires agencies to adopt a conflict-of-interest code that designates employees in decision-making positions and requires them to file periodic statements. Accordingly, the department has adopted regulations that list the designated positions and spell out the disclosure requirements. Although most of the employees who are assigned to designated positions with a role in developing the CCF contracts completed the required statements, some did not. All 20 department staff who had a role in developing the two facilities contracts we reviewed filed statements covering all or part of 2004, but two retired annuitants associated with one of these contracts did not. Also, the department does not ensure the completeness of the statements employees do file. Four of the 20 employees whose statements we reviewed filled out their statements incorrectly. Because the department does not review all the filed statements for accuracy or completeness, it cannot ensure that its employees in designated positions have met their respective disclosure requirements.

The department's practice of continuing former employees as active retired annuitants when they are not actually working could create confusion about whether its retired annuitants are subject to revolving-door prohibitions or the conflict-of-interest provisions that apply to current employees. According to the department, one of the primary reasons it hires staff who retire at the deputy director level and above as retired annuitants is to provide expert testimony in pending litigation. Typically, the department appoints retired annuitants to one-year terms and will reappoint them in the subsequent year if their services are still needed. However, because of the state hiring freeze in effect during 2001, the former department director issued a memo directing each institution and the department's headquarters personnel office to delete the expiration dates of all currently employed retired annuitants as of December 31, 2001, to eliminate the need to seek formal freeze exemptions approved by Finance each new calendar year. According to the chief of Personnel Services, although as of August 2005, the department is still abiding by its policy of not entering expiration dates on its appointments of retired annuitants, it plans to ask each division to annually advise personnel services' staff which retired annuitants are no longer working. The department will then separate the identified retired annuitants from state service. However, until it implements this change, the department will continue to be at risk from potential conflicts of interest with its contractors and has no way of knowing if its retired annuitants are still needed.

We recommended that the department:

- Ensure that its retired annuitants in designated positions submit required statements.
- Ensure that statements submitted by staff are complete.
- When appointing retired annuitants, limit such appointments to a one-year period and require annual reappointment.
- Consider contracting with retired staff to provide expert testimony in litigation instead of its current practice of hiring them as retired annuitants.

Department's Action: Partial corrective action taken.

The department states that retired annuitants performing duties in designated positions will be required to annually file statements of economic interests. For other staff, the department states that it will perform a cursory review on the cover page of each statement of economic interests to ensure all items are complete. The department further states that it is posting expiration dates on all current retired annuitant appointments, and will enter a 12-month expiration date on all new appointments. Finally, the department is studying the feasibility of contracting with former employees to provide expert testimony in litigation rather than hiring them as retired annuitants.

Finding #4: The cost comparisons the department used to justify the no-bid contracts were incomplete.

Although the information on which the department based its decision to open two CCFs using no-bid contracts appears reasonable, its justification for these contracts included incomplete cost comparisons. The department stated in its justification that the two contracts represented a potential cost savings to the State because the per diem rates for the facilities are less than the daily jail rate of $59, the maximum the department can reimburse counties for detaining certain state parolees who have violated parole and therefore are being sent back to prison. However, the two costs are not comparable. Because the CCF contract amounts, unlike the daily jail rate, do not include all the costs of housing an inmate, the department's claim of cost savings is misleading. Compared to other CCF contracts in place in 2004, however, the average annual per-bed cost of the two no-bid contracts appears to be within a reasonable range.

We recommended that the department include all its costs when it decides to include cost comparisons in justification requests or state that the cost comparison is incomplete.

Department's Action: Corrective action taken.

The department states that future no-bid contract justifications containing cost comparisons or benchmarks used for housing inmates will be comparable.

Finding #5: With high error rates, the department's longer-term projections do not accurately predict its need for inmate housing.

In developing its budgets, the department primarily relies on information from the first two years of a projection, which reflects the period for which the department is preparing a budget. The average error rate of the projection process in the first two years is less than 5 percent and therefore appears reasonable for this purpose. However, because of the time needed to build a new prison, the department also uses projections to assess the sufficiency of its facilities to house future inmate populations. For this assessment the department uses all six years of the projection period. The

department's average error rate increases rapidly beginning in the third year, reaching almost 30 percent by the end of the sixth year. Therefore, the department's reliance on its projections in assessing the sufficiency of its facilities and planning future prison construction appears misplaced.

We recommended that, if the department intends to continue using the projections for long-term decision making, such as facility planning, it ensure that it employs statistically valid forecasting methods and consider seeking the advice of experts in selecting and establishing the forecasting methods that will suit its needs.

Department's Action: Pending.

The department states that it is working with the Office of Research to establish an interagency agreement with statistical experts at either the CSU or UC systems to review the existing simulation model and projections process.

Finding #6: The department does not properly update its projection data.

The department's projection model uses data from prior experiences to establish the likelihood of certain events occurring at steps along the projection process. For example, at a given point in the simulation model, an inmate hypothetically may have a 40 percent chance of being released on parole, a 50 percent chance of remaining in prison for at least another month, and a 10 percent chance of dying in prison. However, the department does not always properly update the frequencies—or relative percentages of the likelihood of different options occurring—using sufficient historical data. Rather than using a statistical process to develop the frequencies, the department takes the same frequencies used in its previous projection and then updates the numbers based on analysts' experience and review of the actual data since the last projection. This method increases the possibility of bias entering into the projection. According to our statistical expert, the department cannot support its forecasts using its present methodology.

We recommended that, to increase the accuracy and reliability of its inmate projection, the department update its variable projections with actual information, whenever feasible to do so.

Department's Action: Pending.

The department states that it will develop a database that will store data and be used to update its variable projections in its simulation model.

Finding #7: Contrary to its policy, the projections unit used speculative estimates in its projections.

At the direction of the department and contrary to its own policy, the projections unit used estimates in its projections that are not based on past experience or that include information from programs whose effects could not be reasonably estimated in

several instances. Specifically, in the 2004 spring and fall projections, the department's former chief deputy director of support services directed the projections unit to include the estimated effects of various parole reforms. According to the manager of the projections unit, these estimates were based on changing criteria, and the parole reforms in question had numerous issues that needed to be resolved before any reasonable expectation of population reductions could be estimated. From our review of department policy memos, we noted that criteria such as which inmates were eligible for these programs and the maximum amount of time inmates could be enrolled changed during the time period in which these projections were being made. Nonetheless, department management required the projections unit to include the estimates in its population projections, thus compromising the unit's independence. Without being able to function independently of internal or external pressure to use certain data or arrive at certain conclusions, the credibility of the projections unit's forecasts is diminished.

We recommended that the department disclose when a projection includes estimates for which inadequate historical trend data exists, such as the estimated effects of a new policy, and the specific effect such estimates have on the projection.

Department's Action: Corrective action taken.

The department states that in the future, when a projection includes estimates for which inadequate historical trend data is limited, it will publish two projections; one which will be based on historical trends and one which includes the estimates; and it will show the impact that the estimates have on the trend projection.

Finding #8: The department failed to obtain information from counties that would have alerted it to rising admissions.

In addition to the unrealized effects of parole reforms, the spring 2004 population projection was also understated because of an unexpected rise in inmate admissions from counties. Because county superior courts sentence felons to state prison, changes in county policies on prosecuting criminals can affect inmate admissions at the state level. Los Angeles County was the primary source of the rising inmate admission rate during this period. According to the department's director, the new chief of police of the city of Los Angeles changed the city's approach to policing, increasing the number of people being sent to prison. However, until recently, the department did not have an effective process in place to communicate with local governments to identify such changes and their effect on the number of inmates being sentenced to prison. The department is developing ways to establish better communications with the counties.

We recommended that the department continue its recent efforts to enhance its communications with local government agencies to better identify changes that may materially affect prison populations.

Department's Action: Pending.

The department states that it is communicating with the California District Attorney's Association in an effort to establish contacts with the district attorneys offices in major counties. It adds that the department will work with the association to establish a shared data base.

Finding #9: Lack of documentation casts doubt on the validity of the projection process.

To assess the statistical validity of its projection process, our statistical expert met with key department staff to review the documentation of the projection method. However, the department does not have documentation describing its complete projection model, so we were unable to assess its validity. According to our statistical expert, documenting a projection process, including the computer program used, is important so others can evaluate the process and understand its limitations and capabilities. She added that, for staff within the department, such documentation is very valuable for the continuity of the forecasting process when current staff retire or leave. She concluded that data analysis is a constantly evolving process and appropriate documentation is crucial in all stages to continuously improve the analysis as more and more data become available. According to the chief of the branch that includes the projections unit, it is currently revising the projection model and plans to produce documentation for the revised version.

We recommended that the department fully document its projection methodology and model.

Department's Action: Partial corrective action taken.

The department states that it is in the process of writing documentation for its simulation model, and is about 50 percent complete.

CALIFORNIA DEPARTMENT OF CORRECTIONS

Investigations of Improper Activities by State Employees, July 2004 Through December 2004

INVESTIGATION I2004-0834 (REPORT I2005-1), MARCH 2005

California Department of Corrections' response as of November 2005

Investigative Highlights . . .

The California Department of Corrections (Corrections) improperly granted registered nurses (nurses) an increase in pay associated with inmate supervision as follows:

- ☑ *Between July 1, 2001, and June 30, 2003, Corrections paid 25 nurses $238,184 more than they were entitled to receive.*
- ☑ *Corrections failed to maintain sufficient documentation for 17 of the 25 nurses and although Corrections provided records for the remaining eight nurses, we found that most of these nurses failed to incur the required number of supervisory hours to merit the pay increase.*

We investigated and substantiated an allegation that the California Department of Corrections (Corrections)[1] improperly granted registered nurses (nurses) an increase in pay associated with inmate supervision that they were not entitled to receive.

Finding: Corrections improperly granted nurses premium pay associated with inmate supervision.

We found that 25 nurses at four institutions received increased pay associated with inmate supervision even though they either did not supervise inmates for the minimum number of hours required or they lacked sufficient documentation to support their eligibility to receive the increased pay. Between July 1, 2001, and June 30, 2003, Corrections paid these nurses $238,184 more than they were entitled to receive.

Corrections reported that it could not provide documentation to support the pay increase it authorized for 17 of the 25 nurses because the institutions that employed these nurses either had no inmate supervisory hours to report, did not require nurses to track these hours, lacked sufficient documentation to support the hours claimed, or had destroyed all timekeeping records relating to inmate supervision. Although Corrections provided figures showing that the remaining eight nurses did supervise inmates, we found that in most instances these nurses failed to incur the required number of supervisory hours to merit the pay increase. For example, one nurse received a pay increase

[1] As of July 1, 2005, the California Department of Corrections has been renamed the Department of Corrections and Rehabilitation.

of approximately $7,983 over a 16-month period. However, the nurse met the inmate supervisory threshold of 173 hours per month on only two occasions, resulting in an overpayment of $7,030. Of the 25 nurses we reviewed that received this premium pay, we found that $238,184 of the $255,509 in inmate supervisory pay received was not justified.

Corrections' Action: Partial corrective action taken.

As of June 2005, Corrections reported that it had obtained sufficient documentation to justify the pay increase it gave to 10 of 25 nurses identified in our report. However, Corrections has yet to provide us with this documentation for our review. Previously, Corrections had reported it was unable to provide sufficient documentation to support the premium pay for these nurses. Corrections was unable to locate such documentation for three nurses and has initiated plans to collect these overpayments. In addition, Corrections has yet to complete its analysis of 12 of the 25 nurses identified in our report.

SEX OFFENDER PLACEMENT

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

REPORT NUMBER 2004-111, DECEMBER 2004

Department of Developmental Services, the Division of Juvenile Justice from the California Department of Corrections and Rehabilitation, and Department of Mental Health responses as of November 2005 and December 2005

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.*

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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 Sexually violent predators (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

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.

Act does not require that consumers provide criminal histories, such as prior sex offenses, when accessing services provided through regional centers. Furthermore, the law only allows the California 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: Corrective action taken.

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. Developmental Services reports that it has implemented a plan to use the Megan's Law Web site to identify consumers who are registered sex offenders. Developmental Services states that the information obtained from the Web site will be used solely to ensure that regional center consumers who are registered sex offenders receive appropriate services pursuant to the Lanterman Developmental Disabilities Services Act and will not be used in a manner prohibited by law.

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.

Division of Juvenile Justice's Action: Partial corrective action taken.

The Division of Juvenile Justice (division) within the California Department of Corrections and Rehabilitation (formerly the California Youth Authority) reports that it is working toward addressing the deficiencies in its out-of-home placement standards and modifying its regulations accordingly. Specifically, the division stated that a workgroup was formed and the group has revised the Parole Services Manual (PSM) to incorporate applicable, laws, regulations, rules, and standards of public safety and service delivery. The division formed another workgroup to evaluate parole agents' compliance with its supervisory procedures. This group recommended changes to the PSM that require parole agents to adhere to case conference schedules and document their results. The division anticipates that the changes to the PSM made by both groups will be approved by March 1, 2006. In addition, the division reports that it made changes to its foster home agreement in September 2005 to include a specified period of time for the performance of services, the total amount of the agreement, and a description of the services. The division also reported that it formalized its billing system so that it can track the cost of sex offender group placements and that it has implemented measures to ensure the input of accurate data, and to enhance its ability to manage and monitor the system. Further, the division stated it completed a study of the out-of-home placement rates paid by each of its parole offices and found that the pay rate and services vary from office to office. The division developed a chart with three standard levels of service with a range of applicable costs to allow parole supervisors to review prior to procuring services, which it expects to fully implement by February 2006. Finally, the division reported that it revised its conflict-of-interest code policy for fiscal year 2005–06 to include positions for the employees who are performing duties similar to the supervising parole agent.

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's Action: Corrective action taken.

Mental Health reports that new funding to reestablish positions eliminated through past budget reductions has not been made available, hence it cannot reinstate the auditor position. However, Mental Health states that other steps have been implemented to better monitor and control contract costs. For example, Mental Health has reconciled all fiscal year 2004–05 claims paid to the contractor who has provided pre-release planning and post–release services for SVPs in the Conditional Release Program. In addition, Mental Health has reviewed invoices supporting negotiated rate expenditure claims for fiscal year 2004–05, for this contractor's costs of providing core services to SVPs, to determine if those claims are allowable, reasonable, and properly classified. Further, Mental Health's Conditional Release Program staff also prepare an expenditure profile for each SVP, based on court approved terms and conditions, which outlines all authorized treatment and supervision regimens and compares this profile to actual negotiated rate expenditures to ensure these costs are reasonable, allowable under the contract, and consistent with court-ordered treatment.

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 has updated the Conditional Release Program policies and procedures manual to specify that staff must always be aware of the need to discontinue a contract when current conditions make the procured activity or service unnecessary. This manual also includes a new life support fund policy for SVPs that specifies that the Conditional Release Program hospital liaison for SVPs is responsible for ensuring that SVPs pursue all other sources of support before receiving life support funds and ensuring that the hospital trust office initiates the Social Security Insurance/Medi-Cal application process. This new policy also specifies that SVPs qualifying for and wishing to participate in the life support

program are required to sign a life support repayment agreement before entering the Conditional Release Program and that the amount of life support funds will be evaluated every six months. Finally, the new life support policy addresses housing costs separately from other support activities.

Legislative Action: Unknown.

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

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.***
- ☑ ***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.***

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REPORT NUMBER 2004-105, OCTOBER 2004

California Department of Corrections' response as of October 2005

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.

☑ *Has yet to implement several audit recommendations related to disciplinary matters from audits conducted in 2000 and 2001.*

Department's Action: Partial corrective action taken.

The department stated that it is continuing to implement a database system—the Case Management System (CMS)—in which it will identify and benchmark adverse action timelines for each step in the process. However, although in May 2005 it estimated that the CMS would be operational statewide by August 2005, because of increases in the user base for the CMS and the implementation of a central intake process, it now estimates that the CMS will not be operational until the beginning of 2007. The department also reported that the office of civil rights is now closing investigations in an average of 101 days—an improvement since our audit—and closer to 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's Action: Partial corrective action taken.

The department reported that its office of civil rights implemented procedures allowing for expedited investigations. For other cases, the department indicated that it has developed and is implementing a centralized case

initiation and intake system, which will enable it to take direct adverse action for straightforward cases. In October 2005, the department estimated that it would complete statewide implementation of this system by December 2005. Moreover, the department reported that it implemented the disciplinary matrix in March 2005 and it no longer requires regional or headquarters' reviews of disciplinary actions. Finally, the department stated that it has discontinued the practice of transcribing all interviews and transcribes only those that are necessary.

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's Action: Pending.

The department reported that it will benchmark and monitor cases going before the State Personnel Board once it implements two new database systems—the CMS and ProLaw—and develops a monitoring plan. However, the department indicated that the monitoring plan has been delayed until January 2006 due to the complexities of implementing the two new database systems.

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's Action: Partial corrective action taken.

The department stated that it is taking various actions to assist it in performing workload analyses and to achieve centralized management and monitoring of investigations. These actions include the development and implementation of a case initiation and intake system and the implementation of the CMS, among others. Based on workload estimates, the department indicated that it has internally approved a budget change proposal for additional investigators and it plans to submit a formal

request to the Department of Finance in the near future. 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. Moreover, the department reported that it implemented its statewide disciplinary matrix in March 2005 in addition to developing and issuing several other standardized forms and checklists during the months of April through July 2005. Further, the department indicated that not only is each institution required to use the disciplinary matrix, but it must also complete a form that justifies and provides reasons for each penalty decision, including mitigating and aggravating circumstances. Finally, the department stated that it has developed an audit 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's Action: Corrective action taken.

The department reports that its office of civil rights provides a written summary of each investigation, which clearly identifies all policy or statute violations. Additionally, the office of civil rights then monitors to ensure that remedial action is taken before closing the case files.

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's Action: Corrective action taken.

The department stated that it hired staff, trained them in February 2005, and implemented its vertical advocacy model in March 2005. Further, the department is continuing to conduct time studies 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's Action: None.

The department reported that the adverse action process will reside with the hiring authorities and will be tracked and coordinated by the vertical advocates in the new CMS and ProLaw databases. Further, with the assistance from the regulation and policy management entity within the department, the updating of disciplinary policies and procedures will be the responsibility of the employment law unit and the personnel operations section, while the updating of the investigatory policies and procedures will be the responsibility of the office of internal affairs.

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's 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 continuing its efforts to develop a mediation process to assist with early resolution of complaints. The department anticipates that the mediation process will be initiated by January 1, 2006.

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's Action: Corrective action taken.

The department reported that it incorporated a comprehensive new settlement policy in its operations manual and provided training on its new settlement policy to its hiring authorities, vertical advocates, and employee relations officers in 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's Action: Partial corrective action taken.

The department reported that it is continuing its implementation of both CMS and its ProLaw system. The department indicated it has fully converted its former database into the ProLaw database and the vertical advocates are learning to utilize the new database daily. However, as previously discussed in finding number 1, the implementation of the CMS has been delayed and the department now estimates that the CMS will not be operational until the beginning of 2007. Finally, the department reported that all staff charged with inputting information into the CMS and ProLaw databases receive introductory and ongoing training on data entry. However, the plan for monitoring the accuracy of the data entry has been delayed because of unforeseen complications with the implementation of the vertical advocacy model and the complexities of the database.

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's Action: Partial corrective action taken.

According to the department, the office of civil rights is currently developing a one- to two-week investigative course for new investigative staff. Additionally, the office of civil rights held three 40-hour training sessions during the first six months of 2005 for its current investigative staff and it plans to continue to provide comprehensive 40-hour sessions to investigative staff on a semi-annual basis. Moreover, in May 2005, the department indicated that it plans to 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. In its October 2005 response, the department stated that it is developing a computer-based ERO training textbook lesson that will be available to all staff.

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's Action: Partial corrective action taken.

The department reported that it has modified its current adverse personnel action database to track the success rates of the ERO positions until the CMS is fully implemented and modified to monitor the outcome of cases and the success rates of the various classifications. Additionally, the department stated that it and the Department of Personnel Administration have agreed to use the staff services manager I classification for disciplinary officers.

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's Action: Partial corrective action taken.

According to the department, its Office of Audits and Compliance (OAC) has redirected internally a position that is charged with developing and implementing a project management methodology. The department believes that the project management approach ensures that management and staff are fully aware of the status of every audit from inception through completion of all action items and, on an as-needed basis, can provide information about any specific action item or all action items associated with a specific audit. The department stated that it is through this process that the OAC intends to ensure a higher level of accountability in audit responses.

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

Audit Highlights . . .

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

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

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REPORT NUMBER 2003-125, JULY 2004

California Department of Corrections' response as of February 2005[1]

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.

[1] As of December 23, 2005, Corrections had not submitted a complete one-year response reporting on whether its pending actions were implemented or what, if any, benefits were achieved; therefore, the reported actions are from its February 2005 six-month response to our audit.

☑ *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.*

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

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

Corrections' Action: Pending.

➲ Corrections stated that it continues to enter data from medical invoices and has established validation reports to ensure data is entered appropriately and will perform audits to ensure all available procedure data is entered. It also reported that it would establish a peer review program and develop training plans to improve data integrity. Additionally, Corrections stated that it hired analysts that are responsible for analyzing

health care cost and utilization data and established a workgroup to identify reasons for rising costs and to implement cost containment measures. Further, Corrections indicated that it revised its utilization management database to connect this data to its cost and utilization database, as well as add health care guidelines for reviewing patient treatment and placement, and would transmit reports from these data to each institution for review and action by appropriate staff. Corrections indicated it expects to begin reporting on its cost containment in July 2005.

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

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

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

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

- Revisit hospital contract provisions that pay a discount on the hospital-billed charges and consider renegotiating these contract terms based on hospital costs rather than hospital charges. Corrections should also reassess hospital contract

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

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

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

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

Corrections' Action: Pending.

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

Corrections further reported that it amended its hospital contract language to require hospitals to submit DRG codes on the hospital invoices for all inpatient admissions and would modify its database to capture these codes. It indicated that it is using the DRG code to determine what Medicare would have paid and assessing its payments to hospitals. Additionally, it stated that it identified those hospitals that have stop-loss provisions in their contracts and will renegotiate to tie rates to a

reimbursement benchmark such as Medicare. Corrections indicated that if a hospital refuses all its rate proposals, it would not contract with that hospital. For hospitals that provide emergency services, yet will not negotiate reasonable rates, Corrections pays Medicare rates per state law.

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

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

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

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

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

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

Corrections' Action: Pending.

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

would analyze current outpatient hospital visits. Corrections also reported that it would refine its utilization management system to identify the impact of mental health crisis patients and their effect on cost and use of hospital beds. It stated that this analysis would be available by July 2005.

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

Audit Highlights . . .

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

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

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REPORT NUMBER 2003-117, APRIL 2004

California Departments of General Services' and Corrections' responses as of May 2005

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits (bureau) to examine the process that the California Department of Corrections[1] (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*

[1] On July 1, 2005, the Youth and Adult Correctional Agency and the departments and boards (including the Department of Corrections) within the agency became the California Department of Corrections and Rehabilitation. However, for purposes of our report we use the former department name.

☑ ***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.***

of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care, issued in January 2000.

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.

General Services' Action: Corrective action taken.

General Services has eliminated its long-standing policy exemption and in January 2005 issued Management Memo Number 05-04 (Management Memo), 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.

Corrections' Action: Corrective action taken.

Corrections stated that it has amended its contract boilerplate language to include a requirement for the submittal of charge description masters (CDM). Corrections also reported that it met with the Office of Statewide Health Planning and Development and they developed procedures that will allow Corrections to obtain CDM annually, beginning in July 2005, for each hospital that 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.

Corrections' Action: Partial corrective action taken.

Corrections reported that it developed and implemented a new medical rate exemption form and 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.

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 in April 2005, it awarded a contract for additional services from an expert in health care contract negotiations that will provide financial and technical expertise to improve contract rates and its negotiation process.

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.

Corrections' Action: Corrective action taken.

Corrections stated that its Health Contracts Services Unit (HCSU) in July 2004 initiated an ongoing process for contract renewal requests that requires staff to routinely analyze 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 review and approval, rather than the Office of Contract Services (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.

Corrections' Action: Partial corrective action taken.

Corrections reported that its HCSU staff, except newly hired staff, completed analytical skills, cost benefit analysis, and negotiation skills workshops. Further, as previously mentioned, HCSU has contracted for additional services from an expert in health care contract negotiations. Corrections reported that it anticipates that the contractor will provide training to HCSU staff beginning in September 2005. The training will include financial and technical expertise in contract rates, terms, and the negotiation process. Subsequent to HCSU staff training, Corrections will develop training plans for the field staff.

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.

Corrections' Action: Corrective action taken.

Corrections reported that HCSU staff are currently documenting and including in the files their efforts to obtain per diem rates for each of the hospital contracts. Also, HCSU staff negotiating contracts are requesting rates to be tied to a reimbursement benchmark, such as Medicare. In those cases where hospitals refuse, the HCSU staff are pursuing per diem for inpatient services, as well as maximum caps on all outpatient rates that are a percent of billed charges. Corrections reported that if a hospital refuses all of the Corrections' rate proposals, HCSU staff are not entering into the contracts.

Finding #7: HCSD and prisons have not submitted many medical service contracts to Corrections' 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.

Corrections' Action: Partial corrective action taken.

Corrections stated that it formed a task force in October 2004 to reassess its policy memo and the feasibility of requiring staff to submit corrective action plans. However, Corrections informed us that it had to redirect its focus to address recent legislation requiring it to merge with all departments under the Youth and Adult Correctional Agency to create the California Department of Corrections and Rehabilitation. Corrections stated that the newly created department will continue to issue semi-annual report cards, however, until reports are available on the new divisions and programs, it believes requiring corrective action plans would be premature. Finally, Corrections stated that it has and will continue to place emphasis on reducing late contracts and amendments as well as ensuring fiscal accountability.

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.

Corrections' Action: Corrective action taken.

Corrections reported that it has corrected the errors we identified and has modified its procedures. Corrections also stated that it has and continues to provide training to its staff and managers on the need to attach a report that identifies NTPs associated with each master contract and the residual amount when submitting contract requests for review and approval. Finally, Corrections stated that it conducts random audits to ensure compliance with its master contract 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.

Corrections' Action: Corrective action taken.

Corrections reported that contract services 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, contract services 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.

Corrections' Action: Corrective action taken.

Corrections stated that contract services 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. Contract services 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.

Corrections' Action: Partial corrective action taken.

Corrections reported that it has a process in place to regularly analyze and discuss the usage of registry contracts with the health care managers through the monthly budget review process with fiscal management. Effective July 2004 the health care regional administrators and managers receive a copy of the vacancies versus registry report each month. In December 2004, HCSD's Fiscal Management Unit developed a new reporting form for institutions to complete and submit with their monthly budget plans. The reporting form allows the health care managers to analyze registry usage and vacancies from a global perspective.

Corrections also reported that as part of the HCSD's strategic plan, it has established workgroups that will review data on patterns of registry utilization. Corrections reported that it plans to establish focus improvement teams to monitor processes and expects to have quantifiable data regarding outcomes beginning December 2005.

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.

Corrections' Action: Corrective action taken.

Corrections reported several changes to improve its UM program. Specifically, Corrections stated that its UM program staff have implemented efforts to ensure that field UM nurses adhere to the UM guidelines requiring staff to perform and retain documentation of their prospective and concurrent reviews. UM headquarters staff distributed and trained all UM nurses, health care managers, and chief medical officers on changes to the UM guidelines and its UM database in February and March 2005. Changes in the guidelines included new focus areas for review. These focus areas were established based on consultant reports indicating high cost and high volume services that may have been avoidable. Training also covered Corrections' level of care criteria (Interqual) that it will use to standardize review of all acute care community admissions.

Corrections stated that this will help identify and improve areas of unavoidable community inpatient stays. Changes to its UM database will enable executive staff to view management reports related to utilization of inpatient and outpatient resources.

Corrections stated that it restructured the UM program to include additional supervising registered nurses, which will enable increased oversight, training, and monitoring of all UM program policies and procedures. UM nursing supervisors continue to monitor compliance activities, using a standardized supervisory review tool when they perform UM site visits. This tool will enable UM supervisors to identify the status of the UM program at each institution and provide further direction for improvement. Corrections also stated that the restructuring includes the establishment of additional registered nurse staff to work out of preferred provider hospitals (those with medical guarding units). These nurses will perform daily concurrent reviews using Interqual level of criteria. This will enable Corrections to monitor and decrease the number of unavoidable community hospital stays. In addition, these registered nurses will plan and assist with the discharge of inmate patients back to an institution in a timely manner.

Finally, Corrections stated that it has begun collecting UM data to produce reports that will identify trends for management review and quality improvement.

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.

Corrections' Action: Partial corrective action taken.

Corrections stated that it has finalized specific guidelines and provided training to UM nurses, health care managers, and chief medical officers for retrospective review of unscheduled community emergency room transfers and unscheduled admissions. Corrections stated that it selected specific focus areas based on previous areas of high cost and high volume. A team of physicians at each institution will evaluate these focus areas during the Medical Authorization Review subcommittee meetings, which are to be held on a weekly basis. The subcommittee shall determine after review and discussion which of the following four categories the transfer best describes: necessary and unavoidable, necessary and potentially avoidable, unnecessary due to internal capability, or unnecessary due to criteria not met. The collection of this data and other data will provide an opportunity for planning training needs, developing new protocols, and enhancing the quality and value of care.

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.

Corrections' Action: Partial corrective action taken.

Corrections stated that its Health Care Cost and Utilization Program established a quality control process that includes reviewing a sample of invoices processed by the program's field analysts. The quality control process also contains a peer review focus improvement team to further enhance its ability to identify overpayments/underpayments. Corrections reported that it identified and recovered $9,513 in overpayments as of March 1, 2005. Additionally, Corrections reported that it is reviewing other potential net overpayments/underpayments totaling $96,906 for accuracy and validity and upon validation, Corrections plans to collect or reimburse vendors as appropriate.

Corrections reported that its Health Care Cost and Utilization Program staff and accounting staff have established a process to identify late payment penalties by institution and contractor. Corrections also reported that it has established a cross organizational team to resolve issues identified. Finally, Corrections reported that its Health Care Cost and Utilization Program staff identified the need to capture more detailed penalty payment information and are in the process of developing those enhancements. It anticipates that the enhancements will be included in the fiscal year 2005–06 contracts monitoring database.

CALIFORNIA DEPARTMENT OF CORRECTIONS

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

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

California 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 California Department of Corrections (Corrections)[1] 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.

[1] California Department of Corrections became the Division of Adult Operations and Adult Programs in July 2005.

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's Action: Partial corrective action taken.

As of January 2005 Corrections reported it completed its investigation. Corrections rescinded the appointment of one employee, who held a high-level managerial position, and has not yet determined what action it will take against other employees involved in this case.

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 June 2005

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: Pending.

We are not aware of any legislation that has been introduced to require 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. However, the Legislature has introduced two bills related to condemned inmates at San Quentin. Assembly Bill 1715 proposes to allow the department to house condemned inmates at any prison that contains level four security, or is a condemned facility, designated by the department director. Senate Bill 901 proposes to decommission San Quentin no later than December 31, 2010. This bill, if approved, would require the governor to decide by March 31, 2007, which prison would house death row prisoners and be the site of executions. At June 30, 2005, both bills were pending in legislative committees.

Department's 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's 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.

DEPARTMENT OF FINANCE

Investigations of Improper Activities by State Employees, July 2004 Through December 2004

Investigative Highlight . . .

The Department of Finance improperly divulged confidential information.

INVESTIGATION I2004-1104 (REPORT I2005-1), MARCH 2005

Department of Finance's response as of November 2005

We investigated and substantiated an allegation that the Department of Finance (Finance) improperly disclosed confidential information.

Finding: Finance improperly disclosed confidential information.

In violation of privacy rights, Finance published the name and Social Security number of a former state employee in a publication that is distributed throughout the State and is available on the World Wide Web. In addition, Finance identified two other state employees and a state vendor whose names and Social Security numbers had also been improperly disclosed.

Finance's Action: Corrective action taken.

Finance removed the confidential information from its Web site and from any Web search engines that may have archived information from its Web site prior to being updated. In addition, Finance provided hard copy updates, without the confidential information, to users of the publication and revised its procedures to prevent violations of this nature in the future. Finally, Finance took steps to notify those individuals of the improper disclosure.

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 May 2005

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.

➲ As Industrial Relations stated in its original response to our audit report, its staff attempts to obtain information from both the employer and the worker during its mediation process. However, although it requests that the employer provide either a federal or state employer identification number, Industrial Relations believes it does not have the authority to mandate that employers provide this 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's Action: Corrective action taken.

The board stated that it provided Industrial Relations a report on the backlog of cases in April 2005 covering inventory from July 2004 through April 2005. According to the board, this report showed significant improvements.

Industrial Relations' Action: Corrective action taken.

Industrial Relations stated that it meets quarterly with the board's staff to discuss any issues that may arise, including the board's progress on reducing its backlog of cases. In addition, when requested, the board provides Industrial Relations with status reports on cases referred to it. According to Industrial Relations, the board has shown remarkable improvement in the processing of cases and reducing the backlog.

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's Action: Partial corrective action taken.

The board stated that Industrial Relations increased the amount of funds allocated to the program for the fiscal year 2004–05 contract and loaned the board a part-time employee, effective January 2005. The board also indicated that it hired two temporary employees and is currently working with Industrial Relations to address staffing needs for fiscal year 2005–06. 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: Partial corrective action taken.

Industrial Relations stated that it is currently upgrading its computer system. One component of the upgrade is to determine how to electronically transfer information to the board. To discuss this further, Industrial Relations has scheduled a meeting with the board to determine how best to accomplish this transfer. Industrial Relations also indicated that it continues to discuss the possibility of adopting regulations that would allow the board to collect fees from debtors. However, Industrial Relations believes there is a concern that the board would not collect enough fees and Industrial Relations would still be required to fund the board's collection efforts.

WORKERS' COMPENSATION FRAUD

Detection and Prevention Efforts Are Poorly Planned and Lack Accountability

REPORT NUMBER 2002-018, APRIL 2004

Department of Insurance response as of April 2005, Fraud Assessment Commission response as of August 2005, and Department of Industrial Relations' response as of November 2005

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 . . .

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'

- ☑ *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.*

compensation system. To establish benchmarks to gauge the 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 and Fraud Commission's Action: Partial corrective action taken.

Insurance and the fraud commission reported that they had joined forces in proposing a joint research project and have partnered with the Commission on Health and Safety and Workers' Compensation (CHSWC) and other state and local agencies in assembling a working group to develop a request for proposal to conduct a study to measure workers' compensation fraud and abuse, particularly in the areas of medical providers, uninsured employers, and premium fraud. The proposed research will also address emerging trends in fraud schemes and attempt to quantify the return-on-investment of the antifraud program in California. In March 2005 the fraud commission voted to assess employers $1 million to fund the proposed research project. Insurance and the fraud commission estimate that the request for proposal will be advertised no later than June 1, 2005, and be awarded by early fall 2005.

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 and Fraud Commission's Action: Pending.

Insurance and the fraud commission believe that systematic identification and measurement of fraud is needed to identify the appropriate approach to control workers' compensation fraud. Insurance reports that the Performance Measurement Committee (committee)—comprised of representatives from Insurance, the county district attorneys, and the fraud commission—has met on several occasions and submitted a proposal to the fraud commission for review and approval that will revamp the performance measurement criteria connected with the district attorneys' grant application process. Insurance states the proposed revisions are consistent with the desire of the fraud commission to make the grant application review process standardized, consistent, and accountable. The fraud commission indicated that the new performance measurement criteria would be used to allocate funding to the participating district attorneys beginning with fiscal year 2006–07.

Fraud Commission's Action: Partial corrective action taken.

Until the proposed research study to measure the magnitude of workers' compensation fraud is complete, Insurance and the fraud commission reported that they have been working to develop a strategy to improve the efficiency, consistency, and accountability in the decision-making process. Together with the fraud division and district attorneys, they stated that they will work to provide the best information available on reported fraud and trends, continue with roundtable discussions pertaining to antifraud efforts, and make adjustments to program objectives focused on reducing fraud.

Fraud Commission's Action: Corrective action taken.

Insurance reports that it now submits an annual report to the fraud commission that contains the results of its objectives from the prior year and objectives for the ensuing year together with estimates of the expenditures it will need to accomplish those objectives.

Fraud Commission's Action: Partial corrective action taken.

The fraud commission stated that the fiscal year 2004–05 request for application used by district attorneys to participate in the workers' compensation antifraud grant program had been modified by Insurance to the extent permitted by current regulations. The fraud commission reported that the majority of district attorneys that applied for funding included their prior year accomplishments, current year goals and objectives, and their anticipated expenses to accomplish them.

Fraud Commission's Action: Pending.

The fraud commission did not address our recommendation in its response. We are therefore unsure whether a majority of the commission believes that altering the current funding formula would increase accountability over the use of antifraud program funds. Thus, we do not know if the fraud commission will encourage legislation to change the funding formula now required by law.

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 and Fraud Commission's Action: Partial corrective action taken.

Insurance reports that new regulations have been drafted and are currently under review by the Office of Administrative Law. Insurance indicated that these new regulations include the commissioning of a variety of studies, including effective performance measurement methodologies for the program as a whole and the district attorneys' use of grant funds. The studies will also recommend criteria, weighting and scoring, and baseline benchmarks against which to gauge performance.

According to Insurance, until such studies are complete, it and the fraud commission shall issue written justifications explaining funding recommendations and determinations. The fraud commission reported it continues to work with the committee to develop standard decision-making criteria and performance measurements.

Insurance and Fraud Commission's Action: Corrective action taken.

Insurance reports that for fiscal year 2004–05, district attorneys who apply for antifraud funds are required to provide a statement describing efforts and strategies in combating legal, medical, and premium fraud, and to include those strategic initiatives and objectives in joint plans between district attorney offices and fraud division regional offices. In addition, district attorneys are required to describe prior year's accomplishments as well as proposed plans to meet the objectives identified by the insurance commissioner and the fraud commission. For fiscal year 2005–06, Insurance reports that proposed modifications to antifraud program regulations require the dissemination of the insurance commissioner's strategic goals and objectives for the program at the commencement of each grant funding cycle. The proposed regulations also incorporate a comparison of grantee performance over time for the purpose of recommending and determining grant funding.

The fraud commission reports it discusses its goals and objectives with the deputy district attorneys attending Insurance's annual information meeting on the grant application process. In addition, the fraud commission stated it finalized its fiscal year 2005–06 goals and objectives at its March 2005 meeting, e-mailed them to all county district attorneys to be considered in preparation of grant applications, and provided them to the performance committee.

Insurance stated that the proposed regulatory changes now under review base grant funding on pre-determined performance criteria and no longer includes the award of a base portion.

According to Insurance, its legal staff has determined that the provisions of the Bagley-Keene Public Meeting Act apply to the fraud commission and the fraud commission has decided not to seek an exemption from the Legislature.

Insurance and Fraud Commission's Action: Partial corrective action taken.

Insurance reports it has amended its business plan to include performance measures for the fraud division as recommended by the fraud commission and the insurance commissioner. In addition, Insurance states that it, in conjunction with the fraud commission and representatives of the district attorneys, will establish performance measurements on which all future district attorneys' funding allocation decisions will be based beginning with the fiscal year 2006–07 grant cycle.

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's Action: Partial corrective action taken.

Insurance reports that it and the fraud commission have proposed limiting district attorneys' options for charging indirect costs to the following two—5 percent of total funds granted or 10 percent of a grantee's total salaries and benefits. However, the fiscal year 2005–06 grant application Insurance provided still allows grantees to ➲ choose a third option of charging indirect costs to grants using cost rates approved by the U.S. Office of Management and Budget—the same option that resulted in the condition we originally reported.

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's Action: Partial corrective action taken.

According to Insurance, it has modified its database to provide statistics and trends on workers' compensation fraud. In addition, together with the fraud commission, Insurance stated it has forged partnerships to facilitate the study of the extent and nature of workers' compensation fraud, as well as this type of fraud's economic value.

Insurance reports that it has taken steps to establish benchmarks that it can use to measure its and the participating district attorneys' performance in meeting program goals and objectives, and to determine whether the antifraud program is operating as intended and resources are appropriately allocated.

As stated in its response to finding #1, Insurance reported partnering with the fraud commission and representatives of state and local agencies to facilitate a research study that will measure the nature and extent of workers' compensation fraud. Insurance indicated that a contract will be awarded to conduct such a study in early fall 2007.

Insurance reports that it has modified its database to help identify and assist in increasing efficiencies in the intake process of fraud referrals from workers' compensation insurance carriers and continues to emphasize that supervisors use standard criteria when determining case assignments. Insurance has also requested further modifications to its database to improve its ability to track fraud referrals. Insurance stated the request is pending.

Insurance also reports that the joint research project identified in its response to finding #1 will include a study on the return-on-investment of the workers' compensation antifraud program in California.

Insurance's Action: Corrective action taken.

Insurance reports it has modified its business plan to include its noninvestigative responsibilities, including establishing appropriate goals and objectives, activities, and priorities.

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's Action: Partial corrective action taken.

Insurance reports that it has proposed changes to its regulations regarding independent audits of district attorneys' annual antifraud grants to require their respective financial officers to certify in a management letter included in each county district attorney's independent audit report that all financial information contained in the report was presented accurately and true to the financial officer's best knowledge.

Insurance's Action: Corrective action taken.

According to Insurance, it has developed regulations and procedures to ensure district attorneys comply with the independent audit requirements and promptly submit their audit reports.

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's Action: None.

In its initial response to our audit, Insurance stated it would reevaluate its referral process and evidence standards within the context of existing statutes. Insurance further stated it believed all insurers should submit all suspected fraud claims for trend analysis and the establishment of priorities. Other than the passage of Assembly Bill 1227 discussed below, Insurance has not since responded to our recommendations that it continue its efforts to remove the barriers that prevent insurers from providing the desired level of fraud referrals and seek any necessary legal and regulatory changes in the fraud reporting process.

Further, Insurance has not responded to our recommendations that it work with insurers to reduce the number of referrals that are not likely to result in successful investigation or prosecution, and to ensure that the referrals submitted contain the level of evidence necessary for the fraud division to assess the probability of a successful investigation or prosecution.

Insurance's Action: Partial corrective action taken.

Insurance reports it is currently engaged in the rulemaking process to implement the provisions of Assembly Bill 1227, passed in September 2004, to provide authority and an appropriate penalty structure to increase insurance company compliance with special investigative units.

Insurance's Action: Corrective action taken.

As part of the strategy for its special investigative audit unit, Insurance reports that it has analyzed staff duties and position classifications in its special investigative unit to better complete reviews of insurers in compliance with government auditing standards. In addition, its special investigative unit staff now uses a policy manual to conduct risk-based reviews of insurers, providing for more consistent, accurate, and timely reviews. Insurance also reports that all prior special investigative unit audits have been completed and reports issued. In addition, the new policy manual requires audit follow-up and all follow-up information is being documented and tracked in a newly developed database.

Legislative Action: Legislation enacted.

Assembly Bill 1277 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.

In November 2005, Industrial Relations reported it had jointly with Insurance created a referral form to report uninsured employers and forwards such referrals to Insurance quarterly, and was in the process of implementing a mechanism to allow reporting of suspected medical provider fraud. Industrial Relations also reported it was 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 reported that it had not secured funding to implement a required program where data obtained from the Uninsured Employers' Fund, Employment Development Department, and the Workers' Compensation Insurance Rating Bureau can be compared to discover employers 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 received in November 2004, or its one-year response to our audit report received in November 2005. Therefore, we are unable to provide the status for these recommendations.

CALIFORNIA GAMBLING CONTROL COMMISSION

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

REPORT NUMBER 2003-122, JUNE 2004

California Gambling Control Commission's response as of June 2005

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

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

Audit Highlights . . .

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

☑ ***Some tribes have questioned the Gambling Commission's decisions about such matters as:***

- ***The number of gaming devices that may be operated statewide.***
- ***The offsetting of quarterly license fees by the amount of nonrefundable, one-time prepayments.***
- ***The formula for calculating trust fund receipts.***
- ***The process for allocating gaming device licenses.***

continued on next page . . .

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

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

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

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

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

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

Questions have also been raised about when to require tribes to begin making quarterly license fee payments. The Gambling Commission has taken the position that tribes should begin making quarterly payments when they receive licenses for gaming devices rather than after they put the devices into operation, but the tribes themselves have disagreed on this issue. For example, the Ewiiaapaayp Band of Kumeyaay Indians has contended that its payment obligation to the trust fund should begin only with the commercial operation of the licensed gaming device. Because the tribe had not put any of its licensed gaming devices into commercial operation, it believed it did not owe any quarterly fees to the trust fund. However, the Gambling Commission charged this tribe and continues to charge other tribes quarterly fees from the time the licenses are issued until the licenses are surrendered. Furthermore, according to summaries of meetings the Gambling Commission held with various tribes, at least seven tribes agree with its decision. The Gambling Commission indicated that it based its decision on the operative language of the compact. Specifically, it concluded that the quarterly payments are in exchange for acquiring and maintaining "a license to operate a gaming device" rather than for the actual operation of the gaming device. Additionally, the Gambling Commission stated that it found no expression in the language of the compact requiring quarterly payments for a license to begin only when the tribe begins to receive revenues for the gaming device. The Gambling Commission

has not established when tribes begin operating their gaming devices, so we are not able to determine the extent to which trust fund deposits would have been reduced if the Gambling Commission had charged quarterly fees only when gaming devices were put in operation.

Additionally, some tribes disagree with the Gambling Commission's process for allocating gaming device licenses. Under the Gambling Commission's interpretation of the process described in the compact for allocating licenses to tribes that have applied for them, two tribes that applied did not receive any gaming device licenses during the Gambling Commission's third license draw. The compact indicates that gaming device licenses are to be awarded through a mechanism that places tribes into five categories of priority based on the number of gaming devices the tribes already have and whether they have previously drawn licenses. Noting the compact provisions state that tribes in a particular priority include those that received licenses under a previous priority, the Gambling Commission moves the tribe to a lower priority for the next draw that it participates in, regardless of how many licenses it receives in the first draw as long as it received at least one license. At least two tribes, the Colusa Indian Community of the Colusa Rancheria (Colusa) and the Paskenta Band of Nomelaki Indians (Paskenta), disagree with the Gambling Commission's interpretation of the license draw process. These tribes believe the compact bases the priority for awarding gaming device licenses solely on the number of gaming devices they have. Had the Gambling Commission interpreted the compact as the two tribes do, Colusa would have received 108 licenses and Paskenta would have received 75 during the Gambling Commission's third license draw. However, under the Gambling Commission's interpretation, neither tribe received any licenses.

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

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

Governor's Office's Action: None.

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

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

According to the compact, the license for any gaming device should be canceled if the device is not in commercial operation within 12 months of the license being issued, but the compact does not define what is meant by "commercial operation." At least three tribes have argued that the Gambling Commission staff's definition of commercial operation does not agree with the compact language and that the staff have added requirements not stated in the compact. Gambling Commission staff believe the intent of the 12-month rule, including the term "in commercial operation," is to keep tribes from hoarding licenses for gaming devices, which would prevent other tribes from having the opportunity to obtain the licenses. They have therefore been applying a definition of commercial operation that requires all gaming devices, licensed and unlicensed, to be available to the public on a continuous basis and to be simultaneously placed in service on the casino floor. The underlying rationale for the continuous and simultaneous requirements is the staff's position that the license grants a tribe the right to operate a gaming device, but the license is not attached to any particular gaming device. However, the commissioners have not yet formally endorsed this definition. Nevertheless, the Shingle Springs Band of Miwok Indians had 650 licenses canceled, and the Cahuilla Band of Mission Indians had 100 licenses canceled when they did not challenge the Gambling Commission's notice of intent to cancel them. Two other tribes—the Campo Band of Diegueno Mission Indians and the Pauma Band of Luiseno Mission Indians—challenged the Gambling Commission staff's position that all devices, licensed and unlicensed, must be in commercial operation. They argue that the compact does not require unlicensed devices to be in commercial operation.

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

Gambling Commission's Action: Corrective action taken.

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

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

- The gaming device must be capable of awarding a prize.

The Gambling Commission further stated that once a gaming device is placed into commercial operation, the compact provision would be satisfied. Therefore, the Gambling Commission would consider the Indian tribe in compliance with the compact provision even if the gaming device were placed into operation for only one quarter, one month, or one day.

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

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

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

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

The Gambling Commission should finalize its position regarding gaming devices with more than one terminal to determine whether these devices are counted as one device or as more than one device. Once its position is final, the Gambling Commission should enforce

compliance with the provisions of the compact for those tribes operating more than 2,000 gaming devices and should determine whether any tribe could lose its eligibility for trust fund distributions by exceeding 350 gaming devices.

Gambling Commission's Action: Corrective action taken.

At its February 16, 2005, meeting the Gambling Commission voted to follow the California Department of Justice, Division of Gambling Control's Tribal Casino Advisory regarding the term "Gaming Device" as that term is used in the Tribal-State Gaming Compacts. Pursuant to this advisory each terminal or player station attached to a gaming system is accounted for as a separate gaming device. The Gambling Commission now adheres to this application of the term "Gaming Device" in its treatment of multiple terminal/station systems.

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

The Gambling Commission may have inappropriately underpaid Lower Lake Rancheria (Lowerlake) by $416,000 and overpaid by $5,100 each of the other tribes eligible in a quarterly distribution from the trust fund. The former chief counsel of the Gambling Commission indicated that it did not distribute funds to Lower Lake for the quarter ending September 30, 2000, because the federal register did not list it as a federally recognized tribe. Although the federal Bureau of Indian Affairs (BIA) acknowledged that it erred in excluding Lower Lake from the register, the former chief counsel explained that the Gambling Commission bases eligibility for such payments from the date stated in written evidence of that recognition, and the BIA did not officially reaffirm the government-to-government relationship with the tribe until December 29, 2000. Consequently, the Gambling Commission concluded that Lower Lake was eligible to receive a share of trust fund receipts only beginning with the quarter ending December 31, 2000. However, the BIA also stated in writing that the government-to-government relationship between the federal government and Lower Lake was never severed. Therefore, although Lower Lake did not appear on the register, the federal government acknowledged that the tribe had consistently retained its status as a federally recognized tribe. Furthermore, only an act of Congress can terminate a tribe's federal recognition, and to date no act has terminated Lower Lake's federal recognition. Finally, the Gambling Commission was made aware of the BIA error when it received a letter of protest from the tribe's attorney 11 months before it made the adjustment distribution in question. However, because it chose to focus on the date that Lower Lake's status as a federally recognized tribe was reaffirmed, the Gambling Commission concluded that Lower Lake was ineligible for distributions prior to that date and, consequently, it did not adjust its first quarterly allocation to include Lower Lake.

The Gambling Commission should confer with the federal Bureau of Indian Affairs and determine whether there is any federal requirement that it pay Lower Lake for the quarter ending September 30, 2000, and, if not, whether anything prohibits it

from paying Lower Lake. Barring any prohibition, we believe it is appropriate for the Gambling Commission to provide Lower Lake a share of the funds allocated that quarter and to deduct that amount from distributions to tribes that received distributions in that quarter. If any one of these tribes is no longer eligible to receive trust fund distributions, the Gambling Commission should either bill the tribe for the overpayment or seek other remedies to recover the overpayment.

Gambling Commission's Action: Pending.

The Gambling Commission directed the specific questions raised by the Bureau of State Audits to the BIA. According to the Gambling Commission, it has made every effort, both by letter and telephone, to obtain clarification from BIA and has received no response. The Gambling Commission further stated that this matter has been made even more complex by questions that have been raised about the propriety of the re-recognition action taken by a former director of the BIA. The questions raised about re-recognition involve other tribes in addition to Lower Lake. The Gambling Commission reported that it would continue its efforts to seek clarification from the BIA and to explore options that might be available to it in the resolution of this issue.

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

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

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

To ensure that all tribes applying for gaming device licenses are provided the appropriate opportunity to obtain the number of licenses they are applying for, the Gambling Commission should consistently follow the license allocation procedures it

has adopted. Further, it should change its current policy of limiting to 500 the number of licenses a tribe in the fifth priority may draw, allowing tribes instead to draw up to their maximum total authorization to operate up to 2,000 gaming devices.

Gambling Commission's Action: Corrective action taken.

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

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

Although the Gambling Commission has a conflict-of-interest policy, it has not adequately communicated the policy to designated staff. For example, key staff we interviewed stated that they were not aware of any formal, written conflict-of-interest policy. In fact, after repeated requests for a copy of its conflict-of-interest policy, the Gambling Commission finally provided us with a copy, two months after our initial request. Additionally, a former commissioner had to file an amended statement of economic interest because he was not fully aware of the requirements for completing the form. By not ensuring that the commissioners and its staff are aware of its conflict-of-interest policy, the Gambling Commission runs the risk that affected employees will not understand their obligations under the law.

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

Gambling Commission's Action: Pending.

The Gambling Commission is in the final stages of adopting a conflict-of-interest policy in accordance with the provisions of California Government Code, Section 19990. According to the Gambling Commission, the process of adopting a policy includes employee and labor union(s) review and input. Employees have reviewed the policy and submitted their input to their personnel unit. Labor unions also completed their review and Gambling Commission staff has met with union representatives concerning the proposed policy. As of June 2005, the Gambling Commission was reaching the conclusion of the process and the policy was under review by the Department of Personnel Administration. It is anticipated that the Gambling Commission will give the final draft to the unions by the end of July 2005, with a proposed implementation date of 30 days from the date of the final draft. The Gambling Commission will then provide a copy of the approved policy to its staff.

DEPARTMENT OF GENERAL SERVICES

Opportunities Exist Within the Office of Fleet Administration to Reduce Costs

REPORT NUMBER 2004-113, JULY 2005

Audit Highlights . . .

Our review of the Office of Fleet Administration (Fleet) within the Department of General Services found that:

- ☑ ***Fleet's analyses, indicating that its vehicle rental rates are competitive with those of commercial rental companies, do not fully demonstrate its cost-effectiveness because Fleet lacks assurance that the commercial rates it used are similar to what state agencies typically pay.***
- ☑ ***The terms of the current contracts that Fleet has with commercial rental companies and the noncompetitive method it uses to select companies may not be in the State's best interest.***
- ☑ ***Fleet currently lacks a minimum-use requirement for vehicles that state agencies rent on a long-term basis as well as standards related to the idleness of its short-term rental vehicles, both of which could identify opportunities to reduce the number of vehicles in its motor pool.***

continued on next page . . .

Department of General Services' response as of December 2005

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) conduct an audit of state-owned vehicles with a focus on the cost-effectiveness of the garages that the Office of Fleet Administration (Fleet) within the Department of General Services (General Services) operates. Specifically, the audit committee asked the bureau to determine whether General Services has a process in place to measure the cost-effectiveness of its garages and fleet of rental vehicles and, to the extent possible, determine whether it is cost-effective for the State to own, maintain, and rent its vehicles and own and operate its garages. Additionally, the audit committee asked the bureau to evaluate the potential for cost savings resulting from no longer having Fleet own and maintain vehicles and the potential savings from the consolidation and/or disposition of state-operated garages. Finally, the audit committee asked the bureau to review and evaluate General Services' policies and procedures for ensuring the accountability of state vehicle purchases, including the controls in place to monitor vehicle purchases and determine whether other state agencies purchase motor vehicles in accordance with applicable requirements and in the best interest of the State.

We found the following:

Finding #1: Fleet's analyses of its cost-effectiveness indicate that it is competitive, but its analyses are limited.

To measure its cost-effectiveness, Fleet periodically compares its rates to those of commercial rental companies. The commercial rental rates used in the analyses were generally either rates, obtained through the Internet or by telephone or e-mail, that the companies offered to the general public at individual locations in the State or the maximum rates that the companies have agreed to in their contracts with Fleet. When

☑ *Fleet is responsible for overseeing the vehicle purchases made by state agencies, but its policy defining minimum usage, which Fleet is supposed to consider when assessing a state agency's need to purchase vehicles, may be set too low.*

☑ *Fleet's actions contributed to a $1.4 million deficit at June 30, 2004, in the fund that Fleet uses to operate and maintain parking lots for state employees.*

Fleet compared the two amounts for each vehicle type, the comparisons indicated that its rates are competitive with those that commercial rental companies offer and that state agencies save money by using Fleet's services when they are available.

However, Fleet lacks assurance that the rates state agencies typically pay are similar to the companies' public rates because state agencies are generally required to rent vehicles using the contracts that Fleet has with commercial rental companies; therefore, state agencies would pay the rates offered under the terms of Fleet's contracts. Further, the maximum contract rates used in earlier analyses do not provide for a meaningful comparison because, as Fleet acknowledges, commercial rental companies do not typically charge such high rates.

A more comprehensive way to measure Fleet's cost-effectiveness would be to compare Fleet's costs to operate the motor pool to how much the State would spend using commercial rental companies, considering the rates that the companies typically charge the State. Fleet's contracts with commercial rental companies require them to submit quarterly data to Fleet that could help it determine how much the companies charge state agencies for their services. However, the reports that Fleet receives do not currently identify the average monthly, weekly, or daily rental rates the companies charge by vehicle type. If Fleet required its contractors to report information that would help it determine how much state agencies typically pay, those amounts would be a better basis of comparison.

We recommended that in addition to rate comparisons, Fleet should compare the actual cost of operating its motor pool to the amount that the State would pay commercial rental companies. In doing so, Fleet should use the actual motor pool rental activity, such as the number of days or months that it rents vehicles by each vehicle type, and apply it to rates that commercial rental companies actually charge state agencies. To understand how much state agencies typically pay when using the services of contracted commercial rental companies, Fleet should require, through its contracts, that the companies report information on vehicle rentals that would enable Fleet to determine the average daily or monthly rate actually charged for each vehicle type.

General Services' Action: Partial corrective action taken.

General Services reports that upon the development of the necessary financial and vehicle usage data, Fleet will use that information to compare the actual cost of operating its motor pool to the amounts that commercial car rental companies charge state agencies. General Services reported that Fleet entered into a contract for consulting assistance to provide additional information technology programming support, with the primary goal of extracting more data from the existing system and that it has created various reports that provide additional timely and relevant cost information to help to manage Fleet operations. Additionally, according to General Services, it plans to enter into new commercial car rental contracts to begin on January 1, 2006, which will include provisions for the receipt of information on actual charges incurred for the daily and weekly leasing of vehicles. General Services states that it will use this information in future cost-effectiveness studies.

Finding #2: Existing contracts raise questions as to whether they are in the best interest of the State.

We question whether the contract terms and the noncompetitive method that Fleet uses to select commercial rental companies result in contract rates that are as beneficial to the State as they could be. According to Fleet's chief, the intent of the contracts is to ensure that state employees renting vehicles from commercial rental companies are protected against companies charging them whatever they want. However, the amounts that commercial rental companies actually charge can be significantly lower than the maximum rates specified in the contracts.

An individual representing two of the seven companies with which Fleet contracts stated that Fleet requires the maximum rates in the contracts to encompass all fees such as airport or county fees and that this must be carefully considered as these fees are out of his companies' control. Further, he said that the contract rates have a large cushion built in to protect against vehicle price increases that could occur over the potentially long contract term. Although its contracts are for one year, Fleet can twice exercise the option to extend a contract for one year.

Fleet also requires commercial rental companies to insure the vehicles while state employees drive them, which raises rates. Fleet does not know if this requirement is in the State's best interest because it has not conducted an analysis and could not tell us the cost that insurance adds to commercial rental rates in Fleet's contracts. For example, it has not compared the cost of insuring cars through the commercial rental companies to the costs of other methods, such as self-insuring. If the State is able to self-insure commercially rented vehicles or purchase insurance for less than what it pays through its existing contracts, the rates that commercial rental companies offer the State could decrease significantly.

While still renting under Fleet's contract with one rental company, at least one state agency has an agreement with the company to guarantee lower rates than those specified under the company's contract with Fleet. Such agreements indicate that a more competitive process of selecting contractors may result in lower rates to the State. Because Fleet does not offer the State's business exclusively to one or two companies, contractors may not have an incentive to offer a lower rate during the contract proposal process.

Fleet acknowledges that a more competitive method of selection that would not limit availability of services could result in lower rates. In May 2005, the chief told us that Fleet was exploring a new option for state travelers that would employ competitively bid rental contracts with awards made to a primary and secondary commercial rental company. She also said that Fleet planned to contract for the base cost of vehicles (the cost before additional fees such as airport fees) to recognize the fees that vary by location.

We recommended that before seeking additional commercial rental contracts, Fleet should do the following:

- Determine if it can obtain lower guaranteed contract rates for the State by evaluating the extent to which using contracts that contain extension options contributes to maximum contract rates that are significantly higher than rates that the commercial rental companies could charge.

- Determine if paying for insurance when renting vehicles from commercial rental companies rather than other methods, such as self-insurance, is in the best interest of the State.

- Continue its efforts to obtain lower rates from commercial rental companies by pursuing options for a more competitive contracting process.

General Services' Action: Partial corrective action taken.

According to General Services, Fleet is pursuing a competitively bid process that allows for awards to be made to one primary and one secondary car rental company, instead of the current system whereby seven different companies provide services to the State's employees. General Services reports that in October 2005, Fleet issued a Request for Proposal (RFP) to begin the process and expected to award contracts by mid-December with a start date of January 1, 2006. Additionally, according to General Services, unlike the contracts in place during the audit, the RFP for the new commercial car rental contracts does not allow the contracted rental car company to charge customers any amount up to a maximum rate identified in their contract. Instead, the bidders must propose a set guaranteed base rate for each of several insurance scenarios. Moreover, General Services told us that the Office of Risk and Insurance Management will help Fleet determine the bidder proposal that represents the best value to the State.

Finding #3: Fleet has not established certain requirements and standards related to vehicle use.

Although Fleet has established a minimum-use policy to ensure that state agencies efficiently operate the vehicles they own, it has no such requirement for vehicles that state agencies rent from the motor pool on a long-term basis. Without such a utilization policy, Fleet cannot ensure that its motor pool is used optimally.

By not requiring state agencies to meet a minimum-use requirement for long-term rentals, Fleet may in effect be allowing state agencies that cannot justify vehicle purchases based on usage to obtain vehicles by renting them from Fleet on a long-term basis. Since the function of a minimum-use requirement is to minimize costs, the absence of such a policy can result in higher costs to the State.

In addition to not establishing a minimum-use requirement for its long-term rentals, Fleet has not developed performance measures to determine if the vehicles that it rents on a short-term basis are idle an excessive number of days. Best practices indicate that fleet managers should set policies and develop performance measures to ensure that their fleets consist of the appropriate number of vehicles in the appropriate composition.

In May 2005, Fleet's chief told us that Fleet is putting in place a method for collecting and analyzing data for a minimum-use requirement that will be identical to the requirement for agency-owned vehicles. Fleet expected to make its policy effective in July 2005. The chief also told us that it was developing performance standards to better assess utilization and idle time. Once Fleet establishes these standards, it can monitor its performance and identify opportunities to reduce the number of vehicles it owns.

To ensure that the vehicles in Fleet's motor pool are being used productively, we recommended that Fleet should continue its efforts to establish a minimum-use requirement for the vehicles it rents to state agencies on a long-term basis and should ensure that state agencies follow the requirement or justify vehicle retention when they do not meet the requirement. Additionally, for its short-term pool, Fleet should continue to develop performance standards to better assess vehicle utilization and idle time.

General Services' Action: Partial corrective action taken.

General Services reports that it now applies a minimum vehicle use of 4,000 miles or of 70 percent of workdays within a six-month period as minimum-use requirements to vehicles it leases to state agencies on a long-term basis. However, in the near future it expects to revise the criteria to a minimum of 6,000 miles or 80 percent of workdays within a six-month period. Related to the productivity of its short-term vehicle pool, according to General Services, Fleet is continuing to develop performance standards to better assess utilization and idle time. As part of these efforts, it is contacting other governmental fleet entities to obtain relevant information. As of December 2005, General Services planned that the performance standards will be developed and operational by January 31, 2006.

Finding #4: Fleet does not analyze its costs by vehicle type.

Fleet does not analyze its costs by vehicle type and therefore cannot readily identify vehicles that are not cost-effective to own. It is important for Fleet to understand its costs to manage the motor pool and ensure that the motor pool's composition of vehicles is not costing the State more than is necessary. Potentially, Fleet could reduce its costs by limiting the types of vehicles that it has available.

If Fleet finds that the cost of owning a specific vehicle type significantly exceeds the rate it charges, it could make decisions to align the rate with its costs. Further, if Fleet determines that owning a specific vehicle type costs more than state agencies will spend by using alternatives to the motor pool, Fleet could make decisions to eliminate or limit those types of vehicles. We recognize that the decisions Fleet makes regarding the composition of its motor pool may consider other factors, such as the needs of state agencies for particular types of vehicles. However, if Fleet analyzed its costs by vehicle type, it could better ensure that it is meeting the needs of the state agencies it serves in the most cost-effective manner.

According to its chief, as of May 2005, Fleet was working to develop a feasibility study report for a fleet management system. She expected this system to provide reports that will include information to help Fleet calculate costs by vehicle type, such as fuel use by vehicle type and repair and maintenance costs by vehicle type. The chief also told us that Fleet was in the process of incorporating additional performance measures related to costs by vehicle type to identify other opportunities for cost savings.

We recommended that to ensure that the composition of its motor pool is cost-effective, Fleet should continue its efforts to obtain costs by vehicle type. It should consider this information in its rate-setting process as well as in its comparisons to the costs of alternatives to the motor pool.

General Services' Action: Partial corrective action taken.

According to General Services, Fleet is continuing to take significant actions to obtain the necessary information to determine the actual cost of its motor pool operations and the actual usage of its motor pool. Specifically, Fleet developed a new system that provides for employee time charges to be captured in a manner that provides more useful information on tasks performed in both inspection and garage operations. In addition, General Services indicates that Fleet is continuing to actively work with General Services' information technology staff to assist it in obtaining additional management information, including repair and maintenance records by category, vehicle type, and garage location, from Fleet's existing automated internal fleet management information system. General Services reports that the new financial and usage management information will be available by June 30, 2006, and that it will consider this information in the development of vehicle rates and in comparisons to the costs of alternatives to the motor pool.

Finding #5: Fleet does not periodically assess the cost-effectiveness of individual garages.

Although Fleet operates several garages throughout the State, it does not periodically analyze the revenues and expenses incurred at each garage. Consequently, Fleet does not know if any of its garages are operating at a loss. In fact, Fleet's accounting system does not track most revenues and expenses for its vehicles by their respective garages. Although Fleet tracks certain revenues and expenses, such as tire sales and certain personnel costs by garage location, it does not track the revenue from vehicle rental fees and certain expenses, such as most of Fleet's depreciation, fuel, and insurance expenses, for the individual garages. Instead, Fleet tracks them in the aggregate for all garages.

With its current accounting system, Fleet can determine if its garages as a whole are operating at a break-even point, but it lacks the necessary information to determine the cost of operating each garage. Consequently, Fleet could unknowingly be operating a garage that costs more than the garage generates in revenue. Additionally, Fleet cannot use its accounting system to determine if the State would pay less if it closed one or more garages and obtained the garages' services from alternative sources. As of April 2005, Fleet was reviewing ways to modify the accounting system so that it tracks the revenues earned at each garage and provides Fleet the financial information necessary to analyze each garage.

To ensure that it does not operate garages in areas where alternative methods of transportation, such as vehicles from commercial rental companies, would be less expensive to the State, we recommended that Fleet examine individual garages to determine whether it is cost-effective to continue operating them. Fleet should consider all relevant factors, such as the frequency with which it rents vehicles on a short-term basis, the ability for other garages to take long-term rentals, and the cost-effectiveness of its repair and maintenance services.

General Services' Action: Partial corrective action taken.

General Services states that this is a long-term effort that involves the creation of new budget, fiscal, and information technology management systems and that until further management information is developed to fully judge the operations of the individual garages, Fleet continues to use existing data on utilization and costs to judge the efficiency and effectiveness of its garages. Nonetheless, General Services reports that Fleet has taken significant actions to improve its ability to adequately monitor the efficiency and effectiveness of garage operations. Specifically, Fleet reorganized its garage operations and hired a new manager over those operations who has a strong background in managing fleet programs, including the gathering of data that will allow the cost-effectiveness of the individual garages to be more accurately evaluated.

Finding #6: Fleet does not measure the cost-effectiveness of its repair and maintenance services.

Fleet provides maintenance and repair services to its motor pool and agency-owned vehicles at its garages. However, Fleet does not adequately track its labor costs and therefore does not know how much it actually costs to perform each of the services it provides. As a result, Fleet cannot fully assess its competitiveness. Fleet needs to know the cost of the specific services it provides to make decisions about which services to outsource or perform in-house and which garages to close, consolidate, or expand.

Although labor represents a significant cost for Fleet's garages, Fleet does not determine how much time it spends performing various maintenance and repair services, such as changing oil or servicing transmissions. Fleet employs technicians who perform these services, but it does not require them to allocate their time to specific tasks. If Fleet tracked labor hours by task through its timekeeping system, it could use that data and the information it maintains in its fleet database to determine the labor required to perform each service. Without knowing the labor costs of its services, Fleet cannot determine if the State is spending less to perform repair and maintenance services than it would spend at commercial repair shops.

In May 2005, Fleet's chief told us that measuring its cost-effectiveness is a Fleet priority and that by September 2005 Fleet anticipated implementing a timekeeping system that would allow it to track the amount of time staff spend performing tasks. With that information, Fleet will be able to analyze which tasks it can perform more cost-effectively than commercial repair shops can and if the current ratio of in-house repairs to repairs performed by commercial repair shops is optimal.

We recommended that Fleet should continue with its plan to track the time of its garage employees by task to determine the cost of its repair and maintenance services and that Fleet should compare its costs to the amount that commercial repair shops would charge for the services.

General Services' Action: Partial corrective action taken.

General Services told us that a new system for tracking tasks was installed for use within Fleet in October 2005. According to General Services, it expects that its garage staff and Fleet's asset management staff will be trained in the near future and will be actively using the new system by January 2006.

Finding #7: Opportunities exist to improve Fleet's purchase approval process.

To ensure that state agencies do not make unnecessary vehicle purchases, state law requires Fleet to verify that the state agencies need the vehicles before it approves purchase requests. Fleet has made changes to strengthen its purchase process that have improved the amount of information that state agencies submit to justify their vehicle purchase requests; however, more changes are needed.

Until February 2003, Fleet's policy was to require an agency submitting a purchase request for one or more vehicles to explain the agency's need for the vehicles, but in practice it required no standard form or type of information for new purchases. In February 2003, Fleet introduced a standard form for vehicle purchase requests, specifically requiring state agencies to explain their needs. After improving the form in October 2003, Fleet now requires state agencies to explain how and where the vehicle will be used; why a special vehicle, rather than a standard sedan, is required; and whether the need for the vehicle is urgent. When state agencies provide this additional information, Fleet is able to complete a more thorough, meaningful assessment of need.

Although the new form has resulted in Fleet's receiving more detailed explanations of why state agencies need to purchase vehicles, Fleet still does not require state agencies to report why any underutilized vehicles they might have cannot fulfill their needs. Consequently, if it is to make a thorough assessment of need, Fleet must follow up with the state agencies. By requiring state agencies to explain in writing why their underutilized vehicles are not adequate to meet their needs, Fleet not only would reduce the amount of follow-up it must perform but also could better ensure that state agencies consider increasing utilization of the vehicles they currently own before they request to purchase additional vehicles.

To improve its review of vehicle purchase requests and the related documentation that it receives, Fleet should continue using its new request form with an amendment requiring state agencies to explain, on the request form, why any underutilized vehicles they might have could not fulfill their requests.

General Services' Action: Partial corrective action taken.

General Services indicates that it will issue a Management Memorandum that requires state agencies requesting vehicle purchases to provide more detailed information on their underutilized vehicles as part of Fleet's acquisition request review and approval process. According to General Services, this information will include explanations on why any underutilized vehicles that may exist cannot fulfill the agency's needs and a certification from the agency's fiscal officer that the requested acquisition is the most cost-effective solution to meet the agency's transportation needs.

Finding #8: Fleet's minimum-use requirement for state agencies may be too low.

To ensure that state agencies do not purchase more vehicles than they need, Fleet set a policy that an agency-owned vehicle must be driven at least 4,000 miles or 70 percent of the workdays every six months. A policy requiring that state-owned vehicles be driven a minimum number of miles or days is critical to ensuring that the State's vehicles are an economical method of transportation. Once a state agency owns a vehicle, the head of that agency is responsible for ensuring that it meets the minimum-use requirement. Nevertheless, if a state agency has underutilized vehicles, as defined by Fleet's policy, Fleet may not allow the agency to purchase additional vehicles.

The State's minimum-use requirement provides a level of assurance that state agencies maximize the economic potential of their vehicles. However, Fleet's policy on minimum miles is less demanding than the policies of some other governments. The National Association of Fleet Administrators, a professional society for the automotive fleet management profession, performed a survey of fleet operators in 2003 asking participants how many miles they required their vehicles to be driven in a year. On average, government respondents required vehicles to be driven 10,000 miles each year, 25 percent more than Fleet's policy; and on average, commercial respondents required vehicles to be driven 15,000 miles, nearly 88 percent more than Fleet's policy of 4,000 miles every six months, which equates to 8,000 miles each year.

Further, Fleet could not tell us how it developed its minimum-use requirement. Its policy is the same as it was 20 years ago. Consequently, Fleet cannot demonstrate that the requirement was set appropriately or that it is still applicable. Fleet's chief told us in May 2005 that Fleet was reviewing public-sector guidelines for fleet utilization in other states nationwide and would revise the policy in the near future.

Fleet should continue with its plan to revisit its minimum-use requirement for agency-owned vehicles to determine if the minimum number of miles or days that state agencies must drive their vehicles should be higher. When doing so, Fleet should consider factors such as the cost of alternative modes of transportation and warranty periods. Finally, Fleet should document the reasons for any decisions it makes.

General Services' Action: Partial corrective action taken.

General Services reports that Fleet has completed its review of minimum-use requirements and in the near future, General Services will issue a Management Memorandum advising state agencies of new criteria governing the minimum use of all vehicles. The minimum-use requirements will be increased to a minimum of 6,000 miles or vehicle use of 80 percent of workdays within a six-month period. According to General Services, it developed the new criteria after reviewing the minimum-use requirements used by the federal General Services Administration and nine other states.

Finding #9: Fleet inadequately managed parking lot funds.

Fleet manages approximately 30 parking lots owned or leased by General Services as of May 2005 and is responsible for administering state parking policies. Through this parking program, state employees can obtain parking spaces in lots near state offices for their cars or bicycles. Fleet deposits the fees that it charges state employees for the parking spaces into its Motor Vehicle Parking Facilities Money Account (parking fund), which it draws on to operate and maintain the lots. In recent years, Fleet's inadequate management of its parking program has caused the parking fund to lose money. The parking fund experienced losses in at least two recent fiscal years (2002–03 and 2003–04), and at the end of fiscal year 2003–04 had a deficit of $1.4 million. Although various factors contributed to the fund deficit, we focused on two that were within Fleet's control.

Contributing to the parking fund's losses is an agreement that Fleet has to purchase transit passes from a vendor to shuttle people free of charge from parking lots on the perimeter of downtown Sacramento (peripheral lots) to locations nearer their work sites. This agreement costs more than the peripheral lots are capable of generating in revenue, given the current rate structure, and it makes up a significant percentage of the parking fund's total expenses. Fleet's chief told us that in the near future, Fleet intends to stop paying the entire cost of shuttling passengers to and from peripheral lots.

Another factor contributing to the parking fund's losses is Fleet's failure to collect fees from more than 400 parkers. According to Fleet's parking and commute manager, Fleet staff discovered, while investigating the parking fund's losses, that many individuals either never had or at some point stopped having parking fees deducted from their paychecks. In addition to individuals, some state agencies also had not paid fees for parking vehicles they owned in Fleet's lots. After completing a reconciliation that it started in November 2004, Fleet identified roughly 400 parkers who were actively using their parking passes without paying. According to Fleet's parking and commute manager, the fees for those spaces amount to $24,500 per month in revenue. However, Fleet was uncertain as to how long the oversight had occurred or how many more parkers who no longer have parking passes were involved.

The chief of Fleet explained that these errors went unnoticed because Fleet maintains data on parkers in three databases and did not begin reconciling the information with the amount of fees it collected until November 2004. Fleet has developed a process to reconcile its parking database information with its revenue on a monthly basis. Such reconciliation should help detect these problems should they recur in the future.

To ensure that it does not subsidize employee parking, Fleet should continue with its plan to stop paying the full cost of shuttling parkers to and from peripheral lots. Additionally, Fleet should, to the extent possible, seek reimbursement from parkers who have not paid for their parking spaces.

To reduce the deficit in the parking fund, Fleet should continue with its efforts to reduce expenses and maximize revenues from parking facilities by promptly identifying parking spaces that become available and renting them again.

General Services' Action: Partial corrective action taken.

According to General Services, since September 1, 2005, the parking fund administered by Fleet has not been used to purchase transit passes to shuttle parkers to and from peripheral parking lots. General Services also indicates that based upon Fleet's comprehensive evaluation of information on potential nonpaying parkers that it developed in November 2004, it identified 49 parkers as appearing to owe unpaid parking fees and began contacting each parker to seek repayment of any unpaid fees. Further, General Services states that Fleet has implemented additional procedures to ensure that parking funds are maximized. As part of this process, Fleet is continuing to fill parking spaces the same week as they become vacant except in the peripheral lots.

THE STATE'S OFFSHORE CONTRACTING

Uncertainty Exists About Its Prevalence and Effects

Audit Highlights . . .

Our review of the extent of the State's offshore contracting revealed the following:

- ☑ ***No current state laws or regulations address the use of offshore contracting, making it difficult to judge the prevalence and effects of offshore contracting.***
- ☑ ***Our analysis of the limited survey data suggests the State is spending little on services performed offshore:***
    - ***Thirty-nine entities responding to our survey reported 185 contracts totaling $689.9 million where at least some portion of the work was possibly performed offshore.***
    - ***For 109 of these contracts totalling $349 million, respondents estimated that only $9.7 million (2.8 percent) was for services performed offshore but could not provide an estimate for the remaining 76 contracts.***
- ☑ ***The offshore contracts we reviewed generally contain provisions to protect sensitive and confidential information from disclosure.***

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REPORT NUMBER 2004-115, JANUARY 2005

The Joint Legislative Audit Committee (audit committee) directed us to examine the extent to which state-funded work is being contracted or subcontracted out of the country. Specifically, the audit committee asked us to review any Department of General Services' (General Services) policies and procedures relevant to offshore contracting (offshoring) and directed us to survey selected state agencies to identify those that have, or are most likely to have, contracted for services offshore during the previous three fiscal years. Further, for a sample of those agencies identified as having contracts for services offshore, the audit committee asked us to review and evaluate the agencies' policies and procedures for offshoring, including how the agency protects against the disclosure of sensitive and confidential information.

Finding #1: State agencies receive no guidance on offshore contracting.

State agencies currently receive no guidance related to offshoring and are not required to track where their contracted services are being performed or report the extent to which services are being performed offshore. As the State's contracting and procurement oversight agency, General Services oversees state purchasing, approves contracts for services, and sets contracting policies for the State. According to General Services, neither the State Contracting Manual nor any current state law or regulation specifically addresses the use of offshore contracting, the practice of subcontracting portions of a contract offshore, or the issue of determining where contracted services are performed. This lack of guidance can result in inconsistency in contract provisions among state agencies and makes it difficult to judge the effects and prevalence of offshoring.

We recommended to the Legislature that if it desires information and data on offshore contracting of state services to be more readily available, it may consider granting General Services the authority to require contractors to disclose, as part of their bid

☑ *Proposed legislation designed to place restrictions on and limit offshore contracting could face legal challenges or have unintended consequences.*

on state work or during performance of the contract, details on any and all portions of the project that subcontractors or employees outside the United States will perform.

Legislative Action: Legislation vetoed.

During the 2005–06 session, the Legislature passed Assembly Bill 524 that would have required all successful bidders on state services' contracts to complete a questionnaire and report on the portions of the contract that would be performed by subcontractors or employees outside of the United States. The governor vetoed the bill on September 29, 2005.

Finding #2: The extent of state entities' offshore contracting remains unclear.

Our survey of selected state agencies and campuses (entities) gives a limited understanding of the extent of these entities' offshore contracts because, as mentioned earlier, state agencies are not currently required to collect or track data on state-funded services being performed offshore. Because of the difficulty in identifying where subcontracted work is performed, capturing with any certainty the amount of state funds spent on services performed offshore is a challenge. However, from our limited data, the State apparently has been spending little on services performed in foreign countries.

Specifically, we surveyed the 35 state agencies with the largest dollar amount of contracts for certain services and the five University of California campuses with medical centers about their use of offshoring. These entities reported 185 contracts totaling $638.9 million in which at least some portion of the work has possibly been performed offshore. Asked to estimate the dollar amount of these offshored services, entities reported that they did not know the amount for 76 of these contracts. For the remaining 109 contracts, totaling $349 million, entities estimated that only $9.7 million (2.8 percent) of the contracted services were performed offshore.

Finding #3: Previous efforts to determine the prevalence of offshoring also yielded limited results.

Three other organizations that tried to determine the prevalence of services contracted offshore also produced limited results. Specifically, General Services, in response to a February 2004

legislative directive, provided documentation detailing all the internal contracts it entered into that had work performed out of state or out of the country. General Services found that when contractors' specified work was performed offshore, the degree of offshore work was not always apparent. According to General Services, such data is extremely difficult to gather because the State currently has no requirement for state agencies to collect and track any offshore information. Additionally, a nonprofit corporate research company claims that most states cannot estimate the total amount or value of state contract offshoring because most state governments do not know where service work they contract out is performed. Finally, the U.S. Government Accountability Office concluded that although there are anecdotal accounts of state governments using offshore contracts, no comprehensive data or studies of the extent to which state governments use these contracts are available.

Finding #4: Contract provisions related to subcontracting are not consistent among entities.

Our survey results show that state entities are inconsistent about including contract provisions related to subcontracting, delegating, or assigning contract duties. Specifically, we asked survey participants if their general contract provisions prohibit any or all of the contracted services to be subcontracted, assigned, or delegated. Eleven of the 39 entities responding reported that they generally prohibit any or all services from being subcontracted, assigned, or delegated. Another 24 responded that their contract provisions generally do allow for services to be subcontracted, and the remaining four entities did not respond to the question. Of the 24 entities that generally allow for subcontracting, four reported that their contracts generally do not require the contractor to notify the agency when subcontracting services. However, when entities do not require such notification, they are unaware of who is providing the services, making it difficult to effectively manage the contract.

Finding #5: Offshore contracts generally contain provisions protecting confidential information.

The offshore contracts we reviewed generally contain provisions to protect sensitive and confidential information from disclosure. Current state and federal laws protect an individual's confidential information, such as medical records, from disclosure. Of the 185 contracts that state entities reported as having at least some portion of the work performed offshore, we identified 11 contracts in which the contractor has access to confidential information. All 11 of these contracts contain, at a minimum, general terms that prohibit the contracted parties from disclosing sensitive and confidential information, and some specifically describe the contractor's responsibility in protecting this information. Nine of the 11 contracts allow the State to terminate the contract if the entities consider the contractor to be in material breach of the terms and conditions, including those protecting sensitive and confidential information. Finally, nine of the 11 contracts include a provision dictating that the governing law of the contract shall be the laws of the State.

General Services requires state contracts to include standard terms and conditions that subject the contract to the laws of California, including those related to confidential information, and that impose liability on the contractor for all actions arising out of the contracts. However, it is important that all parties to the contract, including all subcontractors, either domestic or offshore, are aware of these standard terms and conditions and comply with them.

Finding #6: Legislative attempts to restrict offshore contracting raise serious legal concerns.

The federal government and 40 states, including California, have proposed or adopted legislation to restrict offshoring. These include laws that would prohibit all contracts in which work is performed offshore, provides preferences to state or local vendors, require that state contracts detail and report all services performed offshore, and require disclosure if contractors send sensitive or confidential information offshore. Existing research indicates that state efforts to restrict offshoring may violate constitutional provisions allowing the federal government to set uniform policies for the country as a whole in dealing with foreign nations. Also, restricting or limiting offshoring may invite retaliatory trade sanctions against the United States. Before proposing measures to restrict offshoring, policymakers need to consider whether such actions are both legally sound in the United States and capable of withstanding international legal challenges.

DEPARTMENT OF GENERAL SERVICES

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

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

Department of General Services' response as of November 2005

Investigative Highlights . . .

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

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

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

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

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

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

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

General Services' Action: Corrective action taken.

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

WIRELESS ENHANCED 911

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

Audit Highlights . . .

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

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

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REPORT NUMBER 2004-106, AUGUST 2004

Department of General Services' and California Highway Patrol's responses as of August 2005

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

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

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

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

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

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

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

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

General Services' Action: Corrective action taken.

General Services states that it has revised its existing project database to allow wireless E911 costs to be more easily identified and developed a reporting system to assist management in monitoring these costs.

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

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

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

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

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

General Services' Action: Pending.

General Services reports that it is continuing work on its project, which it calls Next Generation E911 Network, in which General Services is evaluating ways to incorporate emerging technologies with a more flexible, sophisticated and cost-effective 911 system. General Services states that it has evaluated responses to a request for information that it sent out to obtain industry feedback on the 911 database requirements. General Services concluded that emerging industry standards must be finalized and technology trials completed prior to formulating a decision to

move ahead with a 911 database replacement, along with supporting network enhancements. General Services states that it is monitoring the industry's progress both in developing the necessary standards and, subsequently, obtaining the National Emergency Number Association standards organization's agreement to those standards. Additionally, General Services states it has continued to follow the progress of several technology trials that are being conducted in various locations in the nation; and that once the trials are conducted and their outcomes are reported, which in some cases may be by the end of 2005, it will be in a better position to make an informed decision regarding the future path for California. Subsequently, if it determines that significant upgrades are justified, General Services states that it will complete a financial plan for the database enhancement phase of the project.

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

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

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

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

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

CHP's Action: Corrective action taken.

The CHP states that it completed and submitted a purchase order for a management information system for all of its communications centers that will enable each center to monitor wait times. The CHP states that all but four of its centers have implemented the new system and the remaining four will be complete by December 31, 2005.

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

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

Disparities in staffing, however, do not fully explain the wide range in wait times at the nine CHP centers. For January through March 2004, the center with the highest average number of calls (1,733) per staff person, the Orange County Region, also had the shortest wait time, 4.7 seconds on average. On the other hand, the Los Angeles and San Francisco Bay Area regions had significantly fewer calls per staff and longer wait times—862 calls with a wait time of 49.2 seconds for Los Angeles and 598 calls with a wait time of 38 seconds for the San Francisco Bay Area Region. Dispatchers at CHP centers, as well as those at some local answering points, have duties other than answering emergency calls, such as answering nonemergency calls, but we do not know the relative impact on wait time of these additional duties at the various sites. The performances at the Los Angeles and San Francisco Bay Area CHP centers may also have been affected by their implementation of wireless E911. The 911 supervisor at the Los Angeles CHP center points out that implementation presented an additional challenge because the center's staff had to accustom themselves to the display

information from the wireless E911 calls they answered while continuing to work with the original system on other calls. Further, he indicated that test calls for wireless E911 implementation take up time, as the dispatcher has to confirm that various data are correctly transmitted.

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

CHP's Action: Partial corrective action taken.

The CHP reports that it is addressing this recommendation through its Command Assessment Program, which requires biennial evaluation of the management practices and the essential functions of each CHP command. The CHP will incorporate innovations noted in these assessments into the training materials and curriculum at its statewide Dispatch Academy. The CHP also states that its Information Management Division, Office of Legal Affairs, and Department Training Division are presently developing the necessary policy and processes for implementation of the new strategy.

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

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

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

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

During 2003, the Los Angeles CHP center performed manual tallies of its 911 counts. However, these manual counts significantly understated its actual number of 911 calls—by almost 705,000, or 43 percent. On the other hand, the Fresno CHP center produced manual call tallies that significantly overstated its 911 calls—by almost 222,000, or 76 percent. Because the CHP does not track actual 911 calls at all its centers, we are unable to determine whether, in total, the CHP overstated or understated its 911 calls. Nonetheless, it is clear that the CHP's current process to develop an estimate of the number of 911 calls it receives produces unreliable results. Without reliable data relating to the number of 911 calls its centers answer, the CHP will have difficulty developing a benchmark for the number of 911 calls per dispatcher that would allow the CHP to answer 911 calls promptly.

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

CHP's Action: Partial corrective action taken.

The CHP states that the management information system it is implementing, as described in finding #3 above, will also enable it to monitor the call volume at each of its call centers. Additionally, the CHP states that it is developing a benchmark that will consider call volume data, communication center size, and incorporate shift parameters and the impact of seasonal and special events that affect high traffic volumes. The benchmarks will be utilized to evaluate and validate dispatch staffing levels. The CHP states that it intends to develop a benchmark using six months of call data collected after its new management information system is implemented. The CHP reports that a committee comprised of management and dispatch personnel has developed a staffing questionnaire and gathered statistical data from representative communication centers. The CHP will use this information to complete a budget change proposal for additional dispatchers for fiscal year 2006–07.

Finding #6: CHP dispatchers' salaries are generally lower than those of dispatchers at the local answering points.

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

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

CHP's Action: Corrective action taken.

The CHP reports that using a salary comparison of 13 public agencies' (agencies) dispatcher salaries that CHP had prepared as a basis, the Department of Personnel Administration surveyed the agencies and confirmed that the CHP dispatcher salary scale is not in parity with that of the agencies surveyed. According to the CHP, based on the results of this survey, the Department of Personnel Administration negotiated a tentative agreement with the dispatchers' union that includes a 10 percent pay raise during the term of the two-year agreement. The contract is still pending ratification of the union membership, and approval by the Legislature and governor. The CHP states that although the dispatchers' salary is still below the average pay of the 13 public safety agencies surveyed, when combined with continued recruitment and retention efforts, it should allow the CHP to fill and retain more dispatcher positions.

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 January 2005

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 (WCIS), 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 WCIS 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.

Industrial Relations' Action: Partial corrective action taken.

In its one-year response, Industrial Relations reported it is continuing to work toward implementing various legislative reforms, including Senate Bills 899 and 228, and Assembly Bills 749 and 227. For example, Industrial Relations reported that it had completed rulemaking activities to implement the new official medical fee schedule required by one of these statutory reforms of the workers' compensation system. In addition, Industrial Relations reported that it had adopted emergency regulations to implement utilization review and was beginning activities to develop permanent regulations.

Further, Industrial Relations reported it was continuing its work to develop and implement its WCIS to collect the data needed to manage the workers' compensation system in a more efficient and effective manner. Industrial Relations reported it was refining the list of data elements to be collected and the electronic billing forms and standards it will use. Industrial Relations stated it expected full implementation of medical data reporting using the WCIS beginning in the fourth quarter of 2005.

DEPARTMENT OF INSURANCE

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

REPORT NUMBER 2003-138, JUNE 2004

Department of Insurance's response as of July 2005

Audit Highlights . . .

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

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

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

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

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

☑ *Despite reducing the backlog of cases in its Investigation Division by 51 percent, Insurance can improve how it reviews and assigns cases to ensure they are not outstanding for long periods of time.*

☑ *Insurance cannot easily demonstrate that its Legal Division used SB 940 funds for allowable activities only.*

☑ *Insurance could not demonstrate that all AB 1050 expenditures were for allowable activities. Specifically, Insurance spent $22,000 on cases that do not meet the criteria in state law.*

☑ *Insurance does not ensure that it follows state laws and regulations for monitoring district attorneys' and the California Highway Patrol's use of AB 1050 funds.*

☑ *Its Market Conduct Division does not fully utilize Insurance's database. Therefore, Insurance cannot report on the time and cost associated with its examinations or measure the efficiency of its market conduct operations.*

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

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

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

- Move forward in its efforts to make regulatory changes that will result in capturing more specific data from insurers about the number of vehicles they insure.

- Compare the number of private passenger vehicles insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and investigate discrepancies.

- Direct its Field Examination Division to follow up on the discrepancies identified in the Budget and Revenue Management Bureau's analysis.

- Periodically perform analytical reviews of insurers' data, such as comparing changes in written premiums to changes in the assessments insurers remit, and investigate unusual trends.

Insurance's Action: Corrective action taken.

Insurance stated new regulations establishing a process that imposes a hard count of the number of vehicles covered by an automobile insurer became effective on July 3, 2005. Additionally, Insurance stated its Field Examination Division has procedures in place for the Budget and Revenue Management Branch to refer insurers to it for limited scope examinations when the Budget and Revenue Management Branch detects problems with the data of the number of insured vehicles and is unable to reconcile or resolve them. Furthermore, Insurance reported that the Budget and Revenue Management Branch established criteria for identifying unusual trends and has incorporated the application of the criteria in its internal procedures. Finally, Insurance reported that its Budget and Revenue Management Branch found it difficult to compare the number of private passenger vehicles insurers report on their assessment invoices to the number they report to its Statistical Analysis Division annually and instead intends to focus on the analysis of unusual trends discussed previously.

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

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

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

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

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

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

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

Insurance's Action: Corrective action taken.

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

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

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

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

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

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

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

Insurance's Action: Corrective action taken.

Insurance reported that it established new procedures for staff to follow when there is a need to transfer hours and expenditures from one fraud program to another. Insurance stated that it has reorganized the Fraud Grant Audit Unit and approved the hiring of two additional auditors. Insurance stated that it has reorganized its Fraud Division, as well as recruited and hired additional auditors to conduct financial and performance audits of the county district attorney offices that receive grants. Furthermore, Insurance reported that its Fraud Division has continued to improve communications with the California District Attorney Association Insurance Anti-Fraud subcommittee, emphasizing effective reporting of performance measures, improvements in laws and regulations, and the requirements for timely reporting of financial statements. Finally, Insurance reported that it has obtained all annual expenditure reports from the California Highway Patrol for fiscal years 2000–01 through 2003–04.

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

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

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

Insurance's Action: Partial corrective action taken.

Insurance stated that it has consolidated the timekeeping of the Field Rating and Underwriting Bureaus and currently one support staff handles this function in each of its bureaus. Additionally, one support staff now handles report publishing for the Market Conduct Division. Insurance believes that its current support staff ratio of 3:41 is reasonable. However, Insurance stated that, as a result of its implementation of a new database, revised duties might evolve and need to be assigned.

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

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

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

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

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

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

Insurance's Action: Corrective action taken.

Insurance reported that in March 2005 its Market Conduct Division implemented a new exam tracking system, which includes timekeeping along with integrated expense and billable hour reporting into Accounts Receivables. The exam tracking system's new features will allow the Market Conduct Division to collect exam time and cost information as well as exam results in an automated fashion for a single insurer exam or an insurer group exam by using exam identification numbers.

DEPARTMENT OF JUSTICE

The Missing Persons DNA Program Cannot Process All the Requests It Has Received Before the Fee That Is Funding It Expires, and It Also Needs to Improve Some Management Controls

Audit Highlights . . .

Our review of the Department of Justice's Missing Persons DNA Program (missing persons program) revealed the following:

- ☑ ***Created in January 2001, the missing persons program reached full operation in July 2004, which appears reasonable considering the issues it faced in establishing operations.***
- ☑ ***As of February 2005, the missing persons program had received 799 requests and completed DNA analysis for 261 of them, but is unlikely to complete testing for all requests before the fee supporting it expires.***
- ☑ ***It may be too soon to decide whether the existing fee supporting the missing persons program should be made permanent.***
- ☑ ***Several elements of the missing persons program are sound, but its management information and timekeeping databases, which could otherwise serve as valuable management tools, include inaccurate data.***

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REPORT NUMBER 2004-114, JUNE 2005

Department of Justice's response as of December 2005

The Joint Legislative Audit Committee requested the Bureau of State Audits to assess the Missing Persons DNA Program (missing persons program) administered by the Department of Justice (Justice), with a focus on determining whether it is meeting its statutory provisions and efficiently using its funds.

Finding #1: The missing persons program has recently reached full operation but will not complete existing work before the fee supporting the program expires.

After the missing persons program was created in January 2001, it faced several challenges in reaching full operation. These challenges included a hiring freeze for state agencies, the extensive training necessary for its staff, and low pay rates compared to other jobs requiring the same skills. Given these challenges, it seems reasonable that it took until July 2004 for the missing persons program to reach full operation. However, as of the end of February 2005, the program had received 799 requests for DNA analysis and 538 were awaiting analysis, which equates to 23 months of work. Program management has acknowledged that it will not be able to complete DNA analysis for all the requests before the fee supporting the missing persons program expires in January 2006.

Although some accumulation of work beyond what can immediately be processed is reasonable, the amount of work the missing persons program has accumulated suggests that in the short term the program does not have the capacity to process all of the requests it receives. In positioning itself for the long term, the program must ensure that its workload estimate is accurate.

☑ ***The missing persons program is receiving the funding to which it is entitled and its costs are appropriate for a laboratory to incur.***

Thus far, the program's estimate has been close to the number of requests it has received. However, the program's workload estimate is based on a calendar year 2000 report from Justice's Missing and Unidentified Persons System showing that coroners and local law enforcement agencies submitted 150 reports of unidentified human remains in that year. More recent information shows that the average number of deceased unidentified persons reported from 2001 through 2004 is 190 per year, 40 more than the program's estimate. In addition, the program's current estimate does not include the number of requests it will receive related to missing persons, including personal articles and DNA supplied by parents and relatives.

To ensure that it is based on the most current data and reflects future program demands, we recommended that the missing persons program review its workload estimate periodically.

Justice's Action: Corrective action taken.

The missing persons program reports that in December 2004 Justice implemented a system for tracking service requests using Justice Trax software. The missing persons program stated that it now has reliable workload statistics on a monthly and yearly basis.

Finding #2: It may be too soon to decide if the existing fee supporting the missing persons program should be made permanent.

Between January 1, 2001, and June 30, 2004, the missing persons program recorded revenues of $11 million and expenditures of $7 million in the Missing Persons DNA Data Base Fund (DNA fund). As of June 30, 2004, the program had a fund balance of nearly $4 million. Justice plans to use the fund balance in the DNA fund to continue operating the program should the $2 fee end on January 1, 2006, as the California Penal Code, Section 14251, currently requires. Using expenditure data from the first six months of fiscal year 2004–05 to estimate the program's expenditures for the full fiscal year, we estimate that the fund balance is sufficient for the program to operate for more than one year at current staffing and expenditure levels after the fee expires. However, Justice's plan assumes that certain changes will occur that would enable the missing persons program to continue operating using its fund balance, even though the authorization for the DNA fund and the $2 fee increase on death certificates both end on January 1, 2006. In

addition to the missing persons program receiving a fiscal year 2005–06 appropriation, the Department of Finance would have to move the program's appropriation and fund balance to the General Fund. The missing persons program's operations would be halted by June 30, 2006, when its fiscal year 2005–06 appropriation expires, unless legislation continues the necessary fee or the Legislature appropriates any remaining fund balance in a successor fund for fiscal year 2006–07.

Assembly Bill 940 proposes making the $2 fee increase on death certificates permanent, to fund the missing persons program indefinitely. However, since the missing persons program has amassed a fund balance of $3.9 million and needs to update its workload estimate, coupled with the fact that the program only recently achieved full operation, it may be too soon to decide if its funding should be made permanent. Therefore, we recommend that it may be more prudent for the Legislature to extend the $2 fee increase on death certificates for a defined period of time and then reassess the program's accomplishments and needs.

Legislative Action: Legislation enacted.

Assembly Bill 940 (Chapter 471, Statutes of 2005) was approved by the governor on October 4, 2005. This bill extends the fee supporting the program until January 1, 2010.

Finding #3: Several elements of the missing persons program are sound.

In creating the missing persons program, Justice has put into place several sound elements. Specifically, the program's staffing approach and training levels appear appropriate, it has successfully educated local law enforcement agencies about its program, and it has made reasonable efforts to obtain federal funding.

Missing persons program staff train for nearly two years before they are qualified to work with minimal direct supervision. Although the timeline is lengthy, the training process ensures that staff meet accreditation requirements and industry standards. In addition, its training process is comparable to that of laboratories doing similar work.

At its inception in 2001, the missing persons program did not have an existing pool of requests on which to begin analysis. By February 28, 2005, it had received 799 requests from local law enforcement agencies in 50 of California's 58 counties, such as Los Angeles, Orange, and San Diego. This suggests that the program has been effective in making its mission and services known to local law enforcement agencies. The program has used a combination of information bulletins, presentations at industry conferences, and a training video to communicate its mission and services.

Section 14251(a) of the California Penal Code states that the $2 fee increase on death certificates would remain in effect until January 1, 2006, or until federal funds became available, whichever is sooner. Thus, it appears that the Legislature contemplated a real possibility of federal funds to operate a missing persons DNA database. Although

our review disclosed that some federal grants relate to DNA analysis, these funding opportunities are not specifically earmarked for DNA analysis of missing persons or unidentified human remains. Nevertheless, according to Justice, its process to identify appropriate federal grants includes sending representatives to the National Institute of Justice's annual meeting where future grant opportunities are discussed and using its budget office to research and coordinate efforts to identify federal funding.

Finding #4: The missing persons program could not provide sufficient documentation to support that it adheres to the priorities its advisory committee established.

The program's advisory committee, consisting of coroners, law enforcement officials, and other stakeholders, set up priorities for the program for processing DNA requests. However, we could not determine if the program is following the guidelines, because its list for documenting the priority it assigns to a request and the reasons why is incomplete. The list is designed to capture the following information: the request number; whether the request concerns a child; the cause of death, if known; whether the request concerns a specific missing person; and comments about the materials available for analysis, for example, a tooth, a femur, or hair. Despite containing these categories, the list does not provide enough information to determine the request's priority, because it does not state the priority that was assigned and does not include all of the priority categories contained in the guidelines.

To ensure that the missing persons program is completing the most critical requests first and that its limited resources are focused on the highest-priority requests, it should amend its priority list to include all of the information used to determine the priority assigned to each request.

Justice's Action: Corrective action taken.

The missing persons program told us that it has included the priority code that is consistent with the guidelines developed by its advisory committee on its priority list for case assignments. The missing persons program stated that each case is maintained in the case assignments list along with its priority code so that the priority assigned to any particular case can be determined. Further, the missing persons program maintains the case assignment list on its computer network such that any laboratory management personnel can access the list and make staff assignments.

Finding #5: Some of the data the program's management information and timekeeping databases contain are not reliable.

The missing persons program uses a variety of databases, two of which contained data we believed would be relevant to the audit. One is a database the program uses to assist it in tracking and storing information related to requests for DNA analysis, and the other is one it uses for staff timekeeping. However, through our testing we determined that the data contained in the databases are inaccurate and not reliable for our audit purposes. The database the program uses to track requests contains some inaccurate

dates and the timekeeping database lacks controls to ensure that approved time records are not changed, was missing a staff member's time, and included some time that was not recorded properly.

To make certain that it has effective tools to help manage and measure the program, missing persons program management should take the necessary steps to ensure that its management information and timekeeping databases contain accurate and reliable data.

Justice's Action: Partial corrective action taken.

The missing persons program reported that it has addressed the inaccuracies in its management information database. The missing persons program concurred with our evaluation of its timekeeping system. It is currently evaluating options that will address the concerns cited in the report. The missing persons program noted that it anticipates having a usable prototype within a few months.

Finding #6: Justice is receiving the revenues earmarked for the program and the program's expenditures appear reasonable.

According to Justice's accounting records, revenues for the program are $3 million per year. This amount substantially agrees with the fees due based on the number of death certificates issued for fiscal years 2001–02 through 2003–04.

We reviewed the program's expenditures for these same three fiscal years. Its facilities costs are the most significant expenditures, totaling $1.4 million for rent and $2 million for tenant improvements. However, these expenditures appear reasonable considering the program's space needs, the tenant improvements made, and the methodology Justice follows to determine the program's share of facilities costs. Finally, Justice's methodologies for apportioning personal services costs seem reasonable and the program's expenditures for other operating expense and equipment costs seem appropriate for a laboratory to incur.

CALIFORNIA MILITARY DEPARTMENT

Investigations of Improper Activities by State Employees, January 2005 Through June 2005

INVESTIGATION I2004-0710 (REPORT I2005-2), SEPTEMBER 2005

California Military Department's response as of November 2005

Investigative Highlight . . .

A supervisor with the California Military Department embezzled at least $132,523 in state funds over an eight-year period.

We investigated and substantiated an allegation that a supervisor with the California Military Department (Military Department) embezzled public funds.

Finding: The supervisor fraudulently appropriated state funds under his control and failed to stop payments to a retired service member who had died and then stole the deceased individual's retirement checks.

Over an eight-year period, the supervisor embezzled at least $132,523 as follows: $111,507 from the Military Department's system for processing emergency state active duty payroll; $12,393 from the department's revolving fund; and $8,623 from the retired state active duty system used to process retirement payments (retirement payments). The supervisor fraudulently initiated at least 60 checks in the names of his family members totaling a gross amount of $123,900. At least 43 of these payments, totaling $87,483, were deposited into his bank accounts. In addition, the supervisor stole at least four retirement payments totaling $8,623 that were payable to a former service member who had died.

Military Department's Action: Corrective action taken.

The Military Department asked the California Highway Patrol (Highway Patrol) to investigate the criminal aspects of this case. The Highway Patrol interviewed the supervisor who admitted to the embezzlement and thefts. After completing its investigation, the Highway Patrol referred the case to the Sacramento County District Attorney for prosecution. The Military Department also enacted internal control practices requiring additional levels of approval for the payroll and payment systems the supervisor manipulated in order to embezzle state funds.

CALIFORNIA MILITARY DEPARTMENT

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

INVESTIGATION I2002-1069 (REPORT I2004-2), SEPTEMBER 2004

California Military Department response as of November 2005

Investigative Highlight . . .

Over a two-year period, the Military Department paid employees at two of its three training centers $128,400 more than they were entitled to receive.

We investigated and substantiated an allegation that the California Military Department (Military Department) improperly granted employees an increase in pay they were not entitled to receive.

Finding: The Military Department overpaid its employees $128,400.

Between July 1, 2001, and June 30, 2003, 19 employees at two of the Military Department's three training centers received increased pay associated with inmate supervision even though they did not supervise inmates for the minimum number of hours required to receive the pay. For the two years we reviewed, the Military Department paid its employees at two of the training centers approximately $128,400 more than what they were entitled to receive. We were unable to determine to what extent, if any, the Military Department's third training center also improperly granted its employees the increased pay because it was not able to provide supporting documents for 23 of the 24 months we requested. At least 10 of the employees of the third training center received the pay increase at some time during the two-year period.

Military Department's Action: Corrective action taken.

The Military Department agreed with our findings and reported that it has implemented changes to correct the problems identified. Specifically, it reported that it has returned all employees receiving the pay increase to their original pay level and implemented a policy at all three training centers for certifying when employees are eligible for the pay increase. The Military Department also implemented a policy that requires the training centers to

maintain employee compensation documentation for two years. Further, the Military Department reported that because its personnel costs for the training centers are reimbursed by the United States Property and Fiscal Officer for California (USPFO), the State has, in effect, already been reimbursed for the overpayments; thus it will not pursue reimbursement from the employees who improperly received the increased pay. The Military Department provided a copy of our report to the USPFO, which has the authority to recoup or waive the overpayments from the State.

PRISON INDUSTRY AUTHORITY

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

REPORT NUMBER 2004-101, DECEMBER 2004

Youth and Adult Correctional Agency response as of December 2005

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's Action: Corrective action taken.

PIA states that it has developed a methodology to allocate central office and transportation costs among its enterprises and will continue to utilize this methodology when analyzing the performance of its enterprises. PIA also states that it has established a system to consistently document its pricing analyses. Finally, PIA states that it has finalized a special or discount pricing policy and incorporated it into its manual of policies and procedures.

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's Action: Corrective action taken.

PIA states that it has established inmate employment targets for the 2005–06 annual plan and that it will continue to monitor and report its final results in the year ending June 30, 2006. PIA further states that it has established "profitability per inmate" criteria, presented it to the Prison Industry Board, and will continue to monitor and report its final results in the year ending June 30, 2006.

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's Action: Corrective action taken.

PIA states that, based on the Department of Corrections and Rehabilitation data, it estimated cost savings regarding sentence reduction credits as well as cost savings that PIA programs provide in lieu of non-PIA programs.

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's Action: Partial corrective action taken.

PIA states that in July 2005 a contractor completed a design for a research study to measure the impact of PIA on its participants' post-release success and that, effective November 2005, PIA entered into a two-year contract with an independent contractor to conduct the study. PIA also states that it is tracking the unique components of the Inmate Employability Program and that, as part of the study, PIA will examine the link between these unique components and post-release employment, earnings, and returns to prison.

CALIFORNIA PUBLIC UTILITIES COMMISSION

It Cannot Ensure That It Spends Railroad Safety Program Fees in Accordance With State Law

REPORT NUMBER 2003-121, MAY 2004

California Public Utilities Commission response as of June 2005

Audit Highlights . . .

Our review of the California Public Utilities Commission (commission) revealed that:

- ☑ ***The commission does not have an effective method to track the time its employees spend on railroad safety activities.***
- ☑ ***The commission cannot ensure that it charges only allowable travel-related expenses to the Railroad Safety Program.***
- ☑ ***Inaccuracies in its cost allocation plan and table have caused the commission to incorrectly charge indirect costs to the Railroad Safety Program.***
- ☑ ***Without a system to track direct and indirect costs, the commission cannot establish reliable budgets and set appropriate fees.***

The Joint Legislative Audit Committee requested the Bureau of State Audits to determine whether the California Public Utilities Commission (commission) uses Railroad Safety Program fees according to requirements specified in the California Public Utilities Code. Specifically, we found:

Finding #1: The commission does not have an effective method to track the time its employees spend on railroad safety activities.

The commission uses a timekeeping system that does not track the actual time its employees spend working on railroad safety activities. As a result, some inspectors inconsistently report their hours, and the commission uses estimates to determine the direct labor expenditures of clerical, supervisory, and legal staff who work on activities related to the Railroad Safety Program. In fiscal years 2002–03 and 2003–04, errors in those estimates resulted in overcharges to the Railroad Safety Program. However, the commission did not take sufficient steps to ensure that similar errors would not reoccur. In fact, we found that between July 2003 and February 2004 the commission incorrectly charged the Railroad Safety Program $281,000 for staff in its legal divisions.

The commission has been trying to upgrade its timekeeping system since as early as spring 2002 to allow its employees to record the actual time they spend on projects or activities and to integrate its timekeeping system with its accounting system. However, the commission has experienced delays and does not expect to complete the system upgrades until September 2004. Thus, it cannot ensure that the fees it collects are spent only on the direct labor charges of Railroad Safety Program employees.

We recommended that the commission should move quickly to fully implement upgrades to its timekeeping system to allow employees to record the actual time they spend on railroad safety activities and to enable the commission to reconcile expenditures to funding sources. We also recommended that the commission should ensure that it determines the effect that incorrectly charging hours for staff in its legal divisions has on the allocation of indirect costs to the Railroad Safety Program and adjust its accounting records for fiscal year 2003–04.

Commission's Action: Corrective action taken.

The commission indicated that, effective April 2005, upgrades to its timekeeping system have been fully implemented and its divisions have begun data entry into the system. Furthermore, the commission stated it made the appropriate adjustments to its accounting records prior to closing its records for fiscal year 2003–04.

Finding #2: The commission cannot ensure that it charges only allowable travel-related expenses to the Railroad Safety Program.

Because of weaknesses in its method of processing travel expense claims submitted by railroad safety inspectors, the commission cannot ensure that all travel-related expenses charged to the Railroad Safety Program are allowable.

Specifically, the commission does not always require inspectors to report the proper program cost account codes or the percentage of time they spend traveling for Railroad Safety Program inspections on their travel expense claims. Further, although inspectors' time sheets may indicate time spent on other programs, the commission does not direct its accounting staff to charge costs among programs according to the indicated percentages. Consequently, the commission cannot ensure that only allowable travel-related expenses are charged to the Railroad Safety Program.

We recommended that the commission should establish procedures requiring inspectors to identify the program cost account codes to be charged for their travel expenses on their travel expense claims. Additionally, the commission should require its accounting staff to enter all valid codes shown on the travel expense claim into the accounting system.

Commission's Action: Corrective action taken.

The commission indicated that it implemented a process under the guidance of the Consumer Protection and Safety Division's budget control and fiscal officers.

Finding #3: Inaccuracies in its cost allocation plan (plan) and table have caused the commission to incorrectly charge indirect costs to the Railroad Safety Program.

The commission has not established a formal process for periodically reviewing and updating its plan in accordance with state accounting procedures. The plan contains the method of distributing operating expenses or equipment costs that cannot practically be charged directly to the programs that benefit from the accumulated costs. Additionally, the commission does not maintain its accounting system's cost allocation table (table), which contains data that are the basis of the allocation of expenditures and encumbrances in the commission's accounting system, the California State Accounting and Reporting System. Consequently, both the plan and table contained inaccuracies that resulted in the commission improperly charging the Railroad Safety Program for indirect costs. For example, the commission did not change its table to reflect all the unit codes established during its reorganization. Without a formal process for evaluating the accuracy of its plan and table, the commission cannot ensure that it appropriately charges indirect costs to various programs, including the Railroad Safety Program.

We recommended that the commission develop policies and procedures to ensure that it maintains its plan and table for indirect charges in accordance with the State Administrative Manual. Specifically, the commission should periodically review and update its plan and table to ensure that the allocation bases are appropriate. Further, it should ensure that management reviews and approves any changes to the plan.

Commission's Action: Partial corrective action taken.

The commission plans to update its existing plan and tables by July 1, 2005. Thereafter, the commission plans to review the cost allocations annually and/or when changes in the organizational structure require adjustments to the cost allocation factors.

OFFICE OF THE SECRETARY OF STATE

Clear and Appropriate Direction Is Lacking in Its Implementation of the Federal Help America Vote Act

Audit Highlights . . .

Our review of the Office of the Secretary of State's (office) administration of federal Help America Vote Act of 2002 (HAVA) funds revealed the following:

- ☑ ***The office's insufficient planning and poor management practices hampered its efforts to implement HAVA provisions promptly.***
- ☑ ***The office's disregard for proper controls and its poor oversight of staff and consultants led to questionable uses of HAVA funds.***
- ☑ ***The office avoided competitive bidding for many contracts paid with HAVA funds by improperly using a Department of General Services exemption from competitive bidding and by not following the State's procurement policies.***
- ☑ ***The office bypassed the Legislature's spending approval authority when it executed consultant contracts and then charged the associated costs to its HAVA administration account.***

continued on next page . . .

REPORT NUMBER 2004-139, DECEMBER 2004

Office of the Secretary of State's response as of December 2005

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the Office of the Secretary of State's (office) fiscal year 2003–04 budget request and verify that all components of the federal Help America Vote Act of 2002 (HAVA) grants were implemented within the spirit and letter of the law. Specifically, the audit committee asked the bureau to review and evaluate relevant laws, rules, and regulations; to determine whether the office used HAVA funds only for allowable purposes and in accordance with Section 28 of the Budget Act of 2003; and to determine whether the office implemented HAVA in compliance with federal requirements. It also asked the bureau to review and evaluate the office's policies and procedures for administering HAVA funds, including the process of awarding and disbursing those funds, and to determine whether it effectively oversees the use of the funds it awards to ensure that recipients use them only for allowable purposes. The audit revealed the following:

Finding #1: The office's insufficient planning and poor management practices hampered its efforts to implement some HAVA provisions in a timely way.

The office is in danger of failing to meet the deadline for at least one HAVA requirement and other important future implementation milestones because of insufficient planning and other poor management practices. According to its current schedule, it may not fully implement by the January 1, 2006, HAVA deadline a computerized statewide voter registration list that is maintained and administered at the state level. Further, the office could have been more proactive in assisting counties in achieving the successful statewide implementation of other HAVA requirements, such as provisional voting procedures, a free access system, the posting of voter information, and voter identification requirements.

☑ *The office failed to disburse HAVA funds to counties for the replacement of outdated voting machines within the time frames outlined in its grant application package and county agreements.*

These shortcomings in meeting HAVA deadlines can be traced to the office's incomplete planning for each of the activities it intended to undertake. As a result of this incomplete planning, as of June 30, 2004, the office had spent only $46.6 million of the $81.2 million authorized by the Legislature for fiscal year 2003–04. The lack of implementation plans for various HAVA projects could have been due in part to a lack of project management oversight. According to the office's executive staff, no one individual was assigned the overall responsibility for HAVA implementation. Instead, direction for administering HAVA activities came from many staff in the executive office. Eventually recognizing the need for project management services to implement HAVA successfully, the office solicited proposals from vendors for consulting services in June and then again in October 2004, and gave notice of its intent to award a contract on December 1, 2004.

To ensure that it successfully implements the requirements called for in HAVA, we recommended that the office take the following steps:

- Develop a comprehensive implementation plan that includes all HAVA projects and activities.
- Designate the individuals responsible for coordinating and assuring the overall implementation of the plan.
- Identify and dedicate the resources necessary to carry out the plan and assign roles and responsibilities accordingly.
- Establish timelines and key milestones and monitor to ensure that planned HAVA activities and projects are completed when scheduled and that they meet expectations.

Office's Action: Partial corrective action taken.

The office stated that it is continually reviewing its implementation plan, and is in the process of revising the plan to ensure that it is usable and contains all necessary changes. The office estimates its efforts in this area are 90 percent complete.

Finding #2: The office's disregard for proper controls and its poor oversight of staff and consultants led to questionable uses of HAVA funds.

Because of a lack of proper control and oversight, the office risks having to repay the federal government for costs charged to HAVA funds that either did not have the adequate support or were for questionable activities. The office did not provide many employees with job descriptions that explained their HAVA responsibilities and that could make employees aware of potential conflicts of interest, incompatible activities, and other requirements important in administering federal funds. Moreover, the office's conflict-of-interest code and incompatible activities policy do not prohibit the real or perceived participation in partisan activity by employees or consultants.

Our review of the $1,025,695 in personal service costs the office charged to HAVA funds in fiscal year 2003–04 revealed that the office neither prepared the certifications for its employees that worked full time on HAVA activities nor instructed its employees to complete monthly time sheets or other activity reports required by federal cost principles to support the personal service costs charged to HAVA funds. Further, two of the five employees we reviewed whose entire salaries were charged to HAVA funds reported attending certain events that did not appear to relate to allowable HAVA activities. Therefore, the office cannot assure that the personal service costs charged to HAVA funds are accurate and allowable.

In addition, the office failed to adequately account for the activities of some consultants it hired to assist in the implementation of HAVA. Of the 169 staff activity reports submitted between December 2003 and September 2004 by the regional outreach consultants it hired, 62 (37 percent) listed one or more activities that had no relationship to HAVA requirements. Some of these consultants reported attending events such as fundraisers and a state delegation meeting for the Democratic National Convention, and indicated they were representing the secretary of state at these events. However, HAVA does not specify these as allowable activities and some appear to be partisan in nature. Although we could not quantify the amounts paid to consultants for these types of activities because the office did not require them to indicate on their invoices the time spent on each one, we question the office's use of HAVA funds to pay for these types of activities.

The office also exercised poor oversight of a law firm's contract to provide legal services relating to HAVA, approving and paying for invoiced services that violated the terms of the contract. The contract stipulated that the law firm's daily charge for services would not exceed $1,200 per day and that the firm would provide services one day a week on an as-needed basis. However, an invoice for payment listed 17 separate days on which the amount the firm charged exceeded the contract's $1,200 per day limit. Moreover, rather than providing services one day a week, the firm billed the office for 22 days in January, 21 days in February, 23 days in March, and five days in the first two weeks of April 2004. Furthermore, the office paid for services rendered before a binding contract was in place, and we found no indication that the former chief counsel reviewed the invoice, even though he was the office's representative for this contract and, therefore,

was presumably more familiar with the legal services rendered and the contract's payment terms. Instead, the invoice was reviewed and approved for expedited payment by the chief assistant secretary of state.

In another example of its poor contract oversight, the office hired a consulting firm to perform public outreach within the context of HAVA. The consultant proposed preparing an outreach plan and was asked to identify specific events, people, and opportunities for outreach. Although the office used HAVA funds to pay this consultant $4,750, it was unable to provide us with a plan or any other work products for this contract.

As a result of the failure to provide proper oversight of employees and consultants and the failure to prepare and maintain adequate documents to support the costs charged to HAVA funds, the office is at risk of having the federal government require repayment of some, if not all, of the HAVA funds used to pay for these activities.

To establish or strengthen controls, comply with federal and state laws, and reduce the risk that HAVA funds are spent inappropriately, we recommended that the office take the following actions:

- Develop clear job descriptions for employees working on HAVA activities that include expectations regarding conflicts of interest, incompatible activities, and any other requirements important in administering federal funds.
- Establish and enforce a policy prohibiting partisan activities by employees and consultants hired by the office; periodic staff training and annual certification by all employees that they have read and will comply should be part of this policy.
- Standardize the language used in all consultant contracts to include provisions regarding conflicts of interest and incompatible activities, such as partisan activities.
- Ensure that time charged to HAVA or any other federal program is supported with appropriate documentation, including time sheets and certifications.
- Require that contract managers monitor for the completion of contract services and work products prior to approving invoices for payment.
- Review invoices to assure that charges to be paid with HAVA funds are reasonable and allowable and conform to the terms of the contract.

Office's Action: Partial corrective action taken.

The office has developed duty statements for the two employees who currently work full time on HAVA activities. While the office has developed a written policy that specifically prohibits the use of any state or federal resources for partisan political activity, the policy is still under review by the Department of Personnel Administration and must ultimately be approved by the applicable unions for represented office employees. The office has distributed the new policy to all of its

nonrepresented employees for them to read and sign. The office also has revised its HAVA contracts to include a provision prohibiting partisan activities, has developed a time sheet and certification process for time spent on HAVA activities, and implemented a process to review invoices to ensure work products are received and that charges are reasonable and allowable prior to approving payments.

Finding #3: The office used questionable practices to procure goods and services related to HAVA.

The office bypassed competitive bidding for most HAVA expenditures. It obtained and then inappropriately used a Department of General Services (General Services) exemption from competitive bidding for 46 of the 77 HAVA-expensed contracts. Most of the contracts under this exemption did not have the urgency described in the justification provided to General Services and could have been competitively bid had the office planned better. Further, the scope of work sections for the voter outreach consultant contracts were vague, generally requiring only that the consultant "perform voter and election outreach activities" and did not establish any way to determine whether the consultants' efforts were successful. Further, the office could not provide us with a plan showing what activities these consultants were to complete by any specified deadlines. Also, the office did not adequately ensure that its voter outreach consultants were using their compensated time to educate voters about HAVA-related issues.

Additionally, the office did not follow General Services policies in making California Multiple Award Schedule (CMAS) procurements when it split purchase orders to avoid CMAS procurement limits and competitive bidding requirements on two HAVA-funded projects. Further, for 10 of the 12 HAVA-expensed purchase orders it made using CMAS, the office did not follow recommended policy and obtain comparison quotes from other qualified vendors. The office also did not follow state procurement policies that require informal bids for two of the three non-CMAS commodity purchase orders in our sample that the office issued and paid with HAVA funds. As a result of these non-competitive procurement practices, the State is less sure that the office obtained the best value for the purchases it made with HAVA funds.

To establish or strengthen controls over procurements, we recommended that the office take the following actions:

- Follow competitive bidding requirements to award contracts and restrict the use of exemptions to those occasions that truly justify the need for them.

- When competition is not used to award contracts, establish a process to screen and hire consultants.

- Follow control procedures for the review and approval of contracts to ensure that contracts include a detailed description of the scope of work, specific services and work products, and performance measures.

- Follow General Services policies when using CMAS for contracting needs.
- Comply with state policy for procuring commodities.

Office's Action: Partial corrective action taken.

The office stated that it intends to use competitive bidding requirements to award contracts except in those rare circumstances in which non-competitive procurement is allowable and appropriate. When competition is not used, the office stated that it would use a process to screen consultants before they are hired. The office indicated that it has already sent 75 percent of its contracting staff to specialized training and seminars and received training certifications regarding the State's procurement and contracting practices, and intends to send the remaining 25 percent of its contract staff to this training in the spring of 2006. The office also stated that it has revised its contracting processes to require that every contract include a detailed scope of work, specific deliverables, and performance measures, and these processes include criteria for using CMAS and procuring commodities.

Finding #4: The office spent HAVA funds on activities for which it had no spending authority.

The office bypassed the Legislature's spending approval authority. It inappropriately executed voter outreach contracts valued at $230,400 in fiscal year 2004–05 although it had no spending authority for these activities. Additionally, while deliberations over the office's fiscal year 2004–05 HAVA spending authority were taking place, the consultants that received fiscal year 2004–05 contracts to perform voter outreach work had already begun work and subsequently submitted invoices for their services. To pay for these invoices, the office charged $84,600 in associated contract costs to its HAVA administration account, which was inconsistent with its past practice for paying for such activities.

We recommended that the office prohibit fiscal year 2004–05 expenditures for HAVA activities until it receives spending authority from Finance and the Legislature.

Office's Action: Corrective action taken.

The office submitted its fiscal year 2004–05 spending plan to Finance in February 2005. Finance and the Joint Legislative Budget Committee subsequently approved spending authority for all requested items except those relating to the statewide database and a source code review.

Finding #5: The office unnecessarily delayed grant payments to counties.

The office failed to disburse HAVA funds for replacing voting machines within the time frames outlined in its grant application package, internal procedures, and contracts with counties, causing some to lose interest income they could have used to replace their

voting equipment. In a September 2003 application packet, the office said that payment would occur approximately 30 days after a county received written confirmation from the office that its application had been approved and a contract had been executed. Correspondingly, the office's internal accounting procedures outlined the timeline for payment at approximately 30 days for application approval and 30 days for disbursement of funds, for a total of 60 days. However, despite these assurances of prompt payment, the office disbursed voting machine replacement funds an average of 168 days after receiving the application, causing one county to submit a claim for lost interest income.

We recommended that the office disburse federal HAVA funds to counties for voting machine replacement within the time frames set out in its grant application, procedures, and contracts.

Office's Action: Corrective action taken.

The office stated it is developing a more streamlined process for disbursing funds to the counties that are replacing their voting equipment. The new process authorizes the State Controller's Office to send reimbursements directly to the counties to save time.

STATE BAR OF CALIFORNIA

It Should Continue Strengthening Its Monitoring of Disciplinary Case Processing and Assess the Financial Benefits of Its New Collection Enforcement Authority

Audit Highlights . . .

Our review revealed that the State Bar of California:

- ☑ *Continued to monitor its backlog of disciplinary cases and reported 402 cases in the backlog at the end of 2004.*
- ☑ *Continued to conduct semiannual reviews of disciplinary case files; however, it noted deficiencies similar to those found in its 2002 reviews.*
- ☑ *Developed a checklist for case files and adopted a policy to spot check active cases as we recommended, but the checklist is not comprehensive and staff have not consistently performed the spot checks.*
- ☑ *Obtained additional legal authority to collect money related to disciplinary cases, but needs approval of administrative procedures before it can implement the new authority.*
- ☑ *Is pursuing an increase in revenues from membership fees to help reduce projected deficits.*

REPORT NUMBER 2005-030, APRIL 2005

State Bar of California's response as of October 2005

As required by Chapter 342, Statutes of 1999, the Bureau of State Audits conducted a performance audit of the State Bar of California's (State Bar) operations covering January 1, 2004, through December 31, 2004. In planning this audit, we followed up on three principal areas identified during our 2003 audit: the State Bar's processing of disciplinary cases, cost recovery as part of processing disciplinary cases, and the use of mandatory and discretionary funds to support State Bar functions.

Our report concluded that the State Bar continued to monitor its backlog of disciplinary cases that resulted from its virtual shutdown in 1998. In addition, the State Bar's semiannual reviews of randomly chosen disciplinary cases in 2004 disclosed deficiencies similar to those found in its 2002 random reviews. To address these deficiencies and in response to our 2003 audit recommendations, the State Bar developed a brief checklist to guide staff in processing disciplinary cases. However, its staff did not always use the checklist and it is not sufficiently comprehensive. The State Bar also adopted a policy to spot check open disciplinary cases to ensure that staff are maintaining files properly and handling complaints correctly. However, we found that staff did not consistently perform the requisite number of spot checks and sometimes failed to document the results.

Further, the State Bar's recoveries of disciplinary costs and Client Security Fund payments remained low. Therefore, to subsidize these costs, it used a larger portion of the membership fees it collected than it would have if its recovery rates were higher. Although a law effective in January 2004 improved its ability to recover past and future costs, the State Bar has not yet been able to use this new authority because it is waiting for approval of

certain administrative procedures by the California Supreme Court. Finally, the State Bar is pursuing a revenue increase to help reduce projected deficits in its general fund and Client Security Fund. Specifically, we found:

Finding #1: The State Bar continued to monitor its case backlog while seeing little change in the number of disciplinary cases it processed.

The State Bar processed almost the same number of cases through its intake and enforcement units in 2004 as it did in 2002. In addition, although it reported that its backlog of disciplinary cases increased to 540 cases in 2003, the backlog it reported at the end of 2004 was 402 cases, which is almost identical to the backlog at the end of 2002. Even though the State Bar maintains an "aspirational goal" of reducing the backlog to 250 cases, it believes that having a backlog of about 400 cases may reflect the norm.

We recommended that the State Bar continue its efforts to control its backlog of disciplinary cases.

State Bar's Action: Corrective action taken.

The State Bar reported that it has reorganized the office of the chief trial counsel, in part, to address structural and reporting issues that have historically contributed to the creation of the backlog. In particular, it eliminated the separate trial unit and investigation unit and created four trial and investigation units that it believes will result in greater teamwork in performing adequate investigations and preparing cases for trial. The State Bar also stated that, since September 1, 2005, its deputy trial counsel, rather than investigators, oversees all disciplinary investigations. Finally, the State Bar indicated that its supervising trial counsel and assistant chief trial counsel monitor the age of investigations, focusing on the completion of backlog cases and avoiding addition of new cases into the backlog. The State Bar expects that these actions will significantly reduce the backlog by the end of 2005.

Finding #2: The State Bar needs to fully implement its procedures and policies for monitoring disciplinary case processing.

The State Bar's random reviews of its disciplinary case files indicate that staff still have not consistently followed policies and procedures when processing complaints filed against its members. In particular, in its 2004 semiannual reviews of randomly chosen case files, the State Bar identified some of the same deficiencies as it identified in 2002 reviews. To address some of these issues, and in response to the recommendations we made in our 2003 report, the State Bar developed a checklist to ensure that staff complete important steps in processing complaints and include all necessary documents in every case file. Further, in 2004 the State Bar instituted a policy requiring team leaders to periodically spot check active files. However, we found that staff have not consistently used the checklist and it is not sufficiently detailed. In addition, we found little evidence of compliance with the spot-check policy.

We recommended that the State Bar:

- Establish a written policy requiring staff to maintain a checklist of the important steps involved in processing disciplinary cases and include all necessary documents in every case file, rather than relying on an informal instruction that the checklist be used.
- Develop a checklist that is more comprehensive than the current investigation file reminder, such as the tool that the audit and review unit uses when it randomly reviews disciplinary case files.
- Make supervisors responsible for ensuring that each case file includes a checklist and that staff use it.
- Enforce its policy of spot checking the files of active disciplinary cases and require team leaders to document the results of their spot checks.

State Bar's Action: Corrective action taken.

The State Bar reported that it has developed a more comprehensive checklist and directed its staff to begin using the checklist effective July 1, 2005. In addition, the State Bar stated that it has issued a policy directive that addresses the monthly random audits of open investigation files, as well as the requirement to document the results of the random audits using a checklist form developed for that purpose.

Finding #3: Changes in state law may improve the State Bar's recovery of disciplinary costs and Client Security Fund payments.

The State Bar's cost recovery rates in 2004 were comparable to its recovery rates in 2002; however, they remained low compared with the total amounts billed. Specifically, the State Bar's cost recovery rates in 2004 for discipline and the Client Security Fund were 40.5 percent and 10.7 percent, respectively. Therefore, the State Bar used a larger portion of its membership fees to subsidize its disciplinary activities and the Client Security Fund than it would have with a higher recovery rate. In the past, the State Bar had little success in recovering costs from disbarred attorneys or attorneys who resigned, in part, because it lacked specific authority to pursue recovery of debts under the Enforcement of Judgments Law. However, based on amendments to the Business and Professions Code, effective in January 2004, the State Bar now has the requisite legal authority, which may improve its ability to recover not only future costs but also some portion of the $64 million in billed costs that remain unrecovered since 1990.

To enable it to carry out the statute, the State Bar has proposed to the California Supreme Court that the California Rules of Court be amended. The proposed amendments, which the State Bar submitted to the supreme court in February 2005, would require the superior court clerk of the relevant county to immediately enter a judgment against an attorney for the amount the State Bar certifies the attorney owes for disciplinary costs or Client Security Fund payments. After obtaining the money

judgment, the State Bar would be able to garnish wages or obtain judgment liens on real property the attorney owns. Until the Supreme Court approves the proposed procedures, the State Bar cannot exercise the money judgment authority.

We recommended that the State Bar prioritize its cost recovery efforts to focus on attorneys who owe substantial amounts related to disciplinary costs and payments from the Client Security Fund.

State Bar's Action: Partial corrective action taken.

The State Bar reported that, as of October 2005, it is still waiting for the Supreme Court's action and approval of the proposed amendments to the rules of court. The State Bar also indicated that it continues to monitor the responses from disciplined attorneys to the demand letters that have been mailed in its two pilot projects—one targeting the most recently disciplined attorneys and another targeting 68 of the 100 disciplined attorneys who owe the most in disciplinary costs. As of October 2005, the State Bar reported that collections as a result of the first and second pilot projects have totaled $46,701 and $2,745, respectively. Further, the State Bar indicated that it is retrieving relevant documents from the files of disciplined attorneys so that it can file requests for money judgments when the Supreme Court's expected order approving the proposed rules becomes effective.

However, the State Bar indicated that one disbarred attorney who received a demand letter for repayment of disciplinary costs has filed a civil rights action in federal court challenging the constitutionality of the amendments permitting the State Bar to enforce disciplinary costs as money judgments. Because the State Bar believes other disciplined attorneys are likely to raise similar challenges, it is seeking to obtain a favorable ruling on the merits and has filed a motion for judgment on the pleadings.

Finally, the State Bar reported that it has derived a list of attorneys with court-ordered restitution from the list of the 100 attorneys owing the most in Client Security Fund reimbursements and is reconciling the amounts these members owe.

Finding #4: The State Bar is pursuing a revenue increase to help reduce projected deficits.

Based on the State Bar's financial forecast, the combined balance of its general fund, which accounts for activities related to the disciplinary system, and its Public Protection Reserve Fund, which was established to ensure the continuity of the disciplinary system, will sink into a deficit of $13.8 million by the end of 2008 unless revenues from membership fees increase.

The forecast assumes a significant increase in staff salaries and wages beginning in 2006 and no change in membership fees. For its general fund the State Bar predicts that expenses will exceed revenues starting in 2005, which will eventually use up the surplus in the general fund. The State Bar also predicts that its Client Security Fund, which

it uses to help alleviate the financial losses suffered by clients of dishonest attorneys, will have a deficit by the end of 2006. To avoid projected deficits, the State Bar has proposed a bill that would increase its membership fees by $5 for active members and $95 for inactive members and would change the criteria for active members to qualify for a partial fee waiver. If approved, these changes would become effective on January 1, 2006.

We recommended that the State Bar continue to update its forecasts for key revenues and expenses as new information becomes available. For example, the State Bar should closely monitor the results of its enhanced collection enforcement authority and the benefits it may have on recovery of disciplinary costs and Client Security Fund payments.

State Bar's Action: Partial corrective action taken.

The State Bar reported that its fee bill for 2006 and 2007 was signed into law in September 2005 and the fees have been incorporated into the 2006 budget adopted by its board of governors. The State Bar believes that the fee structure as authorized by the Legislature should provide sufficient funding to operate through 2007. In addition, the State Bar indicated that it will continue to monitor key 2005 revenues and expenses on a quarterly basis and will update its financial forecast accordingly. Finally, the State Bar reported that it continues to monitor its collection efforts for disciplinary costs and Client Security Fund payments while the proposed rule of court related to its enhanced collection enforcement authority is still pending final approval by the California Supreme Court.

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's response as of January 2004

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

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.

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's 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 STATE AUDITOR

ELAINE M. HOWLE
STATE AUDITOR

STEVEN M. HENDRICKSON
CHIEF DEPUTY STATE AUDITOR

February 28, 2006

2006-406 A4

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

Dear Governor and Legislative Leaders:

The Bureau of State Audits presents its special report for the Assembly Budget Subcommittee No. 4—State Administration. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations.

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

BUREAU OF STATE AUDITS
555 Capitol Mall, Suite 300, Sacramento, California 95814 Telephone: (916) 445-0255 Fax: (916) 327-0019 www.bsa.ca.gov/bsa