Implementation of State Auditor's Recommendations

Audits Released in January 2004 Through December 2005

Special Report to

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

February 2006
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CALIFORNIA STATE AUDITOR

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February 28, 2005

2005-406 S3

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

Dear Governor and Legislative Leaders:

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

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

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State Auditor

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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 Senate Budget and Fiscal Review Subcommittee No. 3—Health, Human Services, Labor and Veterans Affairs. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the left-hand margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

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

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

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

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OVERSIGHT OF LONG-TERM CARE PROGRAMS

Opportunities Exist to Streamline State Oversight Activities

REPORT NUMBER 2003-111, APRIL 2004

Departments of Aging, Health Services', and Social Services' responses as of April 2005

Audit Highlights . . .

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

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

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

Health Services reports that the Legislature has placed a one-year moratorium on certification reviews while it develops a Medi-Cal waiver for the adult day health care program. Health Services also indicates that it believes there are significant differences in purpose, requirements, timing, and frequency of the licensing and certification reviews that would make combining the separate reviews by the two departments problematic. However, as we noted in our audit, we found that the separate reviews duplicated the departments' efforts and may unnecessarily burden health care centers. While developing the Medi-Cal waiver, Health Services indicates that it will work with Aging to clearly separate the licensing and certification requirements in state regulations. Finally, Health Services indicates that staff from the Medi-Cal field offices have coordinated their visits to health care centers with Health Services and Aging staff to the extent possible. In addition, the Legislature passed Assembly Bill 2816, Chapter 455, Statutes of 2004 (AB 2816), to require the California Health and Human Services Agency (agency) to determine by March 1, 2005, the appropriate department to oversee health care centers. However, this determination is dependent on developing a Medi-Cal waiver for the program, and as of November 2005, the agency indicates that it and the federal government have not reached an agreement on this waiver.

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

The State's fragmented oversight of the program of all-inclusive care for the elderly (PACE) also could benefit from a more unified approach. In addition to having to comply with federal regulations and a state contract, PACE providers are subject to multiple state licensing regulations that apply to the various services a provider may offer, so they face multiple oversight visits from Health Services. The State could streamline this oversight by allowing a single license that covers all state and federal regulations pertaining to the various PACE services, regardless of the facility providing the services. With a single license, the State could unite its oversight activities more

easily based on the requirements established in the license agreement. Such oversight could use a cooperative approach—combining staff who specialize in different areas of the single license—for a comprehensive review of all a PACE provider's facilities during the same time period rather than having many reviews scattered over time. This would relieve the extended burden on PACE providers from a succession of licensing visits to each of their facilities.

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

Legislative Action: Legislation enacted.

Although the Legislature did not act on our recommendation to create a single license for PACE, it did pass Assembly Bill 847, which the governor approved in September 2005. This legislation authorized Health Services, Aging, and Social Services to grant exemptions from licensing requirements applicable to clinics, residential care facilities for the elderly, and home health agencies to a PACE provider that submits a written request, along with substantiating evidence to support the request.

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

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

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

Health Services' Action: Corrective action taken.

Effective January 2005 Health Services indicates that it will no longer conduct parallel site reviews with Aging staff unless requested to do so. Further, Health Services states that it is revising its protocol to focus on independently reviewing Aging oversight activities rather than conducting parallel site reviews.

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

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

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

Social Services' Action: Partial corrective action taken.

Social Services previously identified four adult day program facilities that it has licensed and that also share space with a health care center. Social Services indicates it continues to work with local health services departments and adult day program providers to ensure that no client needing services is refused the ability to attend an adult program facility with the rescinding of the adult day program license.

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

Because most Alzheimer's centers reside in facilities offering other long-term care programs—mostly health care centers and adult day programs—the oversight of Alzheimer's centers could benefit from better coordination among state and local agencies. Alzheimer's centers are under Aging's oversight but are directly overseen by local area agencies, which are government or nonprofit entities under contract with Aging to provide services to seniors. However, there is no formal process to share oversight information between the local area agencies and Health Services, which licenses health care centers, and between the local area agencies and Social Services, which licenses adult day program facilities. In the governor's proposed budget for

fiscal year 2004–05, separate funding for the Alzheimer's centers is merged into a block grant that will be provided to the local area agencies. Thus, Alzheimer's centers may continue to exist only to the extent that the local area agencies choose to fund them.

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

Aging's Action: Pending.

Assembly Bill 2127, which the governor approved in August 2004, requires all Alzheimer's centers to be licensed as an adult day program or health care center by January 2008. Aging, Health Services, and Social Services indicates they are working together to implement this requirement.

CALIFORNIA CHILDREN AND FAMILIES COMMISSIONS

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2003-123, JULY 2004

The California Children and Families Commission and various county commissions[1] responses as of August 2005

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

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

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

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

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

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

First 5 Santa Clara's Action: Corrective action taken.

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

First 5 Kern's Action: Partial corrective action taken.

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

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

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

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

First 5 Santa Clara's Action: Corrective action taken

First 5 Santa Clara stated it is actively pursuing outside resources and has recently received three substantial grants.

First 5 Kern's Action: Corrective action taken.

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

First 5 Los Angeles' Action: Corrective action taken.

First 5 Los Angeles stated it had established a team to actively seek matching funds from government agencies, corporations, and other private funding organizations.

First 5 El Dorado's Action: Corrective action taken.

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

First 5 San Diego's Action: Corrective action taken.

First 5 San Diego stated that the commission had adopted a 20-year financial plan that maintains grant-making levels over the plan's horizon by allocating funds to a sustainability reserve and drawing on those funds to stabilize funding levels as revenues decline. First 5 San Diego also stated it will focus on identifying fund sources that assist the commission to leverage, broaden, and deepen its impact on San Diego's children.

First 5 California's Action: Corrective action taken.

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

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

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

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

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

First 5 Santa Clara's Action: Pending.

First 5 Santa Clara stated it is working with the Government Finance Officers Association (association) to develop guidelines for administrative costs for use by county commissions. First 5 Santa Clara stated it will review the association's recommendations on administrative costs and will forward this information to the county commission for its consideration.

First 5 Los Angeles' Action: Pending.

First 5 Los Angeles stated it is working with the association to develop guidelines and a proposed definition of administrative costs, the final draft of which will be issued soon.

First 5 El Dorado's Action: Pending.

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

First 5 San Diego's Action: Pending.

First 5 San Diego will work with the association to construct and adopt a uniform definition of administrative expenses and budgetary reporting categories for county commissions' financial reporting. Once the association's guidelines are finalized and reviewed, First 5 San Diego stated it would prepare a recommendation and forward it to the county commission.

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

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

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

First 5 Santa Clara's Action: Partial corrective action taken.

First 5 Santa Clara stated that it had completed a comprehensive annual evaluation report that was submitted to its commission in September 2004 that found a number of positive outcomes related to indicators in the county commission's strategic plan. First 5 Santa Clara also stated it had completed an updated community indicators report in January 2005 organized by four of its commission's goal areas. According to First 5 Santa Clara, evaluation outcome measures and indicators are being aligned with its new strategies and that an evaluation workshop for commissioners is scheduled for September 2005.

First 5 Kern's Action: Partial corrective action taken.

First 5 Kern stated it is continually addressing the concerns expressed by its independent evaluator and that its evaluator stated that significant progress had been made in addressing and meeting objectives.

First 5 Los Angeles' Action: Partial corrective action taken.

First 5 Los Angeles stated that over the past year, it had made significant progress in the implementation of the results-based accountability framework that forms an integral part of its strategic plan for fiscal years 2004–05 through 2008–09. First 5 Los Angeles stated that its framework tracks outcomes and indicators of child and family well-being on several levels—for example, measurement of outcomes at the county and grantee level will be available in September 2005 and early 2006, respectively.

First 5 El Dorado's Action: Partial corrective action taken.

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

First 5 San Diego's Action: Partial corrective action taken.

First 5 San Diego stated that, starting with its fiscal year 2004–05 evaluation, its performance will be measured through the outcome evaluation that provides data on the performance of each of its major initiatives and the aggregate performance of all of its funded projects during the year. First 5 San Diego stated that its performance would also be compared to community indicators to assess, to the extent possible, its impact countywide.

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

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

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

First 5 California's Action: Pending.

First 5 California stated that it established an ad-hoc working group made up of legislative staff, state and local commissioners, and others to review current evaluation design and annual reporting requirements and to suggest changes and enhancements to clarify and strengthen the reporting of performance outcomes and other program data. Based on the recommendations of this group and a joint county/state working group on technical design issues, First 5 California stated it would develop a request for proposals to secure a new evaluation contract by December 15, 2005.

SEX OFFENDER PLACEMENT

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2004-111, DECEMBER 2004

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

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.

DEPARTMENT OF HEALTH SERVICES

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

INVESTIGATION I2004-0930 (REPORT I2005-2), SEPTEMBER 2005

Investigative Highlights…

Department of Health Services:

- ☑ *Improperly paid contract staff $57,788 for services it did not receive.*
- ☑ *Circumvented procurement procedures and purchased $40,698 in equipment on a services contract.*

We investigated and substantiated an allegation that the Department of Health Services (department), Genetic Disease Branch (branch) improperly paid a contractor for holiday time and improperly purchased equipment under personal and computer services contracts.

Finding #1: The branch improperly paid for contract staff holiday time.

We believe the branch may have violated state law prohibiting gifts of public funds by paying contract employees more than they were entitled to receive. Although terms of the contract did not require it to do so, the branch authorized payment for 13 holidays to Contractor A's staff from December 2003 through November 2004, costing the State $57,788 for services it did not receive. The contract under which the branch made these payments specifies that services shall be provided Monday through Friday, 8:00 a.m. to 5:00 p.m., except for official state holidays.

The branch stated that effective January 1, 2004, it amended Contractor A's three contracts to provide for holiday pay and provided a holiday pay schedule developed and approved by a former branch employee. However, it was never processed through the department's contracts section, and therefore, did not constitute a formal, authorized written amendment to the contract.

Finding #2: The branch circumvented procurement procedures.

The branch circumvented state procurement procedures by using services contracts with both Contractor A and Contractor B to purchase two computers, three fax machines, and two laser printers for the branch. The computers cost $35,000, the fax machines cost $1,845 and the printers cost $3,853.

The branch's agreement with Contractor B was for the contractor to provide maintenance of computer hardware and software. The branch circumvented the goals of state law as well as state procurement procedures by using money from this computer services contract to purchase two computers.

Specifically, the branch approved a $15,500 invoice from Contractor B for, as the invoice stated, "time and materials not covered under the terms and conditions of the regular maintenance agreement" but was actually for the cost of the two computers. We believe the information on this invoice was a misleading statement about the true nature of the transaction. Further, it appears that the branch was aware of the true nature of the amount claimed on the invoice when it approved payment, thereby not only circumventing state procurement procedures but also approving and perpetuating misleading information. The branch also approved a second invoice from Contractor B for $19,500 with the same description of services. The branch told us this invoice was for the installation of emergency backup computers in Sacramento, something that was necessary as part of the recovery system required for critical public health services. It further said both invoices were approved under the mistaken impression that the contract had been amended to provide for this equipment.

Similarly, the branch used a personal services contract with Contractor A to purchase fax machines and laser printers. The branch circumvented state procurement procedures requiring departments to obtain price quotes and compare prices. Furthermore, the contractor charged the branch another 10 percent for "additional administrative and accounting expenses."

Department's Action: Pending.

The department has requested to review our working papers and is in the process of determining what action to take.

DEPARTMENT OF HEALTH SERVICES

Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements

REPORT NUMBER 2004-125, AUGUST 2005

Department of Health Services' response as of October 2005

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) administration of the Medi-Cal Administrative Activities program (MAA) revealed the following:

- ☑ ***School districts' participation in, and reimbursements for, MAA have significantly increased since fiscal year 1999–2000.***
- ☑ ***Despite receiving $91 million for fiscal year 2002–03, we estimate school districts could have received at least $57 million more had all school districts participated and certain districts fully used MAA.***
- ☑ ***Health Services has not performed a sufficient number of local on-site visits.***
- ☑ ***Simplifying the MAA structure would increase efficiency and simplify program oversight.***

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to review the Department of Health Services' (Health Services) administration of the Medi-Cal Administrative Activities program (MAA). Specifically, we were asked to assess the guidelines provided by Health Services to local educational consortia (consortia) and local governmental agencies that administer MAA at the local level. Additionally, the audit committee asked us to evaluate the process by which Health Services selects consortia and local governmental agencies to contract with, how it establishes the payment rates under the terms of the contracts, and how it monitors and evaluates performance of these entities.

We were also asked to evaluate the effectiveness of a sample of consortia and local governmental agencies in administering MAA and in ensuring maximum participation by school districts. Furthermore, we were requested to conduct a survey of school districts regarding their participation in the program.

Finding #1: School districts underused MAA.

Although California school districts received $91 million in federal MAA funds for fiscal year 2002–03, we estimate that they could have received at least $53 million more if all school districts had participated in the program and an additional $4 million more if certain participating school districts fully used the program. School districts we surveyed identified a belief that the program would not be fiscally beneficial as one of the primary factors in their decision not to participate in MAA. However, several of the nonparticipating school districts we surveyed have not recently assessed the costs and benefits of the program, while many of the surveyed school districts that recently performed this assessment have now decided to

participate. The main reasons offered by consortia and local governmental agencies as to why participating school districts did not fully use MAA were that they lacked an experienced MAA coordinator with sufficient time to focus on the program and generally resisted or lacked support for time surveying. If such issues are addressed, school districts may be able to obtain additional MAA reimbursements beyond our $57 million estimate.

Health Services and the consortia and local governmental agencies that help it administer the program have not done enough to help school districts participate in MAA. Health Services acknowledges that it does not try to increase MAA participation and federally allowable reimbursements, commenting that it has neither a mandate nor the resources to do so. However, it is the state entity in charge of Medi-Cal and could use its contracts with these local entities to mandate their performance of outreach activities designed to increase the use of MAA. None of the local governmental agencies we visited perform any outreach activities. Conversely, consortia have already voluntarily assumed some responsibility for increasing program participation in their regions even though Health Services does not contractually obligate them to do so. Consequently, Health Services has not established ways to measure and improve these outreach efforts. Consortia could improve their outreach to school districts by targeting nonparticipating school districts that have the potential for a high MAA reimbursement and by identifying participating school districts that underuse MAA and helping ensure that they have a correct understanding of those costs that are federally reimbursable.

To help ensure comprehensive MAA participation by school districts and that all federally allowable costs are correctly charged to MAA, Health Services should require consortia to perform outreach activities designed to increase participation and hold them accountable by using appropriate measures of performance. In addition to the mass forms of outreach consortia currently perform, Health Services should require them to periodically identify and contact specific nonparticipating school districts that have potential for high MAA reimbursement and periodically identify and contact participating school districts that appear to be underusing MAA to help ensure that they have a correct understanding of those costs that are federally reimbursable. If Health Services believes it does not have a clear directive from the Legislature to increase participation and reimbursements, it should seek statutory changes.

Health Services' Action: Pending.

Health Services is currently developing draft contract language that would require consortia to outreach to a predetermined percentage of nonparticipating schools in their region on a yearly basis. The schools targeted will be those schools with the highest average daily attendance. The draft language will be forwarded to Health Services' Office of Legal Services for review and approval. Health Services will also require consortia to contact all school districts within their region to help ensure that they have a correct understanding of MAA costs and benefits. This will include providing direction and consultation to those school districts that may be underusing MAA.

Health Services will use the increased outreach percentage of nonparticipating schools in their region as a yearly measurement tool to determine if the consortia met the contractual targets. To verify contractual compliance, this measurement tool will also be used during the site reviews. With the addition of newly approved staff, Health Services will develop a database of participating and nonparticipating school districts, by region, that will be referenced in measuring and verifying outreach activities of the consortia during the site visit.

Finding #2: Without regular site visits, Health Services cannot determine if local entities complied with MAA requirements.

Health Services did not adequately monitor the MAA activities of consortia, local governmental agencies, or school districts. Effective November 2002, the federal Centers for Medicare and Medicaid Services (CMS) required Health Services to perform on-site reviews of each consortium and local governmental agency at least once every four years. According to the CMS requirements, these reviews may be performed in one of two ways. Health Services can elect to review a representative sample of claiming units—the entities within a consortium or local governmental agency, including school districts, that participate in MAA. Alternatively, the consortia and local governmental agencies can focus a portion of their annual single audit on MAA claiming every four years. However, based on our review, neither method was consistently employed.

From October 2001 to February 2005, Health Services conducted site visits of only nine of 31 consortia and local governmental agencies, including some school districts. During that period, it did not conduct any site visits during 2003 and only one during 2004. Additionally, four of the five consortia—the Los Angeles consortium performed some reviews—and three of the four local governmental agencies we reviewed did not perform onsite reviews of school districts. According to the chief of administrative claiming, Health Services has implemented new procedures as a result of its most recent MAA manual approved by CMS in August 2004 and has received the authority to hire additional staff to help implement the new manual, including performing site visits. According to the manual, Health Services is required to conduct site visits at a minimum of three consortia and one local governmental agency each year.

Health Services should ensure that the site visits of consortia, local governmental agencies, and school districts are conducted as required.

Health Services' Action: Pending.

Health Services is currently recruiting additional staff. Some of these staff will be specifically targeted for MAA activities. With these additional staff, the planned oversight, monitoring, site visit, and desk reviews will exceed federal monitoring requirements.

Finding #3: Health Services' existing procedures limit its ability to effectively measure MAA performance.

Health Services has decreased the time it takes to pay an invoice, but its current invoice and accounting processes need to be updated so that it can more easily collect data to monitor MAA and to identify where additional improvements could be made. For instance, because it uses a manual process, which has the potential for human error, Health Services cannot easily determine the total federal reimbursements California schools have received from MAA, identify participating school districts, or ascertain the amount each school district receives in MAA reimbursements. Without these basic statistics, it is difficult for Health Services to adequately monitor the success of the program, and its ability to use statistical methods to identify fraudulent or excessive claims is limited. It also does not require regular reporting from consortia and local governmental agencies on their program efforts (annual reports). Further, Health Services has not established a way to measure the performance of consortia and local governmental agencies, and has not outlined the actions it would take if one of these entities consistently neglected their responsibilities.

Health Services should update its current invoicing and accounting processes so it can more easily collect data on the participation and reimbursement of school districts. Additionally, Health Services should require consortia, and local governmental agencies should they continue to be part of MAA, to prepare annual reports that include participation statistics, outreach efforts and results, and other performance measures Health Services determines to be useful. Health Services should then annually compile the content of these reports into a single, integrated report that is publicly available. Finally, Health Services should develop written criteria for consortia, and local governmental agencies should they continue to be part of MAA, and take appropriate action when performance is unsatisfactory.

Health Services' Action: Partial corrective action taken.

Health Services is proceeding with the MAA Automation project, which will improve and streamline business processes and allow collection of data to perform comparative analyses and management reports to monitor consortia activities. Health Services' proposal for MAA automation has initially received internal approval, and Health Services is currently developing the feasibility study. Health Services is currently recruiting for the newly approved staff positions and will have dedicated resources in the MAA to require consortia and local governmental agencies, should they continue to be a part of MAA, to prepare annual reports, and it will annually compile the content of these reports into a single, integrated report that is publicly available. Additionally, with the newly recruited staff, Health Services will develop written performance criteria for consortia and local governmental agencies, should they continue to be a part of MAA, and take action when performance is unsatisfactory.

Finding #4: Some consortia and local governmental agencies are charging fees in excess of their administrative costs.

School districts are receiving a reduced share of MAA reimbursements because some consortia and local governmental agencies are charging fees that exceed their administrative costs. Furthermore, representatives for three of the local governmental agencies we reviewed stated they do not perform an analysis that would allow them to identify whether the fees they assessed exceeded their costs. State law requires that Health Services contract with a consortium or local governmental agency to claim MAA reimbursement for a participating school district and allows that administering entity to collect a fee from the school district for such a service. We reviewed fees assessed by some of these entities, anticipating that the fees charged would be sufficient to cover the administrative costs incurred. However, we found that the fees charged by some consortia and local governmental agencies exceeded costs. This condition does not result in the State receiving additional MAA funds from the federal government. Rather, it results in the school districts receiving a smaller share of MAA reimbursements than they could have. Health Services stated it has not developed policies governing consortium and local governmental agency fees because it was unaware of the overcharging issue.

Health Services should develop polices on the appropriate level of fees charged by consortia to school districts and the amount of excess earnings and reserves consortia should be allowed to accumulate. Health Services should do the same for local governmental agencies if such entities continue to be part of the program structure.

Health Services' Action: None.

Health Services continues to research this issue. However, it believes this is an issue most appropriately handled at the local level rather than managed by the State. We continue to believe it is critical that Health Services develop policies in this area. If Health Services believes it needs express authority to implement such policies, it should seek it.

Finding #5: Some school districts are losing money because of the terms of their vendor contracts.

School districts we reviewed lost an estimated $181,000 in federal MAA reimbursements for fiscal year 2003–04 because the fees they paid their vendors were based on the amount of MAA reimbursements they received. Although federal guidance has long prohibited requesting reimbursement for these types of fees, known as contingency fees, it was not until recently that Health Services issued guidance on this topic. In its 2004 MAA manual, Health Services indicates that claims for the costs of administering MAA may not include fees paid to vendors that are based on, or include, contingency fee arrangements. Although this guidance is helpful, it does not identify alternative fee arrangements that would allow federal reimbursement for vendor fees. Consequently, school districts may mistakenly believe vendor fees are not reimbursable under any circumstances.

We recommended that Health Services help school districts invoice for all reimbursable costs, including vendor fees, by issuing clear guidance on how to invoice for these costs and instructing consortia, and local governmental agencies should they continue to be part of MAA, to make sure school districts in their respective regions know how to take advantage of these revenue-enhancing opportunities.

Health Services' Action: Partial corrective action taken.

Health Services currently provides training and issues Policy and Procedure Letters to the consortia to provide technical assistance and guidance to school districts in obtaining all appropriate reimbursement under MAA. With the addition of new staff, Health Services will strengthen its role in providing training, technical assistance, and guidance.

Finding #6: Because of recent changes in billing practices, the federal government could be billed twice for the same services.

Some consortia and local governmental agencies are changing their fee structures to allow school districts to claim their fees as a federal reimbursable MAA cost. However, because consortia and local governmental agencies also request federal reimbursement for their administrative costs, this practice could result in the federal government reimbursing both a consortium or local governmental agency and a school district for the same services. Health Services has not adequately monitored the activities of these entities and therefore was unaware of these changes at the local level. Consequently, Health Services has not created the policies necessary to prevent activities from being claimed twice. Although we did not identify any duplicate payments to the entities we reviewed, the potential for duplicate payments exists.

We recommended that Health Services follow through on its plans to develop a policy governing the claiming of consortium and local governmental agency fees and instruct these entities to carefully monitor school districts' invoices to make sure that any claiming of consortium or local governmental agency fees does not result in duplicate payments.

Health Services' Action: Pending.

Health Services is currently drafting a Policy and Procedure Letter regarding these issues.

Finding #7: Simplifying the MAA structure would make the program more efficient and effective.

MAA would be more efficient and effective if Health Services required participating school districts to submit invoices through a consortium and to use a vendor selected through a regionwide competitive process. School districts currently submit MAA invoices through 11 different consortia and 20 different local governmental agencies. To ensure that it adequately monitors the activities of these two sets of local administering entities, Health Services plans to conduct site visits of all 31 once every

three years. However, although local governmental agencies represent nearly 65 percent of the 31 site visits to be performed, school districts only submit about 24 percent of their MAA invoices through local governmental agencies. Once Health Services implements the additional monitoring activities we recommend, its efforts would be better spent on the 11 consortia that process 76 percent of participating school districts' MAA invoices. Using such an approach, it would likely be able to increase its oversight activities without requiring a significant increase in staff resources.

We also recommended that Health Services require consortia to perform outreach activities designed to increase MAA participation and that it hold consortia accountable using appropriate measures of performance. We did not include local governmental agencies in this recommendation because the jurisdictions of consortia and local governmental agencies overlap. Efforts by both consortia and local governmental agencies to conduct outreach to the same school districts not participating in MAA would be a duplicative use of resources. In addition, if Health Services required simultaneous outreach efforts by consortia and local governmental agencies, it could confuse school districts and reduce the accountability of both entities for their outreach programs. Consortia are best suited to perform outreach to nonparticipating school districts because they are administered by educational units and thus may have a better understanding of school districts' needs than would local governmental agencies, which are typically county health agencies.

Finally, if each school district that needs MAA assistance is required to use a vendor competitively selected by its consortium, instead of entering into an individual contract with a vendor of its own choosing, vendors could be subject to stronger oversight and compelled to reduce their fees. Nearly all of the 27 participating school districts that responded to our survey used private vendors for some sort of MAA assistance. Some of these school districts used a vendor selected by consortia, but because not all consortia contract with vendors, many school districts do not have that option. Other school districts choose to contract directly with private vendors for MAA assistance, even though their consortia also contracted with vendors. This makes oversight of vendors difficult and does not take advantage of the volume discounts consortia may be able to achieve.

Health Services should reduce the number of entities it must oversee and establish clear regional accountability by eliminating the use of local governmental agencies from MAA. Because current state law allows school districts to use either a consortium or a local governmental agency, Health Services will need to seek a change in the law. Additionally, we recommended that Health Services require school districts that choose to use the services of a private vendor, rather than developing the expertise internally, to use a vendor selected by the consortium through a competitive process. Depending on the varying circumstances within each region, a consortium may choose to use a single vendor or to offer school districts the choice from a limited number of vendors, all of which have been competitively selected. Health Services should seek a statutory change if it believes one is needed to implement this recommendation.

Health Services' Action: None.

Health Services is continuing to review this issue. However, it states that regulations specifically allow school districts the option of claiming through either their consortia or their local governmental agency to afford maximum flexibility at the local level. Further, Health Services does not believe its authority can be extended to school districts' selection of vendors to support operations although it states that it continues to agree with the merits of this recommendation. Health Services continues to support maximum flexibility at the local level in order to appropriately manage MAA and select viable vendors based on regional variances.

However, we continue to believe that simplifying the MAA structure to make the program more efficient is important, and thus, Health Services should implement the recommendations. Further, Health Services should seek a statutory change if it believes one is needed to implement the recommendation regarding vendor selection.

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.

DEPARTMENT OF HEALTH SERVICES

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

INVESTIGATION I2003-1067 (REPORT I2005-1), MARCH 2005

Department of Health Services' response as of November 2005

Investigative Highlights . . .

An employee with the Department of Health Services:

- ☑ *Falsely indicated on at least 22 occasions that she was working in order to receive $1,894 in wages and overtime she was not entitled to receive.*
- ☑ *Claimed and was paid $1,173 for expenses related to her travel that she either did not incur or was not entitled to receive.*

We investigated and substantiated an allegation that an employee of the Department of Health Services (Health Services) submitted false travel and attendance reports.

Finding: The employee submitted false travel and attendance reports in order to receive wages and travel expenses she was not entitled to receive.

The employee, whose duties require her to travel regularly throughout the State to monitor and provide training to retail businesses, improperly received $3,067 by submitting false claims for wages and travel costs. We determined that, by misrepresenting her departure and return times on her travel and attendance reports, the employee was paid $1,894 for overtime and regular hours she did not work. We also found that the employee claimed and was paid $1,173 for expenses related to her travel that she either did not incur or was not entitled to receive. Specifically, the employee claimed $253 for parking expenses that she acknowledged to us she did not incur. The employee also improperly claimed $151 in mileage reimbursements by routinely overstating the distance to and from the airport when conducting state business. Because the employee presented false information on her travel claims, she also received $259 for meal expenses that she was not entitled to receive. Finally, the employee improperly received $510 for travel expenses that she claimed on days she did not work or that otherwise were not allowed.

Health Services' Action: Pending.

Health Services provided training to all its supervisors in the employee's branch so they can better understand their responsibilities for reviewing travel claims and overtime requests submitted by those under their supervision. Those working in the employee's branch will also begin using the State's automated travel claim processing system (system). Because the business rules for travel are programmed into the system, Health Services believes the submission of improper travel claims will be reduced. Finally, Health Services has prepared a recommendation for disciplinary action for the employee and the recommendation is currently under review by Health Services' staff.

EMERGENCY PREPAREDNESS

More Needs to Be Done to Improve California's Preparedness for Responding to Infectious Disease Emergencies

REPORT NUMBER 2004-133, AUGUST 2005

Audit Highlights . . .

Our review of California's preparedness for responding to an infectious disease emergency revealed the following:

- ☑ ***The Emergency Medical Services Authority has not updated two critical plans: the Disaster Medical Response Plan, last issued in 1992, and the Medical Mutual Aid Plan, last issued in 1974.***
- ☑ ***The Department of Health Services (Health Services) does not have a tracking process for following up on recommendations identified in postexercise evaluations, known as after-action reports.***
- ☑ ***Although Health Services has completed 12 of 14 critical benchmarks it was required to complete by June 2004 for one cooperative agreement, we cannot conclude it completed the other two. In addition, Health Services has been slow in spending the funds for another cooperative agreement.***

continued on next page . . .

Department of Health Services, Emergency Medical Services Authority, and five local public health department's responses as of November 2005[1]

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the State's preparedness to respond to an infectious disease emergency requiring a coordinated response between federal agencies, the Department of Health Services (Health Services), local health agencies, and local infectious disease laboratories. Specifically, the audit committee requested that we (1) evaluate whether Health Services' policies and procedures include clear lines of authority, responsibility, and communication between levels of government for activities such as testing, authorizing vaccinations, and quarantine measures; (2) determine whether Health Services has developed an emergency plan; (3) determine whether California's infectious disease laboratories are integrated appropriately into statewide preparedness planning for infectious disease emergencies; (4) determine if the management practices and resources, including equipment and personnel, at the state health laboratories are sufficient to respond to a public health emergency; and (5) review Health Services' standards for providing oversight to local infectious disease laboratories, and determine whether its oversight practices achieved their intended results.

The audit committee further requested that we evaluate whether a sample of local infectious disease laboratories are operated and managed effectively and efficiently and have the necessary resources to respond to an emergency, including sufficient equipment and personnel with the appropriate level

[1] The five local public health departments are: County of Los Angeles, Department of Health Services (Los Angeles); Sacramento County Department of Health and Human Services, Division of Public Health (Sacramento); County of San Bernardino, Department of Public Health (San Bernardino); Santa Clara County, Public Health Department (Santa Clara); Sutter County, Human Services Department (Sutter).

☑ ***None of the five local public health departments we visited have written procedures for following up on recommendations identified in after-action reports.***

☑ ***None of the five local public health departments we visited had fully completed the critical benchmarks for a cooperative agreement by the June 2004 deadline.***

of experience and training. We also were asked to review the local laboratories' testing procedures for infectious diseases and determine if they meet applicable standards.

Finding #1: The Emergency Medical Services Authority needs to update two critical plans.

The Emergency Medical Services Authority (Medical Services) has not updated two emergency plans: the *Disaster Medical Response Plan* and the *Medical Mutual Aid Plan*, the latest versions of which are dated 1992 and 1974, respectively. The state emergency plan, issued in 1998, mentions both plans and describes them as "under development." The state emergency plan indicates that state entities would use the two plans to help respond to emergencies caused by factors that include epidemics, infestation, disease, and terrorist acts, therefore, we believe the two plans are critical for California's successful response to infectious disease emergencies. Medical Services agrees that the plans must be updated to ensure that they reflect the State's current policies and account for any changes in roles or responsibilities since they originally were issued. According to the chief of the Medical Services' Disaster Medical Services Division, these plans have not been updated because Medical Services lacks resources and has competing priorities.

We recommended that Medical Services update the *Disaster Medical Response Plan* and the *Medical Mutual Aid Plan* as soon as resources and priorities allow.

Medical Services' Action: Pending.

Medical Services indicated that it is working to update the Disaster Medical Response Plan that will provide a concept of operations for all-hazard response and define the roles and responsibilities of public and private agencies as part of the Standardized Emergency Management System. Medical Services stated that it plans to include a Medical Mutual Aid annex that will address the resource management process to identify, acquire, deploy, and support medical personnel, supplies, equipment, and casualty evacuation systems. According to Medical Services, a draft plan will be available in approximately 90 days and an interim plan will be available by the summer of 2006.

Finding #2: Health Services does not have a tracking method to ensure that it benefits from the lessons it learned.

Health Services could improve its ability to learn from its experiences by developing and implementing a tracking process for following up on the recommendations made in its postexercise evaluations, known as after-action reports. According to guidelines set forth by the U.S. Department of Homeland Security's Office for Domestic Preparedness, after-action reports are tools for providing feedback, and entities should establish a tracking process to ensure that improvements recommended in after-action reports are made. Similarly, the National Fire Protection Association also suggests in its Standard on Disaster/Emergency Management and Business Continuity Programs (2004 edition) that exercise participants establish procedures to ensure that they take corrective action on any deficiency identified in the evaluation process, such as revisions to relevant program plans. An exercise allows the participating entities to become familiar, in a nonemergency setting, with the procedures, facilities, and systems they have for an actual emergency. The resulting after-action reports give these entities an opportunity to identify problems and successes that occurred during the exercise, to take corrective actions, such as revising emergency plans and procedures, and thus benefit from lessons learned from the exercise. Therefore, we believe that tracking the implementation status is a sound practice to ensure that state entities address all relevant recommendations in after-action reports, which can then serve as important tools for increasing overall preparedness levels.

In response to our concerns that Health Services lacked a written policy and procedures for following up on recommendations identified in after-action reports for exercises, the deputy director for public health emergency preparedness provided us on July 14, 2005, with the recently developed policy and procedures. However, our review of the policy found that it does not include a standard format for tracking the implementation of recommendations, such as assigning an individual the responsibility for taking action, the current status of recommendations, and the expected date of completion. Therefore, Health Services still needs to refine its policy further by developing and implementing written tracking procedures to ensure it addresses all relevant recommendations that it identifies in after-action reports. Without a tracking method, Health Services cannot be certain that it takes appropriate and consistent corrective action, such as revising emergency plans, and thus reduces its potential effectiveness to respond to infectious disease emergencies.

We recommended that Health Services develop and implement a tracking method for following up on recommendations identified in after-action reports.

Health Services' Action: Corrective action taken.

Health Services developed and implemented a policy on after-action reporting in response to our draft report in July 2005. This policy and the associated procedures provide a specific tool for tracking recommendations identified in after-action reports.

Finding #3: We cannot conclude that Health Services completed a critical benchmark requiring it to assess its preparedness to respond to infectious disease emergencies.

In the aftermath of the terrorist attacks in September 2001, and the anthrax attacks later that year, two federal agencies—the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA)—offered cooperative agreements to states, local jurisdictions, and hospitals and other health care entities. The cooperative agreements are intended to provide increased funding to improve the nation's preparedness for bioterrorist attacks and other types of emergencies, including those caused by infectious diseases. However, despite making progress toward completing many of the critical benchmarks established in the CDC cooperative agreement with a June 2004 deadline, we cannot conclude as of our review that Health Services completed critical benchmark number 3, which requires the State to assess its emergency preparedness and response capabilities related to bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies with a view to facilitating planning and setting implementation priorities. Therefore, California may not be as prepared as it could be to respond to infectious disease emergencies.

According to its deputy director for public health emergency preparedness (Health Services' deputy director), Health Services prepared an assessment as did all local health departments. She also stated that some staff documented parts of their assessment and that Health Services' application for CDC funding in 2004 included references to the assessments. However, she also acknowledged that Health Services did not prepare a single written summary of the assessment it prepared and the assessments prepared by local health departments. Without such a summary and without complete documentation of the assessments, Health Services has not demonstrated to our satisfaction that it has fully completed critical benchmark number 3. Health Services' deputy director also told us that to obtain a more current assessment, Health Services has entered into a contract with the Health Officers' Association of California (HOAC) to be conducted from mid-2005 through December 2006.

We recommended that Health Services should ensure that the contractor performing the current capacity assessment provides a written report that summarizes the results of its data gathering and analyses and contains applicable findings and recommendations.

Health Services' Action: Pending.

Health Services stated that it has contracted with HOAC for an assessment of public health emergency preparedness in 61 local health departments. Health Services indicated that these assessments are to be completed by December 2006 and it is requiring HOAC to provide written reports that summarize the results of the analyses and contain applicable findings and recommendations for improvements.

Finding #4: Local public health departments could do more to address after-action reports.

Local emergency plans, such as the counties' overall emergency operation plans and local public health departments' (local health department) emergency operations and response plans, generally included sufficient guidance for emergency preparedness; however, the plans did not include specific procedures for following up on recommendations identified in after-action reports. When we asked officials of the local health departments, they agreed with our assessment and confirmed that they did not have written procedures for following up on recommendations in after-action reports although Los Angeles County has developed a draft policy.

Moreover, the California Code of Regulations requires state entities to complete after-action reports for declared emergencies within 90 days of the close of the incident. There is no requirement for preparing after-action reports for an exercise or drill as there is for a declared emergency, but we believe that promptly writing after-action reports for exercises is prudent and equally relevant. Waiting longer than 90 days to complete the reports might make it more difficult for the individuals involved in the exercise to recall specific details accurately. Therefore, we expected all participants in the November 2004 exercise hosted by Medical Services to have prepared after-action reports within 90 days to identify any weaknesses in plans and procedures and to take appropriate corrective actions. However, as of July 2005, the after-action report from Los Angeles County's health department was still in draft stage, which is approximately seven months after the exercise. According to the executive director of the county's Bioterrorism Preparedness Program (executive director), the Los Angeles County health department had not yet implemented all the recommendations identified. The executive director stated that it experienced delays in drafting its after-action report because the individuals who participated in the exercise were inexperienced with the formalized after-action report process and completing the surveys and observations needed. She further stated that several drafts were reviewed and resubmitted by its management. However, because the Los Angeles County health department did not complete its after-action report promptly, it did not address all the recommendations as quickly as it could have. Consequently, it is not as prepared as it could be to respond to infectious disease emergencies.

We recommended that local health departments establish written procedures for following up on recommendations identified in after-action reports and that they prepare after-action reports within 90 days of an exercise.

Local Public Health Departments' Actions: Partial corrective action taken.

Generally, four of the five local health departments we visited indicated that they have developed written procedures for following up on recommendations identified in after-action reports and for preparing after-action reports within 90 days of an exercise. Further, in its July 2005 response to our draft report, the fifth public health department—Sutter County—agreed that it did not have a written plan in place to assure the deficiencies reported in after-action reports were mitigated properly and it also indicated that it planned to correct this. However, Sutter County has not provided us with a more recent update indicating whether it has done so.

Finding #5: Not all local public health departments have met the deadline to implement several federal benchmarks.

None of the local health departments we visited had met all 14 of the CDC 2002 critical benchmarks by the required deadline of June 2004. Specifically, Los Angeles and Sacramento counties health departments did not meet the June 2004 deadline, but they report that they have since completed the benchmarks. Further, Sutter and Santa Clara counties did not meet one of the 14 2002 critical benchmarks as of June 2005, and San Bernardino County did not meet three. The purpose of the CDC cooperative agreement is, in part, to upgrade local health departments' preparedness for and response to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. Therefore, by not meeting the critical benchmarks, these jurisdictions may not be as prepared as possible to respond to an infectious disease emergency.

We recommended that local health departments complete the critical benchmarks set by the CDC cooperative agreement as soon as possible.

Local Public Health Departments' Actions: Partial corrective action taken.

As we state above, Los Angeles and Sacramento counties health departments reported that they had completed the critical benchmarks. Additionally, Santa Clara now reports that it has completed its last benchmark while San Bernardino reports completing two of three outstanding benchmarks. Finally, although in its July 2005 response to our draft report, Sutter County indicated that it is working to complete critical benchmarks, it has not provided us with a more recent update.

DEPARTMENT OF HEALTH SERVICES

Investigations of Improper Activities by State Employees, January 2004 Through June 2005

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

Department of Health Services' response as of October 2005

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

Investigative Highlight . . .

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

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

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

Health Services' Action: Corrective action taken.

Health Services reported that it served the manager with a formal reprimand and required her to reimburse the State $11,040, which represents her personal use of state vehicles and the misuse of state vehicles she authorized for her subordinates. Health Services reduced another manager's pay by 5 percent for two months and required her to reimburse the State $1,466 for her personal use of state vehicles. Finally, Health Services required three other employees to pay a total of $582 for their misuse of state vehicles.

DEPARTMENT OF HEALTH SERVICES

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2003-124, AUGUST 2004

Department of Health Services and Los Angeles County's responses as of August 2005

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

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

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

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

☑ *Lacking federal approval, the department allows Medi-Cal to pay MTP claims without requiring that other health care insurers, if any, pay first.*

☑ *Limits on the number of times Medi-Cal will pay for certain therapy procedures are a barrier to obtaining Medi-Cal reimbursement for MTP services and may be overly restrictive for children in the MTP.*

☑ *Except for Los Angeles, the counties we visited took reasonable steps to follow up on and correct MTP claims denied for Medi-Cal payment.*

☑ *The department identified approximately $24,000 in MTP claims for fiscal year 2003–04 that are covered by the Healthy Families Program, calling into question whether this program will significantly reduce MTP costs in the future.*

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

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

Department's Action: None.

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

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

The department agreed to refine the methodology for calculating the reimbursement for individual counties for mandated work resulting from AB 3632 interagency regulations. The department issued a policy letter on May 20, 2005, revising its prior instructions to counties. In this letter, the department requires counties to annually report data on the number of children receiving both MTP and special education services. Based on this information, the department calculates the number of state funded FTEs for the year. Although this new information on caseload is useful, the department's new procedures do not require counties to report information on the actual costs associated with these activities. Without information on the time spent by county staff on these liaison and coordination activities, the department cannot know whether the amounts it is paying are reasonable.

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

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

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

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

Department's Action: Corrective action taken.

On June 3, 2005, the department issued a policy letter informing county California Children's Services (CCS) programs that the department would revert to its previous methodology for sharing Medi-Cal reimbursements to the MTP between the State and the counties. In accordance with our recommendation, the new policy calls for the department to reduce the State's MTP costs by the entire General Fund portion and one-half of the federal portion of Medi-Cal payments made for MTP services.

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

Until fiscal year 2003–04, the department did not have a reliable process to collect information on the Medi-Cal payments that COHS agencies make for MTP services. As previously discussed, the department needs this information when it calculates quarterly reimbursements to counties so it can accurately reduce the State's share of MTP costs based on any Medi-Cal payments the counties receive. Because it did not gather all the information related to Medi-Cal payments made by COHS agencies, the department did not reduce the State's MTP costs by a total of approximately $733,000

over the four-year reporting period ending in fiscal year 2002–03, based on data four counties reported to us. The department's failure to obtain complete data on Medi-Cal payments made by COHS agencies for MTP services was particularly detrimental because the department did not reduce the State's costs for any portion of these Medi-Cal payments.

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

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

Department's Action: Corrective action taken.

The department indicated that it has issued an instruction letter to each county using a COHS agency, directing them to report these COHS payments on their quarterly expenditure reports to the department.

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

Federal law and state Medi-Cal regulations require that if an individual eligible for Medi-Cal has other health care coverage, such as Medicare or private insurance, providers must bill the other health care insurers before billing Medi-Cal. According to the department, the Medi-Cal claims-processing system is designed to ensure that Medi-Cal is the payer of last resort. However, in March 2004, the department implemented a modification to its Medi-Cal claims-processing system, allowing MTP claims for services to children with other health care coverage to be paid without attempting to bill the other health care insurers first.

The department explained its implementation of this modification based on its interpretation of other federal and state laws. In particular, the department asserts that according to the federal Individuals with Disabilities Education Act, children in special education with therapy identified as a component of an individualized education program are entitled to a "free and appropriate" education. According to

the department, billing the child's other health care insurer could result in the family incurring a cost for the therapy, such as a deductible or copayment charged by a private insurance company. Further, state law provides that children receiving MTP services in public schools are exempt from financial eligibility standards and are not required to pay enrollment fees. The department has interpreted these laws to mean that the MTP is a free program and other health care insurers should not be billed for MTP services because of the possible financial burden to the families.

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

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

Department's Action: None.

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

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

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

EDS denied more than 42,500 MTP claims, or 6 percent of MTP claims denied for Medi-Cal payment in the period we reviewed, because the number of therapy services provided exceeded that allowed by the Medi-Cal claims-processing system. State regulations limit how frequently Medi-Cal will pay for some therapy services. However, the department admits that some of the current frequency limits may not be appropriate for the MTP. Generally, counties echo this sentiment, contending that the chronic nature of the medical conditions treated in the MTP necessitate more frequent therapy sessions. Our visits to the counties confirmed that many children in the MTP receive therapy procedures more often than the Medi-Cal claims-processing system permits. Based on data provided by EDS, approximately $280,000 to $1.5 million in Medi-Cal claims were denied due to frequency limits from July 2002 through March 2004. When Medi-Cal does not pay claims for MTP services, the State and counties must pay more for the program because they lose the federal funding available under Medi-Cal.

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

Department's Action: Pending.

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

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

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

to resubmit individual denied MTP claims because the county did not have the required knowledgeable staff to follow up on the claims. In addition, the director told us that the county is currently considering the cost-effectiveness of reviewing and resubmitting denied claims.

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

Los Angeles County's Action: Corrective action taken.

Los Angeles County agreed with our recommendation and has assessed the cost-effectiveness of resubmitting previously denied claims that are deemed correctable. Los Angeles County indicates that the electronic resubmission of denied Medi-Cal claims provides additional net revenue to the county and is cost-effective. Therefore, the county will resubmit corrected versions of previously denied claims on an ongoing basis following each quarterly billing cycle.

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

Audit Highlights . . .

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

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

continued on next page . . .

REPORT NUMBER 2002-018, APRIL 2004

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

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'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 MENTAL HEALTH

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

REPORT NUMBER 2003-114, JULY 2004

Department of Mental Health response as of July 2005

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

In March 2005 the Department of Health Services (Health Services) revised state regulations for acute psychiatric facilities that will facilitate the department's efforts to allow psychologists to more fully participate in the treatment of patients as either attending or co-attending clinicians. In addition, the department continues to work with Health Services and employee representatives at the department's four hospitals to revise the special order that defines the duties and responsibilities of hospital medical staff, including psychologists. The department expects to approve the revised special order in the near future.

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

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

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

Department's Action: Partial corrective action taken.

The department issued in September 2004 a special order that directed its hospitals to conduct reviews and modify, to the extent possible, the membership of their medical executive, credentials, and, if possible, bylaws committees to more closely reflect the composition of their medical staffs. In June 2005 the medical staff at one of the department's four hospitals voted to approve amendments to its medical staff bylaws to require the medical executive committee to reflect, as appropriate, the overall membership of the medical staff. The department expects the three other hospitals to modify medical staff bylaws within the next few months. In addition, the department reported that its hospitals have made progress in modifying the membership of the committees to more closely reflect the composition of their medical staffs.