Implementation of State Auditor's Recommendations

Audits Released in January 2007 Through December 2008

Special Report to
Senate Budget and Fiscal Review Subcommittee #3—Health and Human Services, and Labor

February 2009 Report 2009-406 S3

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February 24, 2009 2009-406 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, and Labor. 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. To facilitate the use of the report we have included a table that summarizes the status of each agency's implementation efforts based on its most recent response.

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 an appendix that identifies monetary benefits that auditees could realize if they implemented our recommendations, and is available on our Web site at www.bsa.ca.gov. Finally, we notify auditees of the release of these special reports.

Our audit efforts bring the greatest returns when the auditee acts upon our findings and recommendations. This report is one vehicle to ensure that the State's policy makers and managers are aware of the status of corrective action agencies and departments report they have taken. Further, we believe the State's budget process is a good opportunity for the Legislature to explore these issues and, to the extent necessary, reinforce the need for corrective action.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Introduction

This report summarizes the major findings and recommendations from audit reports we issued from January 2007 through December 2008, that relate to agencies and departments under the purview of the Senate Budget and Fiscal Review Subcommittee No. 3—Health and Human Services, and Labor. 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 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 the auditee provides a written response to the audit findings and recommendations before the audit report is initially issued publicly. As a follow-up, state law requires 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 to provide a response beyond one year or we may 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 2009. The table below summarizes the number of recommendations along with the status of each agency's implementation efforts based on its most recent response related to audit reports the office issued from January 2007 through December 2008.

		FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				
	INITIAL RESPONSE	60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	PAGE NUMBERS
Health and Human Services, and Labor									
California Institute for Regenerative Medicine									
Stem Cell Report 2006-108				●	7	4	0	1	3
Department of Health Care Services									
Skilled Nursing Facilities Report 2006-035				●	0	5	0	1	13
Investigations Report I2007-1 [I2006-0731]			●		0	1	0	0	19
Medi-Cal Providers Report 2006-110				●	4	1	0	0	21
Investigations Report I2007-2 [I2006-1012]				●	2	0	0	0	27
Durable Medical Equipment 2007-122			●		1	1	0	1	29
Department of Mental Health-Coalinga									
Investigations Report I2007-2 [I2006-1099]				●	1	0	0	0	33
Department of Public Health									
Yountville Veterans Home Report 2007-121	●				1	0	0	0	35
Low-Level Radioactive Waste Report 2007-114			●		0	5	1	0	43
Clinical Laboratories Report 2007-040		●			0	9	0	0	49
Licensing and Certification Report 2006-106				●	4	2	2	0	57
Department of Social Services									
Investigations Report I2008-1 [I2006-1040]		●			0	1	0	0	65
Sex Offender Placement Report 2007-115			●		1	0	0	0	67
Safely Surrendered Baby Report 2007-124			●		0	1	5	0	71

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California Institute for Regenerative Medicine

It Has a Strategic Plan, but It Needs to Finish Developing Grant-Related Policies and Continue Strengthening Management Controls to Ensure Policy Compliance and Cost Containment

REPORT NUMBER 2006-108, FEBRUARY 2007

California Institute for Regenerative Medicine's response as of February 2008

In 2004 voters approved the California Stem Cell research and Cures Act (act), which authorized the issuance of $3 billion in bonds over 10 years to fund a stem cell research program and dedicated research facilities in California. The act established the California Institute for Regenerative Medicine (institute) as a state agency with the purpose of funding stem cell research activities. The goal of the research is to realize therapies, protocols, and medical procedures that, as soon as possible, will lead to curing or substantially mitigating diseases and injuries. To oversee the institute's operations, the act established the Independent Citizens Oversight Committee (committee).

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the implementation of the act and the performance of the institute and the committee to the extent that the program is operating. The audit committee asked us to review and evaluate the strategic plan and related policies developed by the institute and the committee. In addition, the audit committee asked us to review and evaluate certain institute policies and procedures and related management controls to determine whether they are necessary and designed to carry out the intent of the act as well as other applicable laws and regulations, and to review the internal oversight structure of the institute and the committee.

Finding #1: The institute has developed a detailed strategic plan but lacks a process to use annual grantee data as a strategic monitoring tool.

During its December 2006 meeting, the committee adopted the institute's strategic plan. The plan outlines the goals and objectives in spending $3 billion in general obligation bonds authorized by the act and provides a strategy that strives to meet its purpose and intent. Our review revealed that the institute's strategic plan contains essential elements, including a mission statement and goals to achieve the mission. Many of the institute's goals depend on scientific discovery, creating the challenge of ensuring that they are achievable. However, the goals outlined in the strategic plan are specific in nature and were adopted unanimously by the committee. Our review also concluded that the institute's strategic plan clearly identifies its approach to achieving the scientific goals through an action plan for the first 1,000 days, as well as performance mechanisms and milestones to ensure accountability, assess performance, and gauge scientific progress at years three and seven of the 10-year strategic plan.

Audit Highlights . . .

Our review of the California Institute for Regenerative Medicine (institute) revealed the following:

- *The institute identified long-term research priorities and considered the industry's best practices to create its strategic plan, but it has yet to implement a process to assess annual progress toward attaining its strategic goals.*
- *A task force formulated draft policies for revenue sharing through a public deliberative process but, because of a lack of documentation, we could not independently evaluate any analyses of the information on which the task force members based their revenue-sharing policies.*
- *Although it has a grants administration policy for academic and nonprofit institutions, the institute is still developing a for-profit policy and is still implementing a monitoring process to ensure that grantees comply with the terms of their grants.*
- *The institute's recent policy revisions addressed our contracting concerns, but not all of our travel reimbursement concerns.*
- *The salary survey conducted by the institute and the compilation of the salary data collected contained enough errors, omissions, and inconsistencies that the institute cannot ensure that the salaries for certain positions comply with the requirements of the law.*

However, the institute has not yet developed and implemented the process to accumulate the annual grant-specific data it plans to use to gauge its progress in meeting strategic goals. The institute's plan indicates that one source of data that performance assessment will rely on are the grantee reports of their progress in meeting the purpose of their respective grants. Institute grantees have annual financial and programmatic reporting requirements specified in the interim grants administration policy they are to follow. However, as of December 2006 the institute had no mechanism to track management information to assess yearly progress toward its strategic goals, and its staff informed us that they are developing such a mechanism to be part of a planned integrated information technology system. The system would allow the institute to pull data from the annual progress reports submitted by grantees, which already are required by the grants administration policy, thereby enabling the institute to monitor various types of information, including progress toward strategic goals and initiatives. The institute also stated it is determining what information grantees must submit with their annual progress reports.

We recommended that the institute fulfill its plans to develop a process to track management information reported annually by grantees, thereby providing accountability and enabling it to assess annual progress in meeting its strategic goals and initiatives.

Institute's Action: Partial corrective action taken.

The institute states that it has implemented three processes for tracking information to assess progress: a comprehensive grants management system, annual progress reporting requirements that will be incorporated into that system, and annual meetings for institute grantees. As part of its bidding process to select a vendor to develop a grants management system, the institute defined its functional requirements, including the tracking and reporting of information. The committee awarded the contract in October 2007, and, as of February 2008, the institute was negotiating the precise terms of the contract. Additionally, the institute envisions the progress reporting requirements it established as part of its grants administration policy to be a crucial part of its management reporting system and grants management system. Further, in September 2007 the institute held its first annual meetings for the recipients of the first institute grants and the only grantees who have had funding for a full year.

Finding #2: The committee has not completed provisions of its intellectual property policies regarding discounted prices and access to therapies.

The committee's intellectual property policy for nonprofit organizations requires that grantees award exclusive licenses involving institute-funded therapies and diagnostics only to entities that agree to have a plan to provide access to those therapies and diagnostics for uninsured Californians. However, the policy does not define what is meant by access. The committee could not agree on the language to refine this provision, but because the committee did not want to delay implementing its regulations regarding intellectual property developed for grants to nonprofit organizations, it took no action to amend the policy and regulations.

In addition, the for-profit policy requires every grantee to develop a plan to provide uninsured Californians with access to therapies that result from institute-funded research. However, as with the nonprofit policy, the for-profit policy does not define its expectation for access. According to the transcripts of the December 2006 committee meeting, the task force established by the committee to create the policies deliberately did not include specific requirements for an access plan. According to the vice chair, it is difficult to specify what should be in a plan for access to future products. As such, the task force believes that most companies working in areas of great concern to public health do end up with plans for access, and that those plans differ from one company to the next. Without a clear definition or expectation of access, however, grantee organizations will be left to apply their own interpretations.

Further, the intellectual property policies for nonprofit entities and for-profit entities do not describe how prices will be discounted for therapies that result from institute-funded research. During the December 2006 committee meeting, the vice chair explained that the task force had difficulty finding

practical benchmarks for the lowest available prices. He further stated that the portions of the policies for both nonprofit entities and for-profit entities that address discounted prices for therapies are works in progress. The committee agreed that once a practical benchmark is identified, it will apply the benchmark as a standard for discounted prices for therapies resulting from institute-funded research to the policies for both nonprofit and for-profit organizations.

We recommended that the committee ensure that it follows through with its plan to identify the appropriate standard for providing uninsured Californians access to therapies developed using institute funds and to convey clearly to grantees its expectations for providing access in its intellectual property policies. In addition, the committee should identify practical benchmarks to use as a standard for discount prices for therapies and apply the standard to its policies for grants to nonprofit and for-profit organizations.

Institute's Action: Partial corrective action taken.

In July 2007 the institute's intellectual property policies for nonprofit organizations became final and were codified as regulations. As of February 2008 the committee had adopted the final regulations for the intellectual property policies for for-profit organizations and the regulations were awaiting final approval by the Office of the Administrative Law. The institute notes that the for-profit regulations include similar, but more specific requirements for access and discount pricing than do the nonprofit regulations. The for-profit regulations reflect a three-pronged policy with respect to access and policy. First, at the time of commercialization, they require grantees to develop and provide a plan for access by uninsured Californians. Second, the regulations require that institute-funded therapies be available according to California Discount Prescription Drug Program benchmarks to institutions. Third, the regulations anticipate state efforts to offer a discount prescription drug program to underinsured Californians and require grantees to participate in this type of program. Once the for-profit regulations have been approved by the Office of the Administrative Law, the institute intends to propose to the committee modifications to the nonprofit regulations where appropriate to harmonize them with the more specific requirements contained in the for-profit regulations.

Finding #3: A provision of the institute's intellectual property policy allowing researchers access to institute-funded inventions warrants further attention.

The intellectual property policy for nonprofits initially included a research use exemption (research exemption) provision that sought to ensure that patented inventions made in the performance of institute-funded research be made freely available for research purposes in California research institutions. The provision was eliminated from the nonprofit policy in the July 2006 meeting of the task force after some members expressed concern over industry opposition to the research exemption provision. The committee's vice chair stated at the meeting that industry representatives expressed concerns that a research exemption might decrease investment if they could not take patented inventions under license from universities and exploit those patents to make them profitable.

In the August 2006 task force meeting, a modified research exemption was reintroduced for consideration in the nonprofit policy after new information from universities expressed that not having a research exemption had been a problem. However, the new language of the research exemption still received considerable objection from industry representatives. As a consequence, the task force agreed on compromise language. The compromise language states that in licensing institute-funded patented inventions, a grantee organization agrees that it shall retain the rights to institute-funded patented inventions for its noncommercial purposes and agrees to make such inventions readily available on reasonable terms to other grantee organizations for noncommercial purposes. Although concerns were raised over whether including the phrase "reasonable terms" was good regulatory language and over who would decide what are reasonable terms, the task force adopted the language. Although the effect of the language on advancing stem cell research is not yet known, we believe that this area warrants continued monitoring by the committee.

We recommended that the committee monitor the effectiveness of its policy to make institute-funded patented inventions readily accessible on reasonable terms to other grantee organizations for noncommercial purposes to ensure that it does not inhibit the advance of stem cell research.

Institute's Action: Corrective action taken.

The institute points to recently-adopted regulations that are intended to promote rapid advancement of the field. These regulations generally require institute grantees to give other researchers access to biomedical materials discussed in published research, at no more than cost, for research purposes. The institute reports that it monitors compliance with these regulations by requiring grantees to submit annual progress reports that identify publications and licensed patented inventions, as well as any requests for access by other scientists for noncommercial research purposes.

Finding #4: The institute is still developing a policy for administering grants to for-profit entities.

Although the committee has adopted a policy to review applications for and administer research grants to nonprofit entities, it has not yet adopted a similar policy regarding for-profit entities. According to the institute's director of scientific activities, the nonprofit policy was created before the for-profit one because the institute anticipates that most of the fundamental research will be conducted by nonprofit organizations and because it believes that information on grants administration policy is more readily available for nonprofit entities than for profit-making organizations. In addition, the grants review working group and the institute intend to use the nonprofit grants administration policy as a template for the for-profit policy. According to the director of scientific activities, as of early January 2007, the institute was at the early stages of developing the for-profit policy and was therefore unable to predict how long the process would take.

We recommended that the institute complete the development of its grants administration policy targeted toward for-profit organizations.

Institute's Action: Corrective action taken.

The committee adopted a grants administration policy targeted toward for-profit organizations in December 2007. As a result of the adoption of the policy, the institute opened its funding request process to for-profit organizations.

Finding #5: The grants review working group substantially followed its policy when it reviewed training grants, but it lacked voting records.

Our review of the institute's available records indicated that the institute, its grants review working group, and the committee substantially followed the grants review and award processes during the review and award of training grants. However, we found that the institute did not maintain records of the grants review working group's votes on grant applications. As a result, we could not conclude that the grants review working group complied fully with the nonprofit grants administration policy. After we shared our concerns with the institute, it developed new procedures designed to ensure that every voting action is recorded. As of December 2006 the only grants the institute had awarded were training grants, which are designed to help pay the costs of the stem cell research activities of pre- and postdoctorate students and clinical fellows in California's universities and nonprofit academic and research institutions.

To provide increased accountability over the grants award process, we recommended that the institute ensure that the grants review working group follows the new procedures to record its votes to recommend funding for stem cell research grants, and that it maintains those records.

Institute's Action: Corrective action taken.

In 2006 the institute developed new procedures designed to ensure every voting action is recorded. Shortly after, it implemented those procedures during its grants working group meetings held during November 28 through November 30, 2006, and January 8 through January 10, 2007. The institute now retains these records as part of its documentation of the grant award process.

Finding #6: The institute is developing procedures to ensure that grantees comply with the terms of the awards.

Although the committee has approved a policy for administering nonprofit grants, the institute still is developing procedures to monitor grantees' compliance with the terms of the grants. For example, the act requires the grants review working group to conduct oversight reviews of grantees and to recommend standards to the committee to ensure that grantees comply with the terms of awards. Although the grants review working group and the institute, through the nonprofit grants administration policy, developed these standards, the institute has not yet implemented a strategy to conduct the reviews.

The institute intends to conduct reviews of grantees through annual financial and programmatic reports mandated by the nonprofit grant administration policy. Failure to submit the reports promptly may result in the reduction, delay, or suspension of a grant award. However, as of December 2006 the institute had not completed the format of the financial and programmatic reports.

In addition, the institute reserves the right to conduct audits, but it has not yet established systematic audit procedures because it still is implementing the grants monitoring process, of which the audit procedures will be a part. In addition, the institute has not yet fully assembled a team to administer the financial aspect of the grants. As of early December 2006 the institute still had substantial work to do in developing procedures pertaining to the grants monitoring process, and the director of scientific activities did not know when these procedures would be complete. However, until the institute and the working group put in place the procedures and team members to monitor grantees' compliance with the terms of the grants, the institute runs the risk that grant funds will not be used for their intended purpose.

To monitor the performance of grantees effectively, we recommended that the institute complete the implementation of a grants monitoring process, including audits, and the development of related procedures.

Institute's Action: Partial corrective action taken.

The institute reports that, as part of the grants monitoring process, it conducts a complete administrative review before releasing funds for grant awards. The institute anticipates that the new grants management system will allow the institute to track grantees to make sure that they have certified compliance with ethical review and notification requirements for funded research. The institute also states that it has designed an audit process with spot checks to ensure that grantees comply with required medical and ethical standards. A similar audit process is being designed for financial compliance and is expected to be in place by summer 2008.

Finding #7: The Fair Political Practices Commission has questioned the exclusion of the working groups from the institute's conflict-of-interest code.

The Political Reform Act requires that the institute submit its conflict-of-interest code to the Fair Political Practices Commission (FPPC) for review and approval. The FPPC must review the code to determine if it provides reasonable assurance that all foreseeable conflicts of interest will be disclosed or prevented, all affected persons have clear and specific statements of their duties under the code, and the code differentiates between designated employees with different powers and responsibilities. The

institute submitted its code to the FPPC in July 2005, and after an exchange of correspondence between the FPPC and the institute, the FPPC approved the institute's code in May 2006. Subsequent to FPPC approval, the institute submitted the conflict-of-interest code to the Office of Administrative Law for its review and inclusion in state regulations. The Office of Administrative Law approved the institute's code in September 2006.

However, the FPPC has raised questions about the exclusion of the working groups from the institute's conflict-of-interest code. The FPPC believes that members of working groups, who perform duties such as advising the committee on standards and policy or evaluating grant applications and making award recommendations to the committee, may need to be included in the conflict-of-interest code. Specifically, the FPPC believes that, under state regulations, working group members may act as decision makers if they make substantive recommendations that are, over an extended period, regularly approved without significant amendment or modification by the committee.

In response to the FPPC, the institute stated that members of the working groups are not subject to the pertinent requirements because the language in the institute's act expressly exempts those members from the Political Reform Act, even when the recommendations of a working group are approved over an extended period. Therefore, according to the institute, it is not necessary to engage in ongoing analysis to determine whether, over time, the committee routinely approves the working groups' recommendations.

The FPPC responded that the language of the act is no basis for exempting working group members from fundamental disclosure rules if it becomes apparent that the members' role is more than purely advisory. As such, the FPPC concluded that this issue may need to be revisited in the future.

In view of the seriousness of a violation of the conflict-of-interest laws and the concerns raised by the FPPC, we believe that it would benefit the institute to seek a formal opinion from the attorney general regarding the matter.

We recommended that the institute seek a formal opinion from the attorney general regarding whether the exemptions created for working groups from conflict-of-interest laws are intended to exempt them from the conflict-of-interest provisions that apply if the recommendations of an advisory body are adopted routinely and regularly by the decision-making body to which they are made.

Institute's Action: None.

The institute believes that the concerns raised have been fully resolved by subsequent events and court decisions. It states that the institute now has a record of more than three years of operation and approval of several rounds of grants, in which recommendations of the working groups have never been routinely or regularly adopted. Additionally, the institute reports that it now has an authoritative, binding legal ruling that as a matter of law, the working groups do not exercise decision-making authority. In our audit report we noted that the Superior Court of the county of Alameda in May 2006, based on the evidence presented at trial, concluded that the committee is the "ultimate decision-making body" and not the working group. However, this ruling was not binding as the case was pending appeal. Since then, the Court of Appeal affirmed the decision of the Superior Court, and the decision became binding in May 2007, when the Supreme Court denied review. Our legal counsel agrees with the institute that no further action is needed in light of the resolution of the court case.

Finding #8: The institute had not included in its conflict-of-interest policy provisions for specialists it might enlist to assist in evaluating grant applications.

Although, during our review, the institute implemented some improvements in its conflict-of-interest policies, it had not yet amended its policy for working groups to include specialists it might enlist to assist in evaluating grant applications. The institute recruited 32 out-of-state specialists in November 2006 to assist in reviewing innovation grant applications because it believed that the number

of reviewers, which the act limits to 15, is not large enough for the number of grant applications it received. In the future, the institute intends to use specialists as needed. Specialists are individuals with scientific expertise on a particular issue who do not have a voting privilege and whose presence is not counted toward a quorum. According to the director of scientific activities, they are contacted through teleconference during the review meeting, act as secondary reviewers, and do not score or vote on any application. The institute's process is for specialists to disclose conflicts of interest before the review meeting and file confidential financial disclosure statements. When we made the institute aware that these specialists were not addressed in the conflict-of-interest policy for the grants review working group, it agreed to propose an amendment that it intended to present to the committee at its February 2007 meeting.

We recommended that the institute follow its plans to amend its conflict-of-interest policies to include specialists invited to participate in stem cell research program activities, such as grant application review.

Institute's Action: Corrective action taken.

In March 2007 the committee adopted a change in the conflict-of-interest policy for the grants working group to include specialists.

Finding #9: Institute employees may not have the information they need to comply with the conflict-of-interest policy.

The institute's conflict-of-interest policy prohibits institute employees from having more than $10,000 of financial interests in any organization that is applying for funding with the institute. However, the institute has not developed procedures to inform its employees of the organizations that apply for grants. According to the institute, such notification has not been necessary because, as of December 2006, all grants were awarded to nonprofit institutions, which do not have shareholders or other investors. However, the institute reports that it will advise its employees of the identity of the applicants when it starts issuing requests for applications to for-profit organizations.

To provide employees with the information they need to disclose all potential conflicts of interest, we recommended that the institute develop the necessary procedures to ensure that its employees are aware of the companies that apply for funding.

Institute's Action: Corrective action taken.

The institute points to two processes to ensure that employees are aware of for-profit companies that apply for its funding. One process occurs shortly after potential applicants submit letters of intent. The general counsel reminds employees of the divestiture provisions in the conflict-of-interest policy and notifies employees of the list of for-profit organizations that submitted letters of intent. The second process follows receipt of applications. Employees are to review a list of all entities that have applied for funding, note any conflicts, and sign the result. Employees are then disqualified from participating in the review of applications for which they have identified a conflict.

Finding #10: The institute could improve steps to detect conflicts of interest before meetings of the grants review working group.

The institute's procedures to avoid conflicts of interest in grants review working group activities require it to review the confidential financial interest disclosure statements of noncommittee members of the working group, but not the Statements of Economic Interest of the committee members of the working group. Therefore, the institute could overlook a conflict of interest. After we shared our concern with the institute, it agreed in December 2006 to revise its procedures to require a review of Statements of Economic Interest to identify potential conflicts of interest before each grants review meeting. Our

examination of the Statements of Economic Interest revealed nothing to indicate such a conflict of interest existed during the review of training grants in August 2005—the only grants awarded at the time of our review.

In addition, the institute's incomplete records of the activities related to the meetings of August 2005 to review training grants do not clearly demonstrate its efforts to follow its procedures and ensure that no conflicts of interest existed. The institute compiles a recusal list—a list of members of the grants review working group who should be disqualified from reviewing, scoring, and voting on certain grants with which they have a conflict of interest—based on its study of reviewers' published articles and the disclosures that working group members make before the grants review meetings. We found that data explaining why certain members were added and removed from the recusal list during the review meeting were lost.

The director of scientific activities stated that the institute gathered data, some of which dealt with past collaborations of reviewers, but destroyed it to maintain the confidentiality of the grants review process, as is the practice at the National Institutes of Health—the federal agency on which the institute modeled its conflict-of-interest policies related to reviewing grants. Lacking the necessary data, we were not able to ensure the accuracy of the recusal list the institute used to determine which grants review working group members had to recuse themselves during the review of training grants. This is problematic because we found that the sheets reviewers used to score applications had three unexplained differences from the institute's recusal list, one of which indicates that a reviewer scored an application on which he may have had a conflict of interest. The director of scientific activities believes her personal records of the meetings would show that the reviewer did not have a conflict of interest with respect to the application he scored; however, she has not been able to locate her personal records since the institute moved to its current location in November 2005.

To ensure compliance with its conflict-of-interest policies, we recommended that the institute revise its procedures for reviewing grants to include a review of the Statements of Economic Interest for committee members of the working groups before every grants review meeting. Moreover, we recommended it revise its procedures for grants review meetings to ensure that it retains documentation regarding conflicts of interest of the working groups, including information that it took appropriate recusal actions.

Institute's Action: Corrective action taken.

The institute's current procedures to identify conflicts of interest of members of the grants working group include staff review of their conflict-of-interest disclosures prior to each meeting. The institute further reports that it now documents the recusal actions of each member with respect to each application reviewed to ensure that no one participating in the review of a particular application has a conflict of interest. The institute reports that it maintains these records.

Finding #11: The institute's contracting policy and travel reimbursement policy did not provide adequate controls.

The institute did not establish a contracting policy effectively ensuring that it received appropriate goods and services at reasonable prices. Based on language in the act, legal counsel for the institute concluded that it is governed by all the provisions of the Public Contract Code that affect the University of California (UC). Additionally, it is the institute's intent to model its policies substantially after those of UC. However, much of the institute's policy, including provisions related to hiring consultants, procuring goods and services, and awarding sole source contracts, did not conform to UC policy. As a result, the institute awarded multiple contracts without a competitive-bidding process and did not maintain documents that demonstrated it received reasonable prices on the goods and services it purchased. In response to our concerns about contracting, in December 2006 the institute

revised its procurement policy to mirror the UC policy, thereby addressing our concerns. In addition, the institute has indicated to us that it is developing an internal procedures manual that will have more-detailed requirements for the contractor selection process.

In addition, the institute's travel reimbursement policy did not provide sufficient control over travel expenses. The institute originally adopted the travel reimbursement policy of the Department of Personnel Administration, but then revised the policy several times to conform more closely to the UC policy, but with certain deviations. In general, the revisions allowed travelers greater flexibility and more liberal reimbursements. For example, the institute removed maximum reimbursable amounts for some expenses, such as meals for committee meetings. The revisions also made the policy confusing because they did not use consistent language, and some new provisions did not specify whether they replaced or supplemented existing policies. For instance, the policy contained multiple reimbursement rates for items such as meals but failed to provide clear guidance on when to use each rate. Moreover, the institute reimbursed costs for air travel and meals without sufficient documentation of travel expenses to ensure that its policies were followed.

In response to our concerns over travel reimbursements, the institute revised its travel reimbursement policy in December 2006. However, the revised policy did not address all of our concerns. For example, the institute did not revise the form that working group members use to claim travel reimbursement to include information specific enough to allow institute staff to properly review the claims to ensure reimbursement policies for meals are followed. Moreover, the revised policy specifies that it applies only to institute staff and working group members, not to members of the committee. The committee chair stated that the committee will consider amendments to the travel policy in the upcoming months.

To ensure adequate controls over its contracting and travel reimbursements, we recommended that the institute ensure that it follows its newly revised policies that address some of the concerns raised in our audit. The institute also should amend its travel reimbursement policies further to address the remaining concerns we raised.

Institute's Action: Corrective action taken.

The institute reports that under its policy and practice, employees are not reimbursed for meals at meetings where meals are provided without prior authorization. The institute reports that it monitors the travel claims of staff who attend meetings to ensure that reimbursement is not claimed when the institute provides a meal.

The institute states that as of March 1, 2007, it uses the standard state travel claim form to process claims for all members of working groups. The institute reviews and allows these claims in accordance with the same policy and procedure applicable to institute employees.

At its January 2008 meeting, the committee amended the travel policy previously adopted for institute employees and working group members to apply to committee members. The institute reports that the committee adopted other amendments at the meeting that were designed to align institute policy more closely to that of the University of California regents. The institute adds that deviations from that policy were adopted when the policy did not address the requirements of the institute's mission or did not make sense in the context of the institute's organization.

Finding #12: The institute's salary survey and salary-setting process did not ensure compliance with the act.

The act states that the committee must set compensation for the chair and vice chair of the committee and the president, officers, and staff of the institute within the compensation levels of specified categories of public and private universities and private research institutes in the State. The institute conducted a salary survey that included not only the entities specified in the act but other entities as well in an attempt to ensure that the established salary levels would be in compliance with the act and justifiable to public inquiries.

We noted that the committee and the institute thoughtfully considered the originally approved salary schedules, and for some positions reduced the salaries from those derived from the survey data. However, because of errors, omissions, and inconsistencies in the survey and in the compilation of the salary data collected, the committee and the institute cannot be certain that all salaries comply with the act's requirements. The institute substantially agrees with our assessment of its salary-setting activities and stated it will conduct another survey to identify the appropriate comparable positions to use to set the salaries for 11 positions.

To ensure that the methodology to set salary ranges complies with the act, we recommended that the institute follow through with its plan to resurvey any positions whose salary ranges were affected by the errors, omissions, and inconsistencies in its initial salary survey and salary-setting activities.

Institute's Action: Partial corrective action taken.

The institute hired Mercer Human Resources Consulting (Mercer) to review and survey all institute salaries. Mercer delivered its final report in January 2008. As of its February 2008 response to us, the institute reported that it planned to discuss the survey with the committee at its March 2008 meeting and propose any changes indicated by the survey, in keeping with its compensation policy adopted in January 2008. Under this policy, the institute is to target base pay at the 80th percentile of relevant market data. The institute also reports that it significantly changed its staffing model since our audit report was published and in the process eliminated some positions that were among those that we questioned in the report. Further, the institute created several hybrid positions that encompass responsibilities that cross multiple positions at other institutions. According to the institute, the Mercer report includes information about new positions that were created during data gathering but does not include data for new positions created after Mercer's data gathering process closed.

Department of Health Services

It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities

REPORT NUMBER 2006-035, FEBRUARY 2007

Department of Health Services' response as of February 2008

The Skilled Nursing Facility Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act), Chapter 875, Statutes of 2004, directed the Bureau of State Audits to review the Department of Health Services' (Health Services)[1] new facility-specific reimbursement rate system. Until the passage of the Reimbursement Act, facilities received reimbursements for Medi-Cal services based on a flat rate. The Reimbursement Act required Health Services to implement a modified reimbursement rate methodology that reimburses each facility based on its costs. In passing the Reimbursement Act, the Legislature intended the cost-based reimbursement rate to expand individual's access to long-term care, improve the quality of care, and promote decent wages for facility workers. The Reimbursement Act also imposed a Quality Assurance Fee (fee) on each facility to provide a revenue stream that would enhance federal financial participation in the Medi-Cal program, increase reimbursements to facilities, and support quality improvement efforts in facilities.

The Reimbursement Act required us to evaluate the progress Health Services has made in implementing the new system for facilities. It also directed us to determine if the new system appropriately reimburses facilities within specified cost categories and to identify the fiscal impact of the new system on the State's General Fund.

Finding #1: Health Services has not yet met all the auditing requirements included in the Reimbursement Act, having reviewed only about two-thirds of the State's facilities.

When a facility reports costs, Health Services has an obligation to perform an audit to ensure that those costs are reasonable. If an audit reveals a discrepancy, Health Services must make an audit adjustment, which becomes the amount Health Services uses to develop the facility's reimbursement rate. In fact, Health Services calculated approximately one-third of all facilities' reimbursement rates using unaudited cost data.

We recommended that Health Services conduct all the audits of facilities called for in the Reimbursement Act to reduce the risk of using flawed data to calculate reimbursement rates.

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) progress in implementing the Skilled Nursing Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act) revealed:

- *Although Health Services promptly obtained federal approval for the reimbursement rate and fee systems, it was delayed in installing the new rates for Medi-Cal payments.*
- *Health Services has not yet met all of the auditing requirements included in the Reimbursement Act, but has recently hired 20 additional auditors to meet the requirement.*
- *Health Services has not reconciled the fee payments made by facilities to its record of anticipated collections.*
- *Health Services believes the Reimbursement Act will result in General Fund savings. However, the savings projections do not consider $5.2 million in ongoing costs prompted by the act.*
- *Health Services did not follow sound contracting practices when it contracted with its consultant to develop a system to calculate rates.*
- *Health Services was not able to provide the methodology underlying the reimbursement rate system. As a result, we could not verify that the system appropriately calculates rates. To make such a verification in a separate public letter, we asked Health Services to provide a complete and accurate methodology of the system within 60 days of this report's publication.*

continued on next page . . .

[1] Effective July 1, 2007, the Department of Health Services was renamed as the Department of Health Care Services as a result of Senate Bill 162.

» *Neither Health Services nor its consultants formally made changes to final reimbursement rates or to the reimbursement rate system.*

» *Health Services' contractor responsible for receiving and authorizing payment for Medi-Cal claims, authorized over $3.3 million in duplicate payments to some facilities for the same services.*

» *Health Services and its contractor have begun the process of recouping the duplicate payments.*

Health Services' Action: Partial corrective action taken.

Health Services reported that it plans to use the additional 19 auditor positions and two audit manager positions approved in the 2006–07 budget to conduct audits of all free-standing skilled nursing facilities (facility) as required in the Reimbursement Act. It plans to complete all of the required audits during the 2007–08 production year.

Health Services does not plan to identify which audits it conducted in 2004 stating that the Reimbursement Act was not enacted until 2005. In addition, it believes the number of audits completed in 2005 met the requirements of the Reimbursement Act. However, as stated in the report, before passage of the Reimbursement Act, Health Services conducted a field audit for each facility once every three years. To meet the requirement for the Reimbursement Act, Health Services must continue to complete a field audit once every three years and also complete a desk audit in the years in between. Since Health Services did not distinguish between field and desk audits in its records, it cannot be sure it has met the field audit requirement. We recommend that Health Services look back to the audits completed in fiscal years 2004–05 through 2006–07 to identify which facilities received a field audit within those three years and adjust its audit plan accordingly.

Finding #2: Health Services has not reconciled its fee receipts to its records of anticipated collections.

In addition to new facility rates, the Reimbursement Act established the fee to provide a new revenue stream for Health Services. Before it started collecting fee payments, Health Services estimated each facility's annual reported resident days and recorded the estimate in a database. Since the fee amount each facility pays is based on resident days, each facility reports actual resident days for the period and the total fee due when it remits the fee payment. On receiving this information, Health Services records it in the database next to its estimates. However, Health Services had not reviewed these records and as a result it may not have collected all the 2004 fees due. By reviewing its records of fee payments received alongside its estimates, Health Services could have promptly identified delinquent facilities and facilities that have incorrectly reported resident days by investigating reported resident days that vary by more than 5 percent from its estimate.

We recommended that Health Services reconcile the fee payments made by facilities to the estimated payments due and follow up on significant variances. For those facilities that have not paid the full fee, we recommended that Health Services promptly initiate collection efforts.

Health Services' Action: Partial corrective action taken.

Health Services reported that it has begun notifying facilities of outstanding fee balances and is receiving regular responses from those facilities. In addition, it reports that it has completed reconciling its fee payment records and has a process in place for collecting aged fee receivables.

Finding #3: Although the Reimbursement Act allows contracting, we are concerned about Health Services' contracting practices and its continued reliance on contracted services to maintain and update the new reimbursement rate system.

Health Services did not always follow sound contracting practices. The consultant it hired to provide advice and research related to reimbursement rate methodologies was responsible for developing the reimbursement rate system, even though development work was not included in the scope of the contract. Health Services should have included detailed expectations in the contract for the final product. Additionally, it should have required the consultant to document the process used to build the system. Because it failed to include these details in the contract, Health Services does not have a blueprint of the system, leaving it vulnerable in the event of a system failure and at greater risk should the system fall short of Health Services' needs. In fact, when we attempted to replicate the reimbursement rate system that produced the 2005–06 rates, neither Health Services nor its consultant were able to provide a complete methodology used to develop the system. As a result, we have asked Health Services to develop and test formal, accurate and detailed documentation that includes all of the complexities of the rate development methodology within 60 days of this report's publication.

Additionally, Health Services anticipated taking over rate development but did not specify in its contract with its consultant a date for doing so.

We recommended that Health Services amend the contract to clearly describe the scope of work, include a statement that Health Services will obtain the logic and business rules of the reimbursement rate system, and a specific date that Health Services will take over the reimbursement rate calculation. In addition, we requested formal and detailed documentation that includes all of the complexities of the reimbursement rate development with its 60-day response.

Health Services' Action: Partial corrective action taken.

According to Health Services, it prepared a contract amendment that included a turnover plan. This turnover plan required the consultant to provide the logic and business rules of the reimbursement rate system and train Health Services' employees to operate the system. Health Services reported that the amended contract was approved in May 2007. Health Services further stated that its staff has received the training necessary to operate the reimbursement rate system and is working with the consultant to calculate and implement rates for the upcoming year.

Additionally, Health Services provided formal detailed documentation that included all of the complexities of the reimbursement rate development methodology used to produce the reimbursement rates Health Services published for fiscal year 2005–06 in its 60-day response.

Finding #4: Health Services does not have a mechanism in place to record changes made to published rates or the reimbursement rate system.

Health Services does not formally document and record changes to its published rates or changes to its reimbursement rate system. As a result of not keeping formal records, it could not provide an overall record of changes it made to its published rates or the basis for changing those rates. Health Services develops rates for facilities and forwards them to the Electronic Data Systems (EDS), Health Services' consultant. EDS is responsible for entering these rates into its system and applying them to Medi-Cal claims. However, EDS authorized payment for some Medi-Cal claims in fiscal year 2005–06 using rates that were different than those Health Services had published. When asked about changes to the published rates, Health Services stated that most of the changes were probably initiated by the facilities after the rates were finalized. However, since Health Services is responsible for developing rates, it is also responsible for formally tracking changes made to those rates.

In addition, neither Health Services nor the consultant that developed the reimbursement rate system have a formal change control process in place to record programming changes the consultant makes or may need to make to the system.

We recommended that Health Services formalize a rate change process that documents the reason for rate changes and any changes either it or its contractor responsible for administering the system makes to the reimbursement system's programming language.

Health Services' Action: Partial corrective action taken.

Health Services reported that it has implemented a system that provides an audit trail for any facility rate change. It further stated that it has developed and implemented procedure changes in the system's programming language. However, procedure changes to the programming language is not a substitute for a formal change control process.

Finding #5: Health Services is to report information that reflects changes in quality of care to the Legislature. Although the law does not require it, we believe including General Fund cost information in those reports would show how the new rates are affecting the General Fund.

Because the Reimbursement Act sunsets on July 1, 2008, the Legislature will be reviewing its overall impact on the quality of care in facilities and its fiscal impact on the State. The Reimbursement Act mandates that Health Services issue reports to the Legislature in January 2007 and January 2008. Both reports are to focus on elements outlined in the Reimbursement Act to give the Legislature an idea of what improvements the increased rates produced. The Reimbursement Act, in its outline of the information that Health Services should include in the reports, did not specify the inclusion of any information related to the effect higher reimbursement rates and the new fee revenue have on overall General Fund expenditures. In addition, although the Reimbursement Act requested that our audit provide information regarding the impact of the new reimbursement rates on the General Fund, we can provide only actual General Fund cost information for fiscal year 2005–06. By including General Fund cost information in both of the required reports from Health Services, the Legislature would have more information to assess the act's true costs and benefits.

We recommended that Health Services include information on any savings to the General Fund in the reports its licensing division is required to prepare.

Health Services' Action: None.

Health Services' Licensing and Certification Division (division) agrees that both cost and benefit information may be useful to the Legislature. However, because General Fund cost information is collected and maintained by other operational areas of the department, the division stated it would have to be prepared by another operational area. Health Services did not state whether it included or intends to include General Fund cost information in its reports to the Legislature.

Finding #6: Health Services ' contractor responsible for receiving and authorizing payment of facility Medi-Cal claims, authorized paying some facilities more than once.

Although this contractor was unaware that it was authorizing duplicate payments, we found more than 2,100 instances of such payments totaling over $3.3 million since October 2005. Because the scope of the audit included only long-term care Medi-Cal payments for the 2005–06 fiscal year, we were unable to reach a conclusion as to whether the duplicate payments extended beyond the population examined.

We recommended that Health Services further investigate the possibility that duplicate payments were authorized by the contract consultant to ensure that the magnitude of the problem is identified and controlled. In addition, we recommended that Health Services begin recouping those duplicate payments.

Health Services' Action: Partial corrective action taken.

After learning that its contractor, EDS, issued duplicate payments, Health Services reported that it took immediate corrective action by implementing a special processing guideline that discontinued the procedure to override suspended claims. It also conducted an investigation to determine the magnitude of the flawed procedure. In its six-month response, Health Services stated that it has also completed its investigation of Medical, Outpatient, and Vision claims and found a similar processing error that resulted in additional erroneous duplicate payments of certain claims. It further reported that it immediately issued a special processing guideline to temporarily correct the processing error and, as of September 2007, has developed the criteria that will permanently correct the error.

In its one-year response, Health Services stated that it expects to recover the duplicate payments by issuing two Erroneous Payment Corrections (EPCs). Health Services stated that the first EPC will recover approximately $5.1 million in duplicate long-term care payments and an additional $780,000 for duplicate or overlapping payments made to one or more different provider entities. The second EPC will recover funds for the Medical, Outpatient and Vision claims by October 2007. Health Services stated that it estimates the total dollar overpayment for that EPC to be $250,000. Additionally, Health Services stated it expected to recover duplicate or overpayments during fiscal year 2007–08.

Department of Health Care Services

Investigations of Improper Activities by State Employees, July 2006 Through January 2007

INVESTIGATION I2006-0731 (REPORT I2007-1), MARCH 2007

Department of Health Care Services' response as of November 2007

We investigated and substantiated an allegation that an employee of the Department of Health Care Services (Health Care Services)[1] improperly received overtime payments.

Investigative Highlight . . .

An employee at the Department of Health Care Services received an inappropriate credit of 241.5 hours to his leave balance for compensated time off, representing a potential overpayment of $7,453.

Finding: The employee violated regulations covering travel expense reimbursements and payment of commuting expenses when he failed to subtract his commute from the total work time he claimed over a four-month period.

The employee, a fraud investigator, failed to subtract his normal round-trip commute time from the total work time he claimed each day during the four-month period he was at a training academy. The employee attended a training academy from mid-August 2005 through mid-December 2005. During this period, he claimed three hours of overtime for each day he attended the training academy, which represented the travel time from his residence to the training academy and back to his residence. Although the State's collective bargaining agreement with the union allows employees to claim travel time as overtime under certain circumstances, state regulations provide that decisions relating to reimbursement for travel expenses be made based on the best interest of the State. In addition, federal regulations specify that an employer who reimburses an employee for travel expenses related to a special assignment in a different location may subtract the employee's regular commute time from the total time claimed.

The employee indicated that other Health Care Services' investigators who previously attended the academy told him that it was common practice for attendees to receive compensation for all their travel time to and from the academy. His supervisor stated that although he was not aware of any law, rule, or regulation permitting investigators attending the training academy to claim overtime for their travel time, he claimed it was standard practice for investigators to claim overtime for their travel time.

As a result of failing to subtract his normal commute time from the total work time he claimed each day, the employee received an inappropriate credit to his leave balances of 241.5 hours of compensating time off to which he was not entitled, representing a potential overpayment of $7,453.

[1] As of July 1, 2007, the California Department of Health Services was reorganized. Current day-to-day operations will continue under the new Department of Health Care Services or the California Department of Public Health.

Health Care Services' Action: Partial corrective action taken.

In its initial response, Health Care Services disagreed with the finding of our investigation. It believes we did not consider that the employee is a peace officer, which requires that he respond to urgent or emergency calls outside scheduled working hours. Further, Health Care Services stated that the employee does not commute to or from a field location or headquarters. Because Health Care Services did not believe the employee's activity was improper, it stated that it would not be taking any action against him or his supervisor.

Subsequently, Health Care Services noted that it plans to examine the future use of overtime in connection with investigator participation in the training academy, specifically the use of overtime in lieu of per diem to ensure that the decision is made in the best interest of the State. In addition, it concurs with the Bureau of State Audits' observation regarding the manner in which overtime hours should be calculated. Therefore, Health Care Services stated that it would no longer include normal commute time of investigators in its determination of approved overtime hours when overtime in lieu of per diem is used.

Department of Health Services

It Needs to Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers

REPORT NUMBER 2006-110, APRIL 2007

Department of Health Services' response as of April 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the Department of Health Services'[1] (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal). Specifically, we were asked to compare the department's enrollment and application procedures to those used by the federal Medicare program and to determine whether any information is shared between the two programs during the enrollment process. Additionally, we were asked to determine whether the department tracks and monitors the average time it takes to review a physician application and to identify the number of full-time staff assigned to review these applications. The audit committee asked us to identify the number of applications denied over the past year and the reasons for the denials. Further, we were asked to review the department's procedures for handling deficient applications and to determine when it notifies applicants about deficiencies. The audit committee requested us to identify the number of applications referred for further review in the past year, including the reason for the referral and the number that were denied. Finally, we were asked to identify the number of applicants requesting preferred provider status in the past year, the total number of applicants awaiting enrollment into the Medi-Cal program, and the number of applications the department did not process within the designated review period.

Finding #1: The department did not process some applications within required time periods, and inaccurate data in its data system continue to hinder its ability to track application status.

In July 2000 the department established the Provider Enrollment Branch (branch) whose primary function has been to review applications and to prevent providers with fraudulent intent from participating in the Medi-Cal program. Although required by law to process applications and notify applicants of its final determination within specific time periods, the branch continues to review some after the end of the required processing period and is forced to automatically enroll other applicants into Medi-Cal, on provisional status, because it cannot make a timely determination on the application. In fact, for the period October 1, 2005, through September 30, 2006 (federal fiscal year 2006), the branch did not process 108 applications within the required time periods. Of these, it automatically enrolled eight applicants into the program on provisional status as required but did not automatically enroll or appropriately notify the remaining 100. When the branch does not automatically enroll applicants into the program when required, or promptly process applications and notify applicants of its final determination, it may prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries.

[1] Effective July 1, 2007, the California Department of Health Services reorganized to form the California Department of Health Care Services.

Audit Highlights . . .

Our review of the Department of Health Services' (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal) found that:

» *Because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives; however, the branch does not process some applications within the time periods specified in statute.*

» *Branch staff continue to enter data incorrectly into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to track the status of applications effectively.*

» *Some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could.*

» *Given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.*

» *The branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals.*

continued on next page . . .

» *State law does not prescribe a required number of days in which the branch must approve or deny referred applications, and we noted that the department takes an inordinate length of time to process referred applications.*

» *Because physicians applying to become providers in Medi-Cal and Medicare are asked to provide much of the same information, and the federal government is beginning two initiatives to ensure that more accurate and updated information is available about Medicare providers, the department may be able to streamline its application process by relying on some of Medicare's data in the near future.*

Further, the applications of seven of the eight automatically enrolled applicants had been recommended for denial and sent to the branch's policy and administrative section (policy section), which generally reviews all denied applications. However, their applications remained in the policy section after their respective due dates for completing processing had passed. Because the branch does not track the length of time applications recommended for denial remain in its policy section, it automatically enrolled these ineligible providers. Although these applicants can be removed from the Medi-Cal program while on provisional status, they may submit claims for services provided from the date the branch received their application to the date of their termination from the program. The department has the authority to recover payments made to ineligible providers, but it incurs additional costs when it must do so for providers whose applications should have been denied during the enrollment process.

Despite concerns we raised in a May 2002 audit regarding whether branch staff were entering data accurately and consistently into the branch's Provider Enrollment Tracking System (PETS), we noted that branch staff continue to enter data incorrectly, decreasing the branch's ability to effectively track the status of applications. For instance, branch management does not perform secondary reviews of the dates branch staff enter into PETS, such as the dates applications were received, returned to the applicant, or processed by the branch. Inaccuracies in these dates prevent the branch from effectively tracking the status of applications. Further, we noted that PETS contains 166 fictitious provider records, created as the result of staff training and branch testing of PETS that were commingled with production data.

We recommended that the branch notify applicants that it has automatically enrolled them as provisional Medi-Cal providers when it has not processed the applications within the required time periods. The branch should also modify PETS to track the length of time applications it recommends for denial remain in its policy section for review to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner. Additionally, the branch should include in management's secondary review of applications periodic reviews to ensure that staff are accurately and consistently entering into PETS the correct dates the branch received, processed, or returned the applications. Moreover, the branch should remove all staff training and branch testing data from PETS and include it in an environment that simulates PETS, thus protecting the integrity of the production data.

Department's Action: Corrective action taken.

The branch reports that it has developed a letter and implemented a process to immediately notify applicants who have been automatically enrolled. Further, the branch states that it has updated its procedure manual with formal written procedures regarding the immediate notification of applicants who have been automatically enrolled and reports that it has implemented the procedures. In addition, the branch states that it has modified the PETS and created a policy denial report that is reviewed on a weekly basis and now includes a tracking capability to ensure that

no applications subject to denial are allowed to default. Further, the branch reports it updated its procedure manual in December 2007 to ensure correct dates are entered into the PETS and asserts that managers are reviewing the accuracy of all data entered into the PETS throughout the application process. Finally, the branch states that the training and testing data was removed from PETS in August 2007.

Finding #2: Many applicants do not resubmit corrected applications on time, which is the leading reason for denials.

Although the branch generally notifies applicants in a timely manner that their applications are deficient, applicants often fail to correct deficiencies within the required 35-day time period, or do not resubmit their corrected applications at all. This failure is the leading reason for denied applications. In comparison, the federal Medicare program allows applicants to remedy their deficient applications by submitting additional information within a 60-day time frame—25 days longer than Medi-Cal's time frame. To determine whether applicants who missed the 35-day deadline would have met the 60-day deadline, we calculated the number of applications that were resubmitted to the branch between 11 and 25 days after the 35-day time period during federal fiscal year 2006 (we allotted an additional 10 days for mail delays). According to PETS data, 258 applications were resubmitted within this time frame and, therefore, treated as new applications subject to the 180-day processing period—of which the branch ultimately approved 126. Had state law authorized the branch to process applications that were resubmitted within a 60-day time frame rather than a new 180-day time frame, a greater number of eligible providers could have provided services to beneficiaries sooner than they otherwise did.

Moreover, the branch could do a better job of informing applicants that one of the leading reasons for denial is submitting an outdated or inappropriate application form. More than 20 percent of applicants were denied during federal fiscal year 2006 for this reason. When the branch does not adequately notify applicants that using outdated or inappropriate application forms will result in denial of application packages, it increases the number of applications it must process and ultimately deny and increases the length of time before some eligible providers can be enrolled in the Medi-Cal program. In turn, this may limit some beneficiaries' access to Medi-Cal providers.

We recommended that the department seek legislation to revise state law to extend the 35-day time period applicants have to remedy deficiencies in their applications. Additionally, the branch should increase its efforts to notify applicants that they must use current and appropriate application forms to avoid being denied enrollment into Medi-Cal.

Department's Action: Corrective action taken.

Chapter 693, Statutes of 2007, effective January 1, 2008, was signed by the governor on October 14, 2007, and extends the former 35-day time period applicants had to remedy deficiencies in their applications to 60 days. Additionally, the branch has updated the Medi-Cal Web site to provide notification to applicants that they must use the current and appropriate forms to avoid being denied enrollment into the Medi-Cal program and has updated the *Top Reasons Provider Enrollment Applications are Denied* to include this information.

Finding #3: Preferred provider status offers few benefits to applicants.

State law allows certain applicants to apply for preferred provider status, however, the only benefit to an applicant of qualifying for this status is that the branch must process the application within 90 days instead of 180 days. According to PETS, only 4 percent of the applications the branch received in federal fiscal year 2006 requested preferred provider status and, given that the branch's average time to process an application in September 2006 was just 30 days, the 90-day processing period appears irrelevant. Because the benefits to applicants appear to be marginal, we question the value of the status.

Additionally, the branch denied preferred provider status to more than half of the 60 applications we reviewed because the applicants submitted application packages that were incomplete or did not contain the required documents. Thus, to the extent that the department chooses to keep this status, it appears the branch should increase its efforts to convey to prospective applicants that their application packages will be denied if they are lacking certain elements. Consequently, the branch could see an increase in the number of applicants that could benefit from the shorter processing period that preferred provider status offers.

We recommended that the department seek legislation to revise state law to eliminate preferred provider status. If it chooses to keep this status and to increase the number of applicants that could benefit from the shorter processing period that preferred provider status offers, the department should increase its efforts to notify applicants of the reasons it denies applications during the prescreening for preferred provider status.

Department's Action: Corrective action taken.

The department asserts that while the majority of physicians have elected not to enroll under preferred provider status, the California Medical Association's intent for introducing the status under Senate Bill 857 remains valid. Thus, the department recommends allowing physicians to weigh the cost/benefit of enrolling as preferred providers. To promote awareness of preferred provider status, the branch posted a bulletin to its Web site describing how physicians can request, and provide documentation and verification for, consideration for enrollment in the Medi-Cal program as a preferred provider. Further, Chapter 693, Statutes of 2007, reduces from 90 days to 60 days the time within which the branch must notify applicants of the reasons it denies applications during the prescreening for preferred provider status. The branch reports that the shorter processing period may encourage qualified providers to apply for preferred provider status. Additionally, the branch completed an analysis on denied preferred provider applications and updated its Web site to include the *Top Reasons Preferred Provider Enrollment Applications are Denied* to coincide with the July 1, 2008, effective date of the new preferred provider provisions within state law.

Finding #4: The branch does not track referral information adequately and the department takes an inordinate amount of time to process some applications that the branch refers.

Although the branch is authorized to conduct additional reviews by referring application packages to other units within the department, as well as to staff within the branch itself, it does not adequately track the reason for the referrals. For example, the reasons that branch staff may select in PETS for referring applications are vague and in some cases are problematic. In fact, nearly one-half of the applications that the branch referred in federal fiscal year 2006 lack a specific reason for the referral. This prevents the branch from contributing to the department's Medi-Cal fraud prevention efforts on an ongoing basis, because it is unable to accurately detect and track potential trends in fraud during the enrollment process.

Further, state law does not prescribe a required number of days within which the branch must approve or deny an application it has referred for further review, and we noted that referred applications take an inordinate length of time to process. For instance, in federal fiscal years 2004 and 2005, PETS indicates the average number of days to process applications that the branch referred was 322 and 255 days, respectively. Referred applications that were processed in federal fiscal year 2006, including those referred in prior years, remained in the enrollment process for an average of 318 days. According to PETS, of the applicants among this group that were ultimately approved or denied (rather than being in process or returned to the applicant as deficient or returned for other reasons), the branch approved 69 percent as Medi-Cal providers, in one case taking up to 1,007 days, thus preventing one eligible Medi-Cal provider from providing services to Medi-Cal beneficiaries for nearly three years.

Additionally, the branch and the Medical Review Branch within the department's Audits and Investigations division do little to coordinate with each other to identify and update the branch's high-risk fraud indicators or to formally track the status of referred applications. In fact, in the past six months the branch has not held its regular meeting with the Medical Review Branch, which served to foster information sharing between the two branches in a more formal setting than the occasional communication they may currently have regarding certain applications. To the extent that the branch's high-risk indicators are no longer current and do not align with the reasons for referral available in PETS, its ability to track the legitimate reasons it has for referring applications is hindered, decreasing the branch's capability to detect potential fraud trends during the enrollment process.

We recommended that the branch coordinate with the department to update PETS to reflect the specific reasons that it refers applications for further review, so that they are aligned with its fraud indicators and high-risk review checklist. Further, to ensure it is referring those applicants at greatest risk of committing fraud and not preventing eligible Medi-Cal providers from providing services to beneficiaries, the branch and the Medical Review Branch, with direction from the department, should reevaluate the appropriateness of the branch's high-risk fraud indicators periodically by consistently communicating and collaborating with one another. Finally, with direction from the department, the branch and the Medical Review Branch should place increased emphasis on processing those applications referred for further review within a reasonable time period, to ensure that some eligible Medi-Cal providers are not unreasonably delayed from providing services to beneficiaries.

Department's Action: Corrective action taken.

The branch reports that it is working collaboratively with the Medical Review Branch to evaluate the fraud indicator checklists on a quarterly basis using findings from the ongoing risk assessment analyses and the annual Medi-Cal Payment Error Study. The branch states that it established a workgroup, consisting of branch and Medical Review Branch staff, which has reviewed the current list of high-risk indicators and identified changes that need to be made to PETS. The branch reports that it updated the reasons applications are referred in the PETS to accurately reflect the referral indicators, which it asserts was completed in March 2008. Further, the branch asserts that it implemented new procedures in June 2007 to ensure that applications referred for comprehensive review are processed within 60 days of receipt of the onsite report from the Medical Review Branch. Finally, the branch claims that it will contact the Medical Review Branch within six months after a referral has been made to obtain status of any outstanding issues and perform a quarterly reconciliation of outstanding cases between the branch and the Medical Review Branch.

Finding #5: The department may be able to streamline its application process for physicians by relying more on Medicare data.

Because applicants seeking to become physician providers in Medi-Cal and the federal Medicare program are asked to provide much of the same information in their application packages, the department may have the opportunity to streamline some of its enrollment processes for Medi-Cal applicants who are already Medicare providers by relying more on Medicare provider information in the near future. The federal government is beginning two initiatives intended to ensure that more accurate and updated information is available about Medicare providers. Specifically, effective November 15, 2006, federal regulations require Medicare providers to resubmit and recertify the accuracy of their enrollment information every five years in order to maintain their billing privileges. In addition, effective May 23, 2007, federal regulations require all health care providers who bill for services to disclose their National Provider Identifier (NPI) to any entity, when requested, to identify themselves as such.[2] Thus, the department can request applicants to provide their NPI on its Medi-Cal provider application, which it plans to do beginning late May 2007. Consequently, for those physician applicants it identifies as being

[2] According to the summary text of the Standard Unique Health Identifier for Health Care Providers final rule by the U.S. Department of Health and Human Services as published in the *Federal Register*, the NPI is a unique identifier for health care providers that will improve the Medicare and Medicaid programs in part by enabling the efficient electronic transmission of health care provider data.

in good standing with Medicare, the department may be able to rely on some of Medicare's data instead of performing redundant procedures to verify the same information. Although it is too early to determine the effectiveness of these two initiatives, it could be worthwhile for the department to periodically assess Medicare's progress and the benefits the department could derive from this centralized source of information.

We recommended that the branch monitor the implementation of Medicare's revalidation process in which it verifies the enrollment information for all of its providers to identify opportunities for streamlining its application and verification procedures, and make modifications as appropriate for Medicare providers seeking enrollment in the Medi-Cal program. Further, the branch should continue its plans to reenroll—a process in which the branch requires existing providers to submit new applications to ensure that they are suitable to continue participating in the Medi-Cal program—all of its Medi-Cal providers and add any resources freed by its streamlining of its enrollment process.

Department's Action: Partial corrective action taken.

The branch indicates that it continues to monitor Medicare's implementation of its revalidation process to identify opportunities for streamlining its application and verification procedures as appropriate, with a specific focus on the implementation of Medicare's federal regulations governing its accreditation and competitive bidding process for furnishing durable medical equipment, prosthetics, orthotics, and medical supplies. In fact, the branch asserts that it attended a Medicare conference to discuss the potential for federal and state uniformity in the use of provider applications. Further, the branch states that it continues to focus on completing current reenrollment phases that are near conclusion and claims it will continue to reenroll providers that were enrolled in Medi-Cal prior to 1999 and that do not have disclosure statements on file.

Department of Health Services

Investigations of Improper Activities by State Employees, February 2007 Through June 2007

INVESTIGATION I2006-1012 (REPORT I2007-2), SEPTEMBER 2007

Investigative Highlight . . .

An employee at the Department of Health Services used a state computer for personal purposes, including uploading modeling photos of a spouse.

Department of Health Services' response as of October 2008

We asked the Department of Health Services (Health Services) to assist us with the investigation, and we substantiated that an employee at Health Services misused state time, resources, and facilities for personal purposes that were inconsistent with the performance of his duties.[1] In addition, Health Services found other misuses of state resources.

Finding #1: The employee inappropriately used his state computer for personal benefit and entered a state building for nonwork-related reasons.

The employee accessed Internet sites on several occasions from July 2006 through October 2006 that were inappropriate. Specifically, Internet monitoring reports showed the employee visited modeling Web sites and Internet-based e-mail sites during the employee's regular weekday work schedule and on six nonbusiness days, such as weekends and holidays. In addition, Health Services found that the employee had no permission to enter the building on any of the six nonbusiness days. Moreover, on one weekend day, the employee's spouse accompanied him into the building. Health Services also determined that on nine days—eight of which were workdays—the employee spent more than three hours each day accessing the Internet, including viewing some modeling Web sites where his spouse had profiles and photos posted. Finally, Health Services found that, on one weekend day, the employee uploaded modeling photos of his spouse.

Health Services' Action: Corrective action taken.

Health Services reported that it initiated content filtering of Internet sites, making certain sites—such as modeling Web sites and Internet-based e-mail—inaccessible to its employees. It further stated that it modified the employee's building access to normal business days and hours only and suspended his Internet access. Subsequently, Health Services informed us that it regularly issues a security newsletter in an effort to remind employees about its information security policy and guidelines.

When we reported the results of the investigation in September 2007, Health Services told us that it was pursuing adverse action against the employee but it appears that the status of the adverse action was inaccurate. Specifically, in December 2007 Health Services reported to us that the employee left in April 2007 before it completed its adverse action against him.

[1] The employee worked in a division of Health Services during the period of investigation. Health Services reorganized effective July 1, 2007. The employee's division is now within the Department of Public Health.

More importantly, Health Services told us that prior to the employee's departure, it did not document in his personnel file the specific circumstances or events leading to its investigation of the employee's misuse of state time and resources. The employee is now employed at another department. As a result, we are concerned that the other department is unaware of the employee's misuse of state time and resources.

Finding #2: The employee misused state resources.

The employee inappropriately used his state e-mail account to send or receive 370 e-mails that were not work related. Specifically, the employee sent and received 113 e-mails that related to his pursuit of modeling assignments for his spouse, with many of the e-mails containing images of his spouse that were not appropriate in the workplace. The remaining 257 e-mails related to the employee's attempt to sell telecommunications services for an outside company and other personal activities.

Health Services' Action: Corrective action taken.

Health Services suspended the employee's e-mail access in February 2007. However, as we stated previously, the employee left Health Services in April 2007 and, prior to his departure, it did not document in his personnel file the specific circumstances or events leading to its investigation of the employee's misuse of state time and resources.

Department of Health Care Services

Although Notified of Changes in Billing Requirements, Providers of Durable Medical Equipment Frequently Overcharged Medi-Cal

REPORT NUMBER 2007-122, JUNE 2008

Department of Health Care Services' response as of December 2008

The Joint Legislative Audit Committee requested the Bureau of State Audits to conduct an audit of the Department of Health Care Services' (Health Care Services) Medi-Cal billing system with particular emphasis on the billing instructions and coding for durable medical equipment (medical equipment).

Although Health Care Services adequately notified medical equipment providers of changes to the reimbursement rates and codes for medical equipment, we noted other findings.

Finding #1: Health Care Services' Allied Health Provider Manual (provider manual) does not include reimbursement guidance for speech-generating devices.

Health Care Services' policies and procedures and the information in its provider manual regarding reimbursement methodologies for medical equipment generally agree with state law and regulations and federal program requirements. However, the provider manual does not contain the methodology for calculating reimbursements for speech-generating devices included in state law.

To better ensure its provider manual represents a comprehensive guide for medical equipment providers, we recommended that Health Care Services include billing procedures for speech-generating devices.

Health Care Services' Action: Corrective action taken.

Health Care Services added the reimbursement methodology for speech-generating devices to its provider manual. According to Health Care Services, it released a provider bulletin in July 2008 informing providers of the change.

Finding #2: Health Care Services has no practical means to effectively monitor and enforce its medical equipment reimbursement rates.

Some providers have overbilled Medi-Cal, and Health Care Services has overpaid providers, for certain wheelchairs and wheelchair accessories with listed Medicare prices. In 2003 Health Care Services implemented new price controls, intended to lessen the opportunity for fraud and abuse. However, as indicated by a small number of limited scope audits that Health Care Services conducted of billings that providers submitted from September 1, 2005, through August 31, 2006, the price controls have not met their intended purpose. During 2007 and 2008 Health Care Services conducted a limited review of 21 providers' billings for wheelchairs and their

Audit Highlights . . .

Our review of the Department of Health Care Services' (Health Care Services) Medi-Cal billing system for durable medical equipment (medical equipment) found that:

- *Health Care Services' policies and procedures regarding reimbursement methodologies for medical equipment generally agree with state laws, regulations, and federal program requirements.*
- *Providers are adequately informed regarding changes in reimbursement methodologies and health care codes.*
- *Because Health Care Services has not identified a practical means to monitor and enforce its billing and reimbursement procedures, price controls enacted in 2003 have not met their intended purpose.*
- *Health Care Services conducted a limited review of providers and found that 21 providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed.*
- *Although Health Care Services has recovered almost $960,000 of the overpayments, it does not know the extent to which other providers may have also overbilled for medical equipment.*
- *Although Health Care Services intends to use postpayment audits to enforce its price controls for medical equipment, its current auditing efforts do not provide enough coverage of medical equipment reimbursements to effectively ensure providers' compliance with the billing procedures.*

accessories with listed Medicare prices and found that providers overbilled, and Health Care Services overpaid, about $1.2 million, or 25 percent of the $4.9 million those providers billed. In addition, because Health Care Services has not yet reviewed billings for medical equipment without listed Medicare prices, including wheelchairs and wheelchair accessories, it does not know the extent to which providers comply with the price controls and bill using the lowest billing rate option. Furthermore, Health Care Services does not require providers to submit documents that would show they billed at the lowest of the billing options for medical equipment with a listed Medicare price or wheelchairs and wheelchair accessories without a listed Medicare price. According to the chief deputy director, for a billing that a provider submits electronically, Health Care Services has no automated method for auditing the claim to determine the relationship between the billed amount and the invoiced amount.

To maintain control over the cost of reimbursements, we recommended that Health Care Services develop an administratively feasible means of monitoring and enforcing current Medi-Cal billing and reimbursement procedures for medical equipment. If unsuccessful, Health Care Services should consider developing reimbursement caps for medical equipment that are more easily administered.

Health Care Services' Action: None.

➲ Health Care Services believes its current process is administratively sound and balances program flexibility with a cost-effective approach to curtail fraud and maintain access to care for beneficiaries. According to Health Care Services, it processes over $300 million each week in payments and it would be a massive and costly undertaking to review each claim and the associated documentation to determine if the providers are following Medi-Cal's billing and reimbursement procedures. Health Care Services believes post-payment audits is the most reasonable method to monitor and enforce its medical equipment and reimbursement procedures.

Finding #3: Current auditing efforts do not sufficiently cover the medical equipment reimbursements to ensure the providers comply with the billing and reimbursement procedures.

Audits of the Medi-Cal providers performed by Health Care Services in 2007 and 2008 revealed that the providers it reviewed billed for most of the wheelchairs and accessories they supplied at the maximum listed Medicare prices, not the significantly lower amounts the upper billing limit would have produced. According to the chief deputy director, Health Care Services has always intended to use postpayment audits to monitor and enforce its medical equipment billing and reimbursement procedures, including the upper billing limit. However, because medical equipment reimbursements make up a relatively small portion of total Medi-Cal payments—0.8 percent according to the 2006 payment error study Health Care Services conducted—current auditing efforts of total Medi-Cal payments do not provide enough coverage of medical equipment reimbursements to effectively ensure compliance. Moreover, perceiving a high cost and a low potential for benefits from the effort, Health Care Services focused its audits in 2007 and 2008 on medical equipment that represented only 10 of the more than 400 health care codes and reviewed a provider only if it had billed more than $50,000 from September 1, 2005, through August 31, 2006, for only one wheelchair type. However, using that methodology excluded some providers from a monitoring device intended to ensure that they adhere to price controls.

If Health Care Services continues using audits to ensure that providers comply with Medi-Cal billing procedures for medical equipment, including the upper billing limit, we recommended it design and implement a cost-effective approach that adequately addresses the risk of overpayment and ensures all providers are potentially subject to an audit, thereby providing a deterrent to noncompliance.

Health Care Services' Action: Partial corrective action taken.

According to Health Care Services, it compared the previous year's billings for durable medical equipment procedure codes with the first six months of such billings in the current year. Of particular interest to Health Care Services were codes with dramatic percentage increases in billings and those codes billed most often. Based on this effort, Health Care Services complied a list of approximately 35 to 40 codes where it believed over billings were likely to have occurred.

After compiling a list of suspicious codes, Health Care Services assembled a list of approximately 30 potentially high-risk providers. Health Care Services stated that it will perform further analysis and audits to determine whether these providers are compliant with the upper billing limit. Health Care Services stated it would report the results of these reviews to us.

Department of Mental Health, Coalinga State Hospital

Investigations of Improper Activities by State Employees, February 2007 Through June 2007

INVESTIGATION I2006-1099 (REPORT I2007-2), SEPTEMBER 2007

Investigative Highlight . . .

The Department of Mental Health misused state funds designated to purchase two law enforcement vehicles by using the vehicles for non-law enforcement purposes.

Department of Mental Health's response as of October 2008

We investigated and substantiated the allegation that the Department of Mental Health (Mental Health) violated provisions of state law that require a state agency to justify its need to purchase motor vehicles and to receive prior approval for the purchase from the Department of General Services (General Services).

Finding: Mental Health misused and wasted state funds by purchasing law enforcement vehicles and using them for non-law enforcement purposes, failed to maintain accurate home-storage permits, and failed to maintain required mileage logs.

In seeking approval from General Services, Mental Health indicated that it intended to use two 2005 Ford Crown Victoria Police Interceptors (Police Interceptors) for law enforcement purposes. However, after it received approval and purchased the vehicles, the Coalinga State Hospital (hospital) misused state funds and violated state law when it assigned the Police Interceptors first to its general motor pool and later to three hospital officials, who used them for non-law enforcement purposes including commuting. General Services indicated that it would not have approved the purchases of the Police Interceptors had it known how they would be used.

Additionally, we found that the purchase of the Police Interceptors was wasteful because Mental Health paid between $18,682 and $19,640 more to purchase the two Police Interceptors than it would have for two light-class sedans.

Also in violation of a state regulation, the hospital did not accurately list the officials' addresses on home-storage permits, thus failing to disclose that two of the officials used the Police Interceptors to commute between 390 and 980 miles per week. Further, the three hospital officials did not maintain the required mileage logs for the Police Interceptors they drove.

Mental Health's Action: Corrective action taken.

Mental Health stated that hospital management erred when it assigned the vehicles to the motor pool and subsequently to the officials who were not entitled to use law enforcement vehicles. It reported that hospital officials have been assigned light-class vehicles for business use only. In January 2008 Mental Health informed us that it had transferred the two Police Interceptors to another state hospital to be used for law enforcement purposes. As of October 2008 Mental Health stated that the Police Interceptors are still in use at the other state hospital.

Regarding the home-storage permits and the vehicle mileage logs, Mental Health stated that the long commutes to the officials' "home" residences were inappropriate. It also reported that it had taken measures to ensure that all home-storage permits were accurate. Mental Health further reported in October 2008 that employees at all Mental Health hospitals who are assigned state vehicles maintain vehicle mileage logs and ensure that home-storage permits are accurate.

Finally, Mental Health also reported that two of the officials retired and the remaining official was transferred to a lower-level position at another hospital.

Veterans Home of California at Yountville

It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement

REPORT NUMBER 2007-121, APRIL 2008

California Department of Veterans Affairs' response as of December 2008 and California Department of Public Health's response as of April 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the Veterans Home of California at Yountville (Veterans Home), with an emphasis on the adequacy of health care and accommodation of members with disabilities. Specifically, the audit committee requested that we determine the roles and responsibilities of the various entities involved in the governance of the Veterans Home, including those responsible for setting guidelines for the care of residents. The audit committee asked that we determine whether any of the entities had evaluated staffing levels for medical personnel, review the Veterans Home staffing ratios, and identify any efforts the Veterans Home had taken to address personnel shortages. Additionally, the audit committee asked us to assess how the Veterans Home manages its medical equipment to ensure that it is up to date and functioning properly and evaluate efforts the Veterans Home has made to ensure that its facilities and services are meeting the accessibility requirements of the Americans with Disabilities Act. Finally, the audit committee asked that we review and assess the policies and procedures for filing, investigating, and taking corrective action on complaints from members and review how the Veterans Home ensures members comply with its code of conduct.

Finding #1: Chronic vacancies have limited the ability of the Veterans Home to serve more veterans.

Our review of the Veterans Home revealed that it has had difficulty filling key health care positions in recent years, especially nursing positions. During fiscal year 2006–07 about 41 percent of all vacant positions at the Veterans Home were nursing positions. As a result, the Veterans Home has been limited in its ability to serve the veterans community and some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members living in the skilled nursing and intermediate care facilities. For example, we determined that although the Veterans Home has sufficient budget-authorized nursing staff to fill 435 beds without the need for substantial overtime, because of nursing staff vacancies its census shows that as of December 2007 it had only 357 beds filled. Moreover, 20 members of the nursing staff worked an average of more than 20 hours of overtime each week during the last three months of 2007. Although we did not observe such matters at the Veterans Home, one research study we reviewed concluded that excessive overtime by health care workers can lead to medical errors and negative patient outcomes.

Audit Highlights . . .

Our review of the Veterans Home of California at Yountville (Veterans Home) found that:

- *Chronic shortages in key health care positions, such as nursing, have limited the Veterans Home in serving the veteran community. Some nursing staff have worked substantial amounts of overtime to meet staffing guidelines for providing care to members who live in the skilled nursing and intermediate care facilities.*
- *Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas.*
- *Weak oversight of its medical equipment maintenance contract provides the Veterans Home little confidence that the equipment has received regularly scheduled testing and maintenance, thereby risking not having properly functioning equipment available when needed and making inappropriate payments to its medical equipment contractor.*
- *The Veterans Home has not assessed its compliance with Americans with Disabilities Act requirements to ensure people with qualifying disabilities have access to the Veterans Home and its programs and services, or designated a representative to respond to complaints of inaccessibility from members.*

continued on next page . . .

» *State agencies responsible for investigating and resolving complaints by Veterans Home members regarding the Veterans Home and its programs and services, the Veterans Home, the California Veterans Board, the California Department of Veterans Affairs, and the California Department of Public Health, could improve their practices regarding those responsibilities.*

We also found that the veterans' community has an unmet need for the services of the Veterans Home. In addition to unfilled beds, the Veterans Home maintains a waiting list of veterans seeking admittance. As of January 2008 the Veterans Home had a waiting list of 250 veterans for skilled nursing beds and 220 veterans for intermediate care beds. Although the Veterans Home does not regularly monitor the status of those waiting veterans, the mere existence of the lists indicates a certain level of demand for entry into the home. Further potentially limiting the ability of the Veterans Home to admit veterans into the level of care they need is a regulation stating that less than 75 percent of skilled nursing beds must be occupied before the home can admit members directly to that level of care. The California Department of Veterans Affairs (Veterans Affairs) has suspended that regulation in the past and intends to initiate a regulatory change within six months to grant the administrators the discretion to admit veterans to skilled nursing care while ensuring that existing members have access to skilled nursing beds.

According to the deputy administrator at the Veterans Home (deputy administrator), the home faces two major challenges in recruiting and retaining health care professionals: comparatively low salaries and the high cost of housing in the community. Salaries offered at the Veterans Home are lower than those offered at other state hospitals in the area, primarily because of the salary increases for medical and mental health positions at the California Department of Corrections and Rehabilitation facilities that resulted from recent federal court decisions. The Veterans Home must also contend with statewide shortages in several high-need health care occupations, such as registered nurses.

Despite these staffing shortages, the Veterans Home has not had a coordinated and comprehensive strategy for filling chronic staff vacancies in especially important occupational areas. Instead, individual departments within the Veterans Home have assumed important recruiting functions, without involvement from the home's human resources department. As a result, the Veterans Home has not been as effective as it could be in conducting recruiting efforts such as advertising vacant positions. It also is not as prompt as it could be in processing successful job applicants so they can start working at the Veterans Home, primarily because the home takes too much time to schedule, perform, and obtain the results of the physical examinations applicants must undergo.

To improve recruitment of health care staff, the Veterans Home has moved to centralize recruiting efforts under its human resources department. In an attempt to lessen the time between candidate job acceptances and employment start dates, the Veterans Home has identified a specific doctor and two nurse practitioners to perform physical examinations. According to the deputy administrator, the Veterans Home plans further action, such as improving the process for advertising open positions, extending outreach to nursing schools, and establishing a more effective exit interview process to gain a better understanding of why employees leave. In addition, the Veterans Home is seeking increased housing assistance for its employees.

Further, Veterans Affairs has taken action to raise salaries in several health care occupations at the Veterans Home and has performed some recruitment activities that might benefit the home. Veterans Affairs is also planning to implement a recruiting program that will coordinate the department's recruiting efforts and require the Veterans Home to develop a local recruitment plan that addresses department-wide recruiting goals.

To improve its ability to fill vacancies in key occupations, we recommended that the Veterans Home develop a comprehensive plan for recruitment and retention that establishes goals and strategies for reducing chronic vacancy rates and sets timelines and monitoring activities to keep recruiting efforts on track. To maximize its efforts to recruit for key health care positions, we recommended that the Veterans Home ensure the recruitment efforts of all its departments are coordinated through a centralized position or program. In addition, the Veterans Home should implement the remaining steps it has currently identified to better recruit and retain health care staff.

To prevent its nursing staff from working excessive overtime, we recommended that the Veterans Home consider adopting a formal policy for distributing overtime more evenly among nurses, establishing a cap on how much overtime nursing staff can work, and monitoring overtime usage for compliance with these policies.

If Veterans Affairs is concerned that its ability to serve California veterans is limited by a regulation stating that less than 75 percent of skilled nursing beds must be occupied before it can admit new patients directly to that level of care, we recommended it consider changing or eliminating that regulatory requirement.

To help ensure that newly hired employees at the Veterans Home can start work as soon as possible, we recommended that the Veterans Home monitor its new process for completing preemployment physicals. If the process is not resulting in new employees starting work more quickly, the Veterans Home should consider contracting with a vendor to provide the physicals.

To bolster recruitment efforts at the Veterans Home, we recommended that Veterans Affairs continue to develop its department-wide recruiting plan and oversee the recruiting plan the Veterans Home is implementing to ensure that it meets department-wide goals.

Veterans Home's Action: Partial corrective action taken.

The Veterans Home established a plan to guide its recruitment efforts that includes information about the Veterans Home's proposed recruitment strategies, marketing and advertising, and monitoring and follow up. Examples of the proposed recruitment strategies include developing a recruitment calendar, exploring the possibilities for an internship program for dieticians and having students from the Napa Valley College Nursing Program do clinical rotations at the Veterans Home, which are similar to steps the Veterans Home told us it planned to take during our audit. Marketing and advertising activities specified in the plan include purchasing various products to give away at recruiting events and obtaining recruitment brochures from Veterans Affairs. Under the Veterans Home's recruitment strategy, recruitment plans will be monitored on a monthly basis and the annual recruitment plan will be renewed each year in January.

In addition, under the Veterans Affairs' recruitment program, supervision of recruiting efforts is vested at the Veterans Homes. Veterans Home administrators designate a recruitment coordinator, ensure managers and supervisors are aware of their recruiting assignments, and monitor recruiting achievements. Veterans Homes' recruitment coordinators are responsible for reporting on the conduct of annual recruitment at their respective home and developing and maintaining rapport with community groups who may serve as a resource for recruitment.

According to Veterans Affairs, the Veterans Home is developing new policies and a new program to reduce overtime among nursing staff that it anticipates implementing by January 2009. For example, Veterans Affairs states the Veterans Home developed a unit-based staffing program designed to improve staffing accountability and decrease overtime in the nursing department. Veterans Affairs

also indicated that the nursing department at the Veterans Home will manage overtime tracking and the Veterans Home's fiscal officer will implement improved cost accounting for overtime. Veterans Affairs did not address our recommendations that the Veterans Home establish a cap on how much overtime nursing staff can work.

In response to our recommendation that it consider changing or eliminating the requirement that less than 75 percent of skilled nursing beds must be occupied before the Veterans Home can admit new patients directly to that level of care, Veterans Affairs drafted a Notice of Proposed Rulemaking to eliminate the requirement.

According to Veterans Affairs, the Veterans Home is monitoring its hiring process, including a new process for completing preemployment physicals. Veterans Affairs indicated that the new process has reduced by 50 percent the number of days from the physical being requested to the examination date.

Veterans Affairs created a department-wide recruiting program that includes its recruiting mission and goals, as well as information about program coordination, roles and responsibilities, and recruitment techniques and strategies. The recruiting program also establishes a recruitment program officer to coordinate Veterans Affairs' recruitment efforts. Among other things, the recruitment program officer is responsible to assist offices and divisions and the Veterans Homes with focused recruitment, monitoring recruitment costs, preparing reports regarding recruitment goal attainment, and developing the Veterans Affairs' annual recruitment plan.

Finding #2: With weak oversight of its medical equipment contract, the Veterans Home cannot ensure that equipment is working properly and payments to its contractor are appropriate.

Our review also revealed that the Veterans Home has weak oversight of its medical equipment contract. From the medical equipment inventory provided to us by the Veterans Home, we tested 31 pieces of equipment and found that one piece of equipment had been entered into the inventory twice, leaving 30 items in our sample. Of those 30 items, six were not in use by the Veterans Home and five new items were not promptly added to the inventory. In addition, for 14 of the 19 remaining items, we could not find evidence that the contractor scheduled or performed the required maintenance within appropriate time frames. Without an accurate inventory and regularly scheduled maintenance of its medical equipment, the Veterans Home risks not having properly functioning equipment readily available when needed. Further, the Veterans Home routinely approves invoices for the contractor responsible for maintaining medical equipment but fails to verify that the contractor has met the requirements of its contract. Consequently, the Veterans Home may be making inappropriate payments to the contractor and, more importantly, it further decreases its assurance that every piece of medical equipment will function properly whenever it is needed to meet a member's health care needs.

To ensure the Veterans Home's medical equipment is maintained as prescribed by the equipments' manufacturers, we recommended that the Veterans Home take the steps necessary to ensure the medical equipment inventory, on which maintenance activities are based, is accurate. In addition, to ensure payments to the maintenance contractor are appropriate, we recommended that the Veterans Home require the contractor to provide records of inspections and maintenance work performed prior to authorizing payments.

Veterans Home's Action: Corrective action taken.

According to Veterans Affairs, the Veterans Home inventoried its medical equipment in all service areas and updated the inventory list for bio-medical equipment maintenance and repair. In addition, the Veterans Home states its service area managers are now required to submit an updated equipment list monthly and the medical equipment contractor has implemented changes to improve its record-keeping process. Veterans Affairs indicated that the Veterans Home is also using a new contract billing report to help ensure payments to the contractor are appropriate and has developed a new approach to monitoring the contractor's performance for compliance with the contract.

Finding #3: The Veterans Home does not have a plan to comply with the Americans with Disabilities Act but has made accommodations for members with visual impairments.

The Veterans Home does not have a plan for fully complying with the Americans with Disabilities Act (ADA). Title II of the ADA and federal regulations require state agencies to ensure that people with disabilities are not excluded from services, programs, and activities because buildings are inaccessible. As a first step toward meeting this requirement for program accessibility, all public entities had to conduct self-evaluations of their policies and practices and correct any that were inconsistent with the requirements of Title II. Additionally, any public entity needing to make structural changes to achieve program accessibility had to develop a transition plan. According to its equal employment opportunity/civil rights officer, Veterans Affairs has not performed a self-assessment of the Veterans Home for compliance with the ADA. Consequently, neither Veterans Affairs nor the Veterans Home can develop a plan for achieving full compliance with the ADA. The director of residential programs at the Veterans Home said that when repairs and alterations were made to the infrastructure at the Veterans Home, they were done to ADA design codes in force at the time. Nonetheless, it is not clear to what extent the Veterans Home meets the program accessibility requirements of the ADA.

Federal ADA regulations also require state agencies to develop grievance procedures and identify an employee as the agency's ADA coordinator. According to its director of residential programs, the Veterans Home has not met either of those requirements. However, the Veterans Home has made accommodations in its dining hall for members with visual impairments and provided training to dining hall workers to enable them to better serve members with visual impairments.

To meet the requirements of federal ADA regulations, we recommended that the Veterans Home develop and update as needed a plan that identifies areas of noncompliance and includes the appropriate steps and milestones for achieving full compliance. In addition, we recommended that the Veterans Home develop grievance procedures and identify a specific employee as its ADA coordinator.

Veterans Home's Action: Partial corrective action taken.

According to Veterans Affairs, the Veterans Home assigned an employee as ADA coordinator, and has updated its grievance policy to include handling of grievances related to accessibility. The Veterans Home plans to consider hiring a surveyor to identify areas of noncompliance with the ADA, which is a precursor to developing a plan to achieve compliance.

Finding #4: The California Department of Public Health (Public Health) has not always promptly completed its investigations of complaints against the Veterans Home.

Our review of complaints lodged against the Veterans Home, including complaints filed with legislative staff, showed that the responsible agencies handled some complaints appropriately. For example, we reviewed the nine complaints concerning the Veterans Home filed with Public Health between October 2005 and October 2007 and found that in every case Public Health met the requirements to conduct an initial on-site investigation within 24 hours or 10 days of receipt of the complaint, depending on its severity. In addition, Public Health's classification of the severity of each complaint appeared appropriate. However, we noted that Public Health did not complete its investigations for three of the nine complaints within 40 business days, its recommended maximum time frame. For another of the nine complaints, Public Health has yet to make a final determination on whether to issue the Veterans Home a citation, even though the complaint was filed more than one year ago. According to the chief of the state facilities unit in Public Health's licensing and certification program, this complaint was mistakenly dropped from his pending file and not addressed again until it was discussed during our audit.

To promptly resolve complaints it receives against the Veterans Home, we recommended that Public Health monitor its system for processing complaints.

Public Health's Action: Corrective action taken.

Public Health has developed a report from an existing complaint and incident tracking system that will identify complaints needing closure as of 30 days from receipt of the complaint to ensure Public Health is in compliance with its recommended time frame for resolving complaints.

Finding#5: The Veterans Board has not always maintained evidence of complaint resolution.

We also reviewed five complaints submitted to the California Veterans Board (Veterans Board) between June 2006 and December 2007 but were unable to determine whether they were resolved appropriately because neither the Veterans Board nor Veterans Affairs could locate documentation concerning actions they took on the complaints. Although the Veterans Board adopted a policy indicating the types of complaints it will process and those it will direct to Veterans Affairs, it did not specify a time frame for resolving the complaints it will process.

To ensure that all complaints against the Veterans Home submitted to the Veterans Board are properly resolved, we recommended that the Veterans Board specify a time frame for resolving complaints in its new policy for complaint resolution and ensure it implements the policy.

Veterans Board's Action: Corrective action taken.

The Veterans Board revised its policy concerning complaints to specify a time frame for resolving complaints. Under its revised policy, the board chair will respond to the complainant through the board executive officer within 10 business days if the complaint does not require board deliberation and action. If board action is required, the response will be provided within 10 days following the next board meeting. If the board chair deems that the complaint requires more urgent action, a special meeting by teleconference may be convened. If the complaint concerns Veterans Affairs' operations, it will be forwarded to the deputy secretary for resolution. The revised policy calls for Veterans Affairs to provide a response to the complainant with a copy to the board within 10 business days of Veterans Affairs' receipt of the complaint.

Finding #6: Veterans Affairs has generally followed its procedures for tracking complaints.

Veterans Affairs received 11 complaints from members between July 1, 2005, and October 5, 2007. In seven cases Veterans Affairs closely followed its established policies and procedures for resolving complaints. Four complaints were not processed entirely according to Veterans Affairs' policies governing written communication, which is its basic policy for handling written complaints. Specifically, Veterans Affairs did not prepare routing slips for the four complaints; according to the assistant deputy secretary of Veterans Homes, these were clerical errors. A routing slip is intended to identify and record on the official file all staff who contribute to the completion of a written communication, including staff who investigate and those who sign or approve the final product, thereby providing accountability to the complaint resolution process. Although lacking routing slips, the four complaints were addressed within a reasonable period by Veterans Affairs, given full consideration by the responsible parties, and documented according to Veterans Affairs' policies.

To ensure that complaints against the Veterans Home are processed so there is accountability in the complaint resolution process, Veterans Affairs should enforce its policy of using routing slips with complaints.

Veterans Affairs' Action: Corrective action taken.

According to Veterans Affairs, it revised its policy for tracking complaint resolution to ensure closure of complaints with accountability. The revised policy, which requires the use of a routing slip, has been distributed to the relevant staff at Veterans Affairs.

Finding #7: The Veterans Home does not always maintain evidence it resolved issues raised at resident council meetings.

As part of our analysis of complaint-handling procedures, we reviewed documents prepared by Veterans Home staff following resident council meetings. These monthly meetings are held in Holderman Hospital and its intermediate care facility annexes to give members the opportunity to raise issues, concerns, and complaints. According to the supervisor of therapeutic activities, the hospital's therapeutic activities staff facilitate the meetings, and social services staff are responsible for taking meeting minutes. We reviewed the available meeting minutes and memos prepared by the social services staff from May through December 2007 to communicate to Veterans Home departments the issues they needed to address. Our review revealed that 20 complaints were raised in the 2007 resident council meetings and, as of December 2007, the Veterans Home took reasonable steps to resolve 16 and had been unsuccessful in resolving two. We could not determine whether the Veterans Home had resolved the remaining two issues because no resolution was apparent in the minutes of resident council meetings or in the memos. The Veterans Home had communicated the outcomes of its investigations at subsequent resident council meetings for 14 of the 20 issues and had yet to report its findings for six. When complaints lodged by members in resident council meetings are not promptly resolved, or resolutions of the issues are not communicated to members, it can lead to dissatisfaction among the members of the Veterans Home.

To appropriately address complaints raised at resident council meetings, we recommended that the Veterans Home better document such issues, ensure that the relevant department resolves them, and promptly communicates the resolutions to all affected members.

Veterans Home's Action: Corrective action taken.

According to Veterans Affairs, the Veterans Home will record the minutes of all resident council meetings, and complaints and concerns of residents are to be routed to the appropriate supervising registered nurse for resolution. Therapeutic Activities at the Veterans Home is to follow up to ensure all complaints and concerns are addressed and communicated to the residents.

Finding #8: The Veterans Home needs to better document the resolution of code of conduct violations.

When we attempted to assess the process the Veterans Home has established for handling alleged violations of its code of conduct for members, we found that the Veterans Home did not adequately document its processing of the alleged violations. The code of conduct specifies behaviors prohibited by members so as to preserve the tranquility of the Veterans Home and to ensure the rights and independence of each member. Our review of 25 violations alleged to have occurred in 2006 and 2007 found complete documentation in only 11 cases. For all 11 cases with complete documentation, we were able to verify that the Veterans Home followed its policies and procedures. In 12 of the 25 cases we reviewed, the Veterans Home did not maintain sufficient documentation for us to determine whether it followed all its policies and procedures. In the remaining two cases, using the limited documentation available to us, we determined that the Veterans Home did not follow appropriate policies and procedures that required referral of members caught using illegal drugs to the drug treatment program at the Veterans Home. Without maintaining appropriate documentation, executive staff at the Veterans Home cannot be assured that alleged violations of the code of conduct receive consistent and equitable treatment.

To handle alleged violations of the code of conduct consistently and equitably, we recommended that the Veterans Home ensure that staff responsible for investigating the allegations fully document the investigations and their results.

To ensure that members of the Veterans Home receive treatment for drug abuse when necessary, we recommended that staff of the Veterans Home follow its policy to refer members who use illegal drugs to the drug treatment program.

Veterans Home's Action: Corrective action taken.

Veterans Affairs revised the code of conduct policy for clarity and the Veterans Home plans to train all staff who investigate code of conduct violations to improve the quality and consistency of investigations. In addition, the Veterans Home will be monitoring investigations for completeness. Further, the Veterans Home updated and strengthened its polices requiring staff to refer members who use illegal drugs to the appropriate treatment professional or medical provider at the Veterans Home.

Low-Level Radioactive Waste

The State Has Limited Information That Hampers Its Ability to Assess the Need for a Disposal Facility and Must Improve Its Oversight to Better Protect the Public

REPORT NUMBER 2007-114, JUNE 2008

Department of Public Health's response as of December 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) conduct an audit assessing the management and oversight of low-level radioactive waste (low-level waste) by the California Department of Health Services (now the Department of Public Health (department)), the Radiologic Health Branch (branch), and the Southwestern Low-Level Radioactive Waste Commission (Southwestern Commission). Although we reviewed the Southwestern Commission's policies and practices, we did not have recommendations for it and, as a result, we do not mention the Southwestern Commission further in this subcommittee report write-up.

Public concern related to the disposal of low-level waste will likely increase in the near future because entities in California that generate this waste are losing access to one of the two disposal facilities they currently use. In June 2008 the disposal facility in Barnwell, South Carolina, is scheduled to cease accepting low-level waste from generators in many states, including California. Generators of low-level waste will need to consider alternative methods, including long-term or off-site storage, to deal with their most radioactive low-level waste. Unfortunately for decision makers in California, the implications of this pending closure and what it means for the State's public policy are not clear-cut.

Finding #1: The department has not adopted dose-based decommissioning standards.

Decommissioning is a process in which the department concludes that a physical location that formerly contained radiation is sufficiently clean for the public to use it safely and qualifies the location for release from further regulatory control. The department is responsible for approving and overseeing plans to decommission licensed equipment and facilities within its jurisdiction. In 1998 the department began informally applying the U.S. Nuclear Regulatory Commission's (NRC) standard of .025 rems, or 25 millirems (thousandths of a rem) per year (mrem/yr) whenever it decommissioned licensed equipment or facilities under its jurisdiction and terminated such licenses. Applying the new dose-based standard meant that equipment or facilities could be released from further regulatory control as long as the degree of residual radioactivity remaining at the site would not result in more than 25 mrem/yr of exposure to those members of the community who would likely be affected. In October 2001 the department formalized this practice of using the 25 mrem/yr standard by adopting regulations that incorporated by reference the federal standard. These new regulatory standards were controversial; within a matter of months, they were challenged in court. In April 2002 the court found that the new regulatory standard had been adopted without satisfying

Audit Highlights . . .

Our review of the State's approach to managing low level radioactive waste (low-level waste) found the following:

» *In June 2008 generators in California will lose access to one of the two low-level waste disposal facilities that currently accept their waste.*

» *The Department of Public Health (department) has yet to follow a 2002 executive order requiring it to develop dose-based decommissioning standards, resulting in a lack of public transparency and accountability over its actions.*

» *The department's Radiologic Health Branch (branch) cannot demonstrate that its inspections of those that possess radioactive material and radiation-emitting machines are performed timely in accordance with federal and state requirements.*

» *The branch has poorly planned for its resource needs, is unable to justify the magnitude of its 2005 fee increases, and used old and incomplete data when asking for more staff.*

» *More than five years after the effective date of the law, the branch is still unable to provide required information on the amount of low-level waste generated in California.*

the requirements of the Administrative Procedure Act and the California Environmental Quality Act (CEQA). In May the court issued an order directing the department to set aside its approval of the challenged regulations, insofar as the regulation incorporated the 1998 NRC standard.

On September 30, 2002, the former governor issued Executive Order D-62-02 (executive order). Unlike the 2002 court order, which simply directed the department to set aside the challenged regulations, the executive order imposed a direct obligation on the department to adopt regulations that would establish dose-based standards for the decommissioning of low-level waste. The executive order also directed the department to comply with all applicable laws, including CEQA, when it adopted those dose-based standards. When we asked the department to describe the efforts that it had undertaken to adopt such regulations, it told us that it had not done so because of the prohibitive expense and because of the likely opposition it might encounter.

To provide greater public transparency and accountability for its decommissioning practices, we recommended the department begin complying with the Executive Order D-62-02 and develop dose-based decommissioning standards formally. If the department believes that doing so is not feasible, it should ask the governor to rescind this 2002 executive order.

Department's Action: Pending.

The department stated that its administration continues to assess the public health and budgetary pros and cons of various options to implement or rescind Executive Order D-62-02.

Finding #2: The branch lacks sufficiently reliable data to ensure it conducts all required inspections on time.

One of the branch's key oversight activities includes inspecting licensees that use radiation-emitting machines or possess radioactive material, ensuring they do not expose the public to harmful radiation. Although federal guidance and state law define how frequently such inspections should occur, the branch is unable to demonstrate that it promptly performs these inspections. Its data systems contain data that are not sufficiently reliable, and this shortcoming prevents the branch from accurately assessing whether all inspections take place when necessary. For example, in one data system, we noted that the data values in the priority code field were incorrect in two of the 16 sample items for which we were able to obtain documentation. Since this field defines the required inspection interval for a given licensee, errors would result in too frequent or too few inspections being scheduled based on this data. Overall, the branch's lack of sufficiently reliable information appears attributable to its use of data provided by its own information technology staff, who do not fully understand what data they are extracting or why they are extracting it, as well as to the lack of management controls that would help guard against inaccurate data entry. Although the branch recognizes the limitations of its current data systems and has tried to replace them since 1996, it continues to operate in an environment in which it cannot adequately manage its work, thus limiting its ability to protect the public from potential health risks. The branch's data needs are currently included as part of the development of a department-wide data system. It states that the project's first phase, which supports the branch, should be completed in November 2010.

To make certain that the branch uses sufficiently reliable data from its current systems to manage its inspection workload, we recommended the department do the following:

- Improve the accuracy of the branch's data for inspection timeliness and priority level. The branch can do so by comparing existing files to the information recorded in the data systems.

- Improve its internal controls over data entry so that it can maintain accurate data on an ongoing basis. Such controls might include developing a quality assurance process that periodically verifies the contents of licensee files to the data recorded electronically. Other controls might include formalizing data entry procedures to include managerial review or directing the information technology staff to perform periodic logic checks of the data.

Finally, to ensure that the branch uses sufficiently reliable data from its future data system to manage its inspection workload, the department should develop and maintain adequate documentation related to data storage, retrieval, and maintenance.

Department's Action: Partial corrective action taken.

The department stated that it will make functional system modifications to address data reliability and quality concerns with its existing systems. These changes include issue management, change and test management, work-arounds, access control, business rules compliance assurance, error reports, peer and supervisor reviews, and tracking sheet capability development. The department expects to complete these modifications by January 2009.

Regarding its future data system, the department acknowledged our recommendation to use sufficiently reliable data. The department stated that it received administrative and legislative approval of a feasibility study report for its new enterprise-wide, on-line licensing system (licensing system). The department also stated that it has begun selecting staff for the project and anticipates issuing a request for proposals by July 2009. The department believes that this licensing system will help it further develop and implement a Web-based information technology system that will not only meet management and customer needs but also address the bureau's data improvement recommendations. The department expects the licensing system to be fully deployed by 2011.

Finding #3: The branch cannot demonstrate that the extent of its 2005 fee increase was necessary.

The State's Radiation Control Fund (Control Fund) supports most of the branch's operations, and money in the Control Fund comes from the fees that the branch levies on entities that possess radioactive materials or use radiation-emitting machines, fines and penalties assessed, and interest earned from money in the Control Fund. For each fiscal year from 2000–01 through 2004–05, the ending balance of the Control Fund declined. According to the State Controller's Office, the balance of the Control Fund was $13 million at June 30, 2001, declining to $4.3 million at June 30, 2005. Sparked in part by the declining balance, the branch obtained approval in June 2005 from the State's Office of Administrative Law for changes to the regulations that establish its fees. As a result, some of the branch's fees increased by more than 200 percent over the previous fee levels, while other fees increased by less than 35 percent.

Although it appears that the branch needed to address the declining balance of the Control Fund, the analysis and justification for its higher fees lacked specific quantitative workload and fiscal analyses one would reasonably expect. Lacking such analyses, the branch is unable to sufficiently demonstrate how it calculated the various new fee levels and that its fee increases were reasonably related to the costs of services provided to those that pay them. Additionally, the branch's inability to fix problems with its billing systems, and the resulting uncertainty as to whether it was collecting all the revenue it could have, further calls into question the need for the fee increases in June 2005.

To ensure that the branch can sufficiently demonstrate that the fees it assesses are reasonable, we recommended the department evaluate the branch's current fee structure using analyses that consider fiscal and workload factors. These analyses should establish a reasonable link between fees charged and the branch's actual costs for regulating those that pay the specific fees. Further, the analyses should demonstrate how the branch calculated the specific fees.

Department's Action: Partial corrective action taken.

The department stated that to ensure that current fees are appropriate, it initiated fiscal and workload analyses. Further it stated that it is developing workload standards that identify responsible individuals, tasks to be accomplished, milestones, time and resource factors, status, and anticipated completion date. Finally the department stated that it now has the information for the fiscal analysis and that information for the workload analysis of its various sections will be completed in stages with the analysis for the last section being available by March 2009.

Finding #4: The branch has not determined how many employees it needs to fulfill its federal and state obligations.

The NRC, which periodically evaluates the branch's performance, raised concerns regarding its inadequate staffing in 2004 and again in 2006. In addition, the branch justified its need for fee increases in 2005 by citing increased work backlogs. It obtained the approval for eight health physicists for fiscal year 2006–07 and an additional eight positions for fiscal year 2007–08. As of March 2008 it has filled 13 of its 16 new positions with 12 health physicists and one associate governmental program analyst.

The branch claimed in its fiscal year 2006–07 budget change proposal that the additional staff would allow it to meet all its federal and state mandates. However, we question how it could make such a claim when it used workload analyses that were at least three years old, focused only on the current workload and excluded the backlog, and did not account for the staff needed to meet certain state mandates. Although the department indicated that it had not fully evaluated the branch's staffing needs since the mid-1990s, the branch requested an additional three permanent and two limited-term positions for health physicists for fiscal year 2008–09. However, the branch's inability to fulfill its goal of reducing backlog and meeting state mandates, at a minimum, raises questions as to whether it understands the staffing levels necessary to successfully accomplish all of its responsibilities.

To make certain that it can identify and address existing work backlogs and comply with all of its federal and state obligations, we recommended the department develop a staffing plan for the branch based on current, reliable data. The plan should involve a reevaluation of the branch's assumptions about workload factors, such as how many inspections an inspector can perform annually. The plan should also include an assessment of all backlogged work and the human resources necessary to eliminate that backlog within a reasonable amount of time, and an assessment of all currently required work and the human resources necessary to accomplish it.

Department's Action: Partial corrective action taken.

The department stated that it developed a plan to correct and eliminate existing inspection backlogs to ensure compliance with federal and state requirements and that it continues to resolve backlogs in accordance with that plan. Although this suggests progress, the department did not provide us with its plan or an update on the sufficiency of its current staffing levels.

Finding #5: The branch has not complied with a state law requiring that it report data on low-level waste within California.

More than five years after its September 2002 enactment, the branch still has not implemented requirements that the Legislature added to the Health and Safety Code, at Section 115000.1, which call for reporting on the amount of low-level waste stored in California or exported for disposal. As of April 2008 the branch had not produced the report, nor had it yet implemented the information system needed to generate such a report. In fact, the branch did not initially request the necessary data from licensees until April 2007. Without this information, neither the Legislature nor the branch can accurately assess the need for a disposal facility in California. Further, without this information, the department does not have a documented basis to know how to plan for the closure in June 2008 of one

of the two low-level waste disposal facilities that accept such waste from California's generators. State law requires the department to have a contingency plan in the event that an out-of-state disposal facility is closed.

Furthermore, when the branch finally does prepare the report, it may not contain all the information required under law. The provisions place data collection and reporting requirements on the department and allow it to use copies of shipping manifests from generators to provide the necessary information. However, the branch determined that the shipping manifests do not provide information on 12 of the 57 discrete data elements required by the legislation. The department is aware of these deficiencies and has stated the branch will need to revisit the issue with the department's executive management and the legislation's author to ensure that the required information meets the intent of the legislation.

To inform the Legislature when it is likely to receive the information to evaluate the State's need for its own disposal facility, we recommended the department establish and communicate a timeline describing when the report required by Section 115000.1 of the Health and Safety Code will be available. The department should also see that its executive management and the branch discuss with appropriate members of the Legislature as soon as possible the specific information required by state law that it cannot provide. Further, to the extent that the department cannot provide the information required by law, it should seek legislation to amend the law. Finally, when the branch has an understanding of the disposal needs for generators in California based on this data, it should develop an updated low-level waste disposal plan.

Department's Action: Partial corrective action taken.

The department agreed with the recommendation to communicate its timeline to the Legislature regarding the availability of the required report. It currently anticipates completion of a report based on 2007 information by May 2009 and expects to issue subsequent reports annually thereafter. The department also intends to confer with the Legislature regarding data limitations related to the law when the first report is completed.

The department disagreed with the recommendation to develop an updated low-level radioactive waste disposal plan. It asserted that disposal of low-level radioactive waste is a national issue that affects the ability of 36 states due to the closure of the Barnwell disposal facility in June 2008 and that a national solution will provide the only permanent solution for the states. The department also stated that existing data from other sources like the U.S. Department of Energy can be used to evaluate disposal needs.

Finding #6: A complete strategic plan could help the branch operate more effectively.

Although no state law specifically requires the branch to have a strategic plan, its inability to completely address issues concerning inspection data that is not sufficiently reliable, as well as its inability to justify its resource requests, suggest the branch might benefit from improving the limited plan it currently has. According to guidelines published by the Department of Finance, strategic planning is a long-term, future-oriented process of assessment, goal setting, and decision making that maps an explicit path between the present and a vision of the future. The branch currently uses a plan that lacks many essential elements of strategic planning and could benefit from setting priorities that would help it more effectively manage its work. The branch's plan contains some objectives tied to the goals, but they are not specific or measurable, as recommended by the Department of Finance. Without measurable objectives, action plans, performance measures, timelines, and monitoring, it is more difficult for branch management to know whether it is meeting the plan's goals.

To better manage its performance in meeting key strategic objectives, we recommended the branch establish a new strategic plan that contains all essential elements, including performance metrics and goals that the branch believes would be relevant to ensuring its success.

Department's Action: Partial corrective action taken.

The department stated that it agrees with the recommendation and that the branch's revised strategic plan will include specific goals and objectives, and metrics to ensure that the branch measures its performance. It also stated that the branch is soliciting bids for assistance with strategic planning and that a strategic plan is expected to be completed by May 2009.

Department of Public Health

Laboratory Field Services' Lack of Clinical Laboratory Oversight Places the Public at Risk

REPORT NUMBER 2007-040, SEPTEMBER 2008

Laboratory Field Services' response as of November 2008

Chapter 74, Statutes of 2006, required the Bureau of State Audits to review the clinical laboratory oversight programs of the Department of Health Services (now the Department of Public Health and referred to here as the department). Specifically, the law directed us to review the extent and effectiveness of the department's practices and procedures regarding detecting and determining when clinical laboratories are not in compliance with state law and regulations; investigating possible cases of noncompliance, including investigating consumer complaints; and imposing appropriate sanctions on clinical laboratories found noncompliant. The law also specified we review the frequency and extent of the department's use of its existing authority to assess and collect civil fines and refer violators for criminal prosecution and bar their participation from state and federally funded health programs, and its use of any other means available to enforce state law and regulations regarding clinical laboratories. Laboratory Field Services (Laboratory Services) within the department is responsible for licensing, registering, and overseeing clinical laboratories. Specifically, we found:

Finding #1: Laboratory Services is not inspecting laboratories every two years as required.

Laboratory Services is not inspecting clinical laboratories every two years, which is required by state law and is a critical component of the State's intended oversight structure. State law requires Laboratory Services to conduct inspections of licensed clinical laboratories no less than once every two years. According to Laboratory Services, 1,970 licensed laboratories required such inspections in California as of June 2007. Based on the state requirement, we expected to find that Laboratory Services was conducting regular inspections. Although inspections help ensure that laboratories follow appropriate procedures and that personnel have appropriate qualifications, Laboratory Services has not conducted any regular, two-year inspections of clinical laboratories.

Further, state law requires a laboratory located outside California but accepting specimens originating inside the State to have a state license or registration. However, Laboratory Services does not conduct regular, two-year inspections of out-of-state laboratories. According to Laboratory Services, 91 laboratories outside California had California licenses as of June 2007.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including inspecting licensed laboratories every two years.

Audit Highlights . . .

Our review of Laboratory Field Services' (Laboratory Services) clinical laboratory oversight activities revealed the following:

- *It is not inspecting laboratories every two years as state law requires and has no plans to do so unless it receives additional resources.*
- *Laboratory Services has inconsistently monitored laboratory proficiency testing, and its policies and procedures in that area are inadequate.*
- *It closed many complaints without taking action, and Laboratory Services' recently revised complaint polices and procedures lack sufficient controls.*
- *Laboratory Services has sporadically used its authority to impose sanctions against laboratories for violations of law and regulations.*
- *The chief of Laboratory Services attributes its inability to meet its mandated responsibilities primarily to a lack of resources; it has only been successful in obtaining approval for two recent funding proposals.*
- *Because it had raised its fees improperly one year and failed to impose two subsequent fee increases the budget act called for, Laboratory Services did not collect more than $1 million in fees from clinical laboratories.*

Department's Action: Partial corrective action taken.

Laboratory Services reported that it has begun to prioritize and address the audit recommendations. It has initiated a workload assessment and begun to strategize ways to maximize use of existing staff and to identify specific additional resources needed to perform all mandated activities. Laboratory Services also told us that it is evaluating its ability to phase in inspections of licensed laboratories every two years and is working with its Office of Legal Services to identify potential legal issues related to contracting with accrediting organizations.

Finding #2: Inconsistent monitoring and inadequate policies and procedures weaken Laboratory Services' oversight of proficiency testing.

State law stipulates that laboratories performing tests considered moderately to highly complex must enroll and achieve a certain minimum score in proficiency testing, a process to verify the accuracy and reliability of clinical laboratory tests. It is Laboratory Services' policy to monitor proficiency-testing results. However, we found that it did not identify or take action on some testing failures. Specifically, Laboratory Services had not contacted the laboratories or had not identified all the failed tests in five of the six instances we reviewed. Further, it did not review the proficiency-testing results of laboratories located outside California that are subject to the testing. Because the goal of proficiency testing is to verify the reliability and accuracy of a laboratory test, without adequate monitoring, Laboratory Services cannot ensure that laboratories are reporting accurate results to their customers.

Laboratory Services also did not enforce its policy to verify whether laboratories are enrolled in state-approved proficiency testing. State law requires that laboratories conducing moderate-to-high-complexity tests enroll in a state-approved proficiency-testing program. This is a condition of licensure, but it is also important to verify enrollment on an ongoing basis because proficiency testing is a key method for ensuring that laboratories conduct their tests reliably and accurately.

Finally, Laboratory Services has inadequate policies and procedures regarding proficiency testing. For example, the policies and procedures do not specify timelines for key steps in the proficiency-testing review process, including how frequently Laboratory Services will review proficiency-testing results. Lacking specific timelines, Laboratory Services could apply proficiency-testing requirements inconsistently and create confusion within the regulated community.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including monitoring proficiency testing results.

We also recommended that Laboratory Services adopt and implement proficiency-testing policies and procedures for staff to do the following:

- Promptly review laboratories' proficiency-testing results and notify laboratories that fail.
- Follow specific timelines for responding to laboratories' attempts to correct proficiency-testing failures and for sanctioning laboratories that do not comply.
- Monitor the proficiency-testing results of out-of-state laboratories.
- Verify laboratories' enrollment in proficiency testing, and ensure that Laboratory Services receives proficiency-testing scores from all enrolled laboratories.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it has modified its proficiency testing oversight procedure to include federal timelines, require reviews of proficiency test results every 30 days, and for laboratories to resolve testing failures within 90 days. In addition, it is evaluating its ability to track and review plans of corrections and to take appropriate enforcement action within a specified time frame. Laboratory Services also reported that it has obtained a list of out-of-state laboratories and is developing a pilot project to electronically monitor 135 laboratories' proficiency tests. Laboratory Services stated that it has not yet initiated a response to verifying laboratories' enrollment in proficiency testing and ensuring that it receives proficiency-testing scores from all enrolled laboratories.

Finding #3: Laboratory Services is focusing on increasing licensing of California laboratories but not out-of-state laboratories.

Recognizing a problem within its licensing process, in May 2008 Laboratory Services began implementing a plan to identify and license laboratories within California that are subject to licensure but have not applied for or obtained it. However, Laboratory Services has not placed the same priority on identifying and licensing laboratories operating outside the State that receive and analyze specimens originating in the State, even though these laboratories are subject to California law. Laboratory Services plans to continue processing applications for licenses and renewals that out-of-state laboratories submit voluntarily, but it does not plan to perform any additional activities. According to the Laboratory Services chief, insufficient staffing has always prevented Laboratory Services from properly administering the licensing of out-of-state laboratories and pursuing licensed out-of-state laboratories. By not enforcing licensing requirements, Laboratory Services cannot ensure that out-of-state laboratories are performing testing to state standards established to protect California residents.

We recommended that Laboratory Services continue its efforts to license California laboratories that require licensure. Further, it should take steps to license out-of-state laboratories that perform testing on specimens originating in California but are not licensed, as the law requires.

Department's Action: Partial corrective action taken.

Laboratory Services told us that it has inspected and licensed 13 laboratories in California that required licensure out of a pool of 64 laboratories it has contacted since May 2008. Laboratory Services reported that it has identified the resources needed to expand the registration of in-state laboratories and licensure of out-of-state laboratories.

Finding #4: Laboratory Services has struggled to respond to complaints, and its new complaints process lacks sufficient controls.

Laboratory Services has not always dealt systematically with complaints as required. It receives complaints from several sources, including consumers, whistleblowers, various public agencies, and other laboratories. State law mandates that Laboratory Services investigate complaints it receives, but it often closed complaints after little or no investigation. Laboratory Services acknowledges it investigated only a small percentage of the complaints it received and conducted only one major investigation during the three-year period ending December 2007. Moreover, Laboratory Services lacks information to know the total number of complaints it has received, investigated, or closed during a specific period. Although Laboratory Services internally developed a database to capture complaints information, it did not consistently enter complaints it received into that database or update its complaints data to reflect progress or resolution. Laboratory Services' complaints database lists 313 complaint records for the three-year period between January 2005 and December 2007; however, Laboratory Services has no assurance that number is accurate.

We reviewed 30 complaints Laboratory Services received between January 2005 and December 2007 and later closed. Among the complaints we reviewed, we found 16 that Laboratory Services closed without taking action. Laboratory Services told us it did not have jurisdiction over six of these complaints; however, we did not find evidence that it alerted the complainant to that fact when the complainant was known or that Laboratory Services forwarded the complaint to an entity that had jurisdiction. Of the 10 complaints Laboratory Services closed without action and over which it acknowledged having jurisdiction, we found five complaints that alleged conditions with health and safety implications, raising concerns about Laboratory Services' decision to close them.

The second category of complaints we identified comprised 14 cases in which Laboratory Services took some type of action—for instance, sending a letter, making a telephone call, or referring the allegation to another entity. However, Laboratory Services did not conduct on-site laboratory investigations in response to the allegations related to any of the complaints in this category. Although Laboratory Services' files suggest it took some action in response to all 14, we are particularly concerned that the action Laboratory Services took was inadequate or not timely for three complaints having health and safety implications. For example, two complaints alleged that laboratories made testing errors that resulted in the patients receiving unnecessary medical treatment.

Certain key controls in Laboratory Services' complaint policies and procedures are missing or insufficient. Typically, an entity with a complaints process establishes certain key controls to ensure that staff promptly log, prioritize, track, and handle information they receive. Moreover, controls should exist to make certain that substantiated allegations are corrected. Laboratory Services needs controls such as logging and tracking to be able to account for each complaint it receives and to confirm that each complaint is being addressed. Tracking also gives management necessary estimates of workload. The controls of prioritizing and setting time frames are important for Laboratory Services to address serious complaints first and all complaints promptly. Finally, Laboratory Services' follow-up on corrective action is necessary to ensure that the basis of the complaint is removed or resolved. We did not find these controls in Laboratory Services' complaints policies and procedures.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including, but not limited to reviewing and investigating complaints and ensuring necessary resolution.

We also recommended that Laboratory Services establish procedures to ensure that it promptly forwards complaints for which it lacks jurisdiction to the entity having jurisdiction. Further, to strengthen its complaints process, Laboratory Services should identify necessary controls and incorporate them into its complaints policies. The necessary controls include, but are not limited to, receiving, logging, tracking, and prioritizing complaints, as well as ensuring that substantiated allegations are corrected. In addition, Laboratory Services should develop and implement corresponding procedures for each control.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it conducts weekly complaint reviews and prioritizes complaints it receives as high, medium, or low based on the potential risk to public health. In addition, it is working with the Information Technology Services Division to add new fields to the Health Applications Licensing system (HAL), and has redirected one staff person to assist with prioritizing and categorizing complaints.

Laboratory Services stated that it concurred with the recommendation to identify necessary controls and incorporate them into its complaints policies, but it had not yet initiated actions in response to it.

Finding #5: Laboratory Services has imposed few sanctions in recent years.

Laboratory Services did not always have staff dedicated to its sanctioning efforts from 1999 through 2007. Because it lacks an effective tracking mechanism, Laboratory Services could not identify the total number of and types of sanctions it imposed. Therefore, we had to consider various records to compile a list of imposed sanctions. We focused our review on Laboratory Services' records from 2002 through 2007. Our review of those records revealed that Laboratory Services imposed 23 civil money penalties, terminated five licenses, and directed three plans of corrective action during that six-year period. Most of those sanctions were imposed in 2002 and 2003. Of the seven civil money penalties we reviewed, Laboratory Services could not demonstrate that it collected the penalties from two of the laboratories or imposed the penalty on one laboratory, nor could it substantiate how it calculated the penalties. Our review of two license terminations showed that in both cases Laboratory Services imposed the sanctions after the laboratories failed to apply promptly for new licenses when the directorship changed. Although Laboratory Services enforced both sanctions and required the laboratories to obtain new licenses, it could not provide documentation that it notified a federally funded health program as its policy requires.

We recommended that Laboratory Services perform all its mandated oversight responsibilities for laboratories subject to its jurisdiction operating within and outside California, including sanctioning laboratories as appropriate.

We also recommended that, to strengthen its sanctioning efforts, Laboratory Services maximize its opportunities to impose sanctions, appropriately justify and document the amounts of the civil monetary penalties it imposes, ensure that it always collects the penalties it imposes, follow up to ensure that laboratories take corrective action, and ensure that when it sanctions a laboratory it notifies other appropriate agencies as necessary.

Department's Action: Partial corrective action taken.

Laboratory Services told us that it has begun to develop standardized procedures for enforcement of unsuccessful proficiency testing. In addition, it is working with the Office of Legal Services to determine the extent to which it can contract with accrediting organizations for sanctioning purposes. Laboratory Services reported that it has not initiated actions to justify and document the amounts of civil money penalties it imposes, to ensure that it always collects the penalties or that laboratories take necessary corrective actions, and to notify other appropriate agencies when it sanctions a laboratory. However, Laboratory Services told us that it will develop policies and procedures explaining how a civil money penalty assessment is determined and will use an existing database to track imposition and collection of civil money penalties. Laboratory Services also reported that it has identified resources for necessary onsite inspections. In addition, it will develop policy and procedures that specify time frames for laboratories to submit documentation of corrective action and for evaluating whether the appropriate corrective action was taken. Finally, Laboratory Services noted that it will develop policy and procedures to improve documentation of communication of laboratory sanctions to other governmental agencies.

Finding #6: Laboratory Services believes that limited resources have affected its meeting its mandates.

The Laboratory Services' chief attributes much of its inability to meet its mandated responsibilities to a lack of resources. Laboratory Services has only been successful in obtaining approval for two funding proposals for clinical laboratories in recent years. A funding proposal approved for fiscal year 2005–06 resulted in additional spending authority for two positions intended to help Laboratory Services meet its clinical laboratory oversight responsibilities. A funding proposal approved for fiscal year 2006–07 granted Laboratory Services seven positions designated for clinical laboratory oversight activities.

To gain perspective on Laboratory Services' funding issues, we spoke with the deputy director and assistant deputy director for the Center for Healthcare Quality (Healthcare Quality). On July 1, 2007, the Department of Health Services was split into two departments: The Department of Public Health (department) and the Department of Health Care Services. The department was organized into five centers, which are comparable to divisions; Laboratory Services became part of Healthcare Quality. We asked why the department has not submitted a funding proposal for Laboratory Services since it became a part of the department. We also asked about future funding proposals. According to its assistant deputy director, Healthcare Quality needs to assess Laboratory Services, understand its unique features and issues, and prioritize its needs. The assistant deputy director stated that Healthcare Quality wants to fully understand Laboratory Services' operations and history before determining the steps needed to meet Laboratory Services' mandates and to ensure that public health and safety is protected. The assistant deputy director told us that the analysis could lead Healthcare Quality to consider rightsizing Laboratory Services. The assistant deputy director explained that rightsizing is the process for ensuring that revenues collected will fully meet program expenditures. In doing so, expenditures need to be assessed and projected based on workload mandates and program needs.

We recommended that the department, in conjunction with Laboratory Services, ensure that Laboratory Services has sufficient resources to meet all its oversight responsibilities.

Department's Action: Partial corrective action taken.

Laboratory Services reported that it is identifying and evaluating the resources necessary to conduct a laboratory oversight program. It will continue to explore contracting with accrediting organizations for onsite inspections and proficiency testing monitoring. It is also working to recruit and hire qualified staff.

Finding #7: Laboratory Services' information technology resources do not support all its needs or supply complete and accurate data.

A lack of complete and accurate management data related to the work it performs also has contributed to Laboratory Services' struggles in meeting its mandated responsibilities. Laboratory Services relies on HAL to support licensing, registration, and renewal functions; however, HAL cannot adequately support Laboratory Services' activities related to complaints and sanctions. For example, HAL does not have sufficient fields to capture complaints Laboratory Services receives. To compensate for that and other data-capturing shortcomings of HAL, Laboratory Services has created several internal databases over the years. However, those databases lack the controls necessary to ensure accurate and complete information. All the internal databases we reviewed contain some illogical, incomplete, or incorrect data and could not be used to track activities effectively or to make sound management decisions.

We recommended that Laboratory Services work with its Information Technology Services Division and other appropriate parties to ensure that its data systems support its needs. If Laboratory Services continues to use its internally developed databases, it should ensure that it develops and implements appropriate system controls.

Department's Action: Partial corrective action taken.

Laboratory Services told us that it is seeking to hire staff with information technology database skills to help improve its internal databases and develop management reports. In addition, Laboratory Services reported that it is exploring replacing HAL, determining if its data needs can be supported by other existing systems within the department, and assessing whether the departmentwide enterprise licensing initiative can include its data systems needs.

Finding #8: Laboratory Services has opportunities to leverage its resources better.

Because it has numerous mandated responsibilities for a finite staff to fulfill, it is important that Laboratory Services demonstrate that it is using its existing resources strategically and maximally. During the audit, we identified several opportunities for Laboratory Services to provide oversight of clinical laboratories by leveraging its resources better, including its license and registration renewal process and the inspections and proficiency-testing reviews its staff currently perform on behalf of the federal government. Further, Laboratory Services has not taken advantage of its authority to approve accreditation organizations or contract some of its inspection and investigation responsibilities.[1] Exploring these ideas and others could help Laboratory Services better meet its mandated responsibilities.

We recommended that, to demonstrate that it has used existing resources strategically and has maximized their utility to the extent possible, Laboratory Services explore opportunities to leverage existing processes and procedures. These opportunities should include, but not be limited to, exercising clinical laboratory oversight when it renews licenses and registrations, developing a process to share state concerns identified during federal inspections, and using accreditation organizations and contracts to divide its responsibilities for inspections every two years.

Department's Action: Partial corrective action taken.

Laboratory Services reported that it has begun a quality assurance process to review 10 percent of personnel licensure including laboratory supervisor and director qualifications. It will take action to determine what review is needed to assure that owners and directors are in good standing. Additionally, Laboratory Services told us that it is evaluating the use of contract inspectors from accrediting organizations to assist with inspections needed every two years. In its 60-day response dated November 2008, Laboratory Services did not address its progress on our recommendation to develop a process to share state concerns identified during inspections its staff conduct on behalf of the federal government. In its initial response to the report, Laboratory Services commented that it would establish policies and procedures to require concurrent federal and state inspections.

Finding #9: Improperly imposed and revised fees led to a substantial revenue loss.

As Laboratory Services pursues additional resources and strives to ensure that it maximizes its use of existing resources, it is important to demonstrate that it has assessed fees appropriately. In three instances since fiscal year 2003–04, Laboratory Services incorrectly adjusted the fees it charged to clinical laboratories, resulting in more than $1 million in lost revenue. According to state law, Laboratory Services must adjust its fees annually by a percentage published in the budget act. From fiscal years 2003–04 through 2007–08, the budget acts included two fee increases: an increase of 22.5 percent effective July 1 of fiscal year 2006–07 and an increase of 7.61 percent effective July 1 of fiscal year 2007–08. However, Laboratory Services raised fees by 1.51 percent effective July 1 of fiscal year 2003–04, when it was not authorized to do so, and failed to raise fees effective July 1 of fiscal years 2006–07 and 2007–08, when it should have done so. Laboratory Services relied on an incorrect provision of the budget act in calculating its fees, and we found evidence of communication from the budget section within the department directing Laboratory Services not to raise its fees and citing the wrong provision of the budget act.

We recommended that Laboratory Services work with the department's budget section and other appropriate parties to ensure that it adjusts fees in accordance with the budget act.

Department's Action: Partial corrective action taken.

Laboratory Services stated that it has begun developing policy and procedures to adjust fees and will use the policy and procedures in future years to seek fee adjustment authority. It also noted that it is assessing the fiscal year 2008–09 fee increase the budget act authorized.

[1] An accreditation organization is a private, nonprofit organization the federal government has approved to provide laboratory oversight.

Department of Health Services

Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities

REPORT NUMBER 2006-106, APRIL 2007

Department of Health Services' response as of April and July 2008

The Joint Legislative Audit Committee requested the Bureau of State Audits to conduct an audit assessing the Department of Health Services' (Health Services)[1] oversight of skilled nursing facilities. Specifically, we found the following:

Finding #1: Health Services has been unable to initiate and close its complaint investigations promptly.

We found that Health Services has struggled to investigate and close complaints promptly. The Health and Safety Code requires Health Services to initiate investigations of all but the most serious complaints within 10 working days. Additionally, according to its policy, Health Services' goal is to complete a complaint investigation within 45 working days of receiving the complaint. To measure how promptly Health Services initiated and closed complaint investigations, we used data from its complaint-tracking system. We found that data related to the dates Health Services received complaints, initiated investigations, and closed complaints were of undetermined reliability. The data were of undetermined reliability primarily because of weaknesses in application controls over data integrity. According to these data, Health Services received roughly 17,000 complaints and reports of incidents that facilities self-reported between July 1, 2004, and April 14, 2006. Although not every complaint Health Services receives and reviews warrants an investigation, we found that Health Services promptly initiated investigations for only 51 percent of the 15,275 complaints for which it began investigations and promptly completed investigations only 39 percent of the time. To proactively manage its complaint workload, we recommended that Health Services periodically evaluate the timeliness with which district offices initiate and complete complaint investigations. Based on this information, Health Services should identify strategies, such as temporarily lending its staff to address workload imbalances occurring among district offices.

Health Services' Action: Partial corrective action taken.

Health Services reports that since April 2007, the date the court ordered it to meet statutorily required time frames for initiating complaint investigations, 5,359 complaints have been received. Of those, 33 were initiated beyond 10 working days for a compliance rate of 99.38 percent. However, Health Services did not provide statistics on how long it has taken to complete these investigations.

[1] On July 1, 2007, the California Department of Health Services was reorganized and became two departments—the Department of Health Care Services and the Department of Public Health. The Department of Public Health is now responsible for monitoring skilled nursing facilities.

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) oversight of skilled nursing facilities revealed the following:

- *Health Services has struggled to initiate and close complaint investigations and communicate with complainants in a timely manner.*
- *Health Services did not correctly prioritize certain complaints and understated the severity of certain deficient practices it identified at skilled nursing facilities.*
- *Health Services has yet to implement an Internet-based inquiry system as required by state law to provide consumers with accessible public information regarding skilled nursing facilities.*
- *The system Health Services uses to track complaint investigations regarding skilled nursing facilities has weak controls over data integrity that could allow erroneous data to be entered into the system without being detected.*
- *The timing of some federal recertification surveys is more predictable than others, which diminishes the effectiveness of these reviews.*
- *Health Services has weak controls over its disbursements of funds from the Health Facilities Citation Penalties Account, which limit its ability to ensure that funds are used for necessary purposes.*
- *Despite efforts to increase staffing, Health Services has struggled to fill its vacant facility evaluator positions with registered nurses. This reliance on registered nurses is also problematic because of the current nursing shortage and higher salaries offered elsewhere.*

Finding #2: Health Services did not always communicate with complainants within required time frames.

Health Services' staff could not demonstrate that they have consistently communicated with complainants promptly. Program statutes require Health Services to acknowledge its receipt of complaints within two working days and inform complainants in writing of the results of their investigations within 10 working days of completing their work. For 21 of the 35 complaints we reviewed, the files contained copies of the initial letters to the complainants. In seven of these 21 cases, we found that Health Services notified the complainant beyond the two working-day time frame. For the most delayed case, it took Health Services 104 days to notify the complainant. Similarly, for all 22 cases that contained copies of the second letter, we found that Health Services notified the complainant of the results of the investigation beyond the 10 working-day time frame. In the most delayed case, it took Health Services 273 days to provide this notification to the complainant. The main cause for delays in providing the second notice appears to be Health Services' practice of waiting for the facility to first submit its plan of correction, which can take another 10 to 15 days beyond the date the facility was notified, before informing the complainant of the investigation results. By failing to consistently meet deadlines for communicating with complainants, Health Services unnecessarily exposes complainants to continued uncertainty about the well being of residents at skilled nursing facilities.

To ensure that it fully complies with state law regarding communication with complainants, we recommended that Health Services reassess its current practice of delaying notification to complainants about investigation results until after it receives acceptable plans of correction from cited skilled nursing facilities. If Health Services continues to support this practice, it should seek authorization from the Legislature to adjust the timing of communications with complainants accordingly.

Health Services' Action: Corrective action taken.

Health Services has inserted additional guidance in its complaint investigation procedures to address our recommendation. Specifically, Health Services now requires its staff to notify complainants of the results of investigations within 10 days following the last day of the on-site inspection. Further, Health Services' quality assurance process includes auditing complaint files to see if the letter was sent in a timely manner and is included in the hard copy file.

Finding #3: Health Services has not consistently investigated complaints and included all relevant documentation within complaint files.

Our review noted that, although there is a policy to close complaints within 45 working days of receiving them, Health Services' complaint investigation procedures do not establish guidelines for the timely completion of the various stages of the complaint investigation process. Without timelines for individual steps in the complaint investigation process linked to the parties responsible for performing them, Health Services cannot be sure its objectives are being met and will have difficulty holding staff accountable for the timely completion of work. Further, we found that Health Services' complaint files did not always contain sufficient documentation to help explain where delays in the process were occurring, and to evidence the completion of required activities.

To evaluate Health Services' practices for investigating complaints, we reviewed five complaint investigation files at each of the seven district offices we visited. We found that for 18 of the 35 complaints, just the time it took between starting an on-site investigation and notifying the facility in writing of the results equaled or exceeded the 45 working-day policy for closing complaints. In 15 of these 18 instances we were able to identify the cause of these delays, such as facility evaluators needing more time to complete their work prompted by obtaining additional information or interviewing other individuals not located at skilled nursing facilities. However, in three cases we could not make this determination either because of missing investigation reports or reports that were completed after Health Services notified the facility about the results. We saw similar documentation problems regarding Health Services' efforts to provide timely notifications to complainants.

Specifically, Health Services could not provide evidence that it acknowledged receipt of a complaint for four of the 35 complaints we reviewed, while similarly being unable to produce evidence that it informed complainants of the results of investigations in seven instances.

To ensure that district offices consistently investigate complaints and include all relevant documentation in the complaint files, Health Services should clarify its policies and procedures, provide training as necessary, and periodically monitor district office performance to ensure compliance. At a minimum, Health Services should:

- Clarify its 45 working-day policy for closing complaints by establishing target time frames for facility evaluators, supervisors, and support staff to complete key stages in the complaint process.
- Ensure that each complaint file includes a workload report (timesheet), an investigation report, and copies of both letters sent to complainants.
- Clarify that investigation reports should be signed and approved prior to notifying skilled nursing facilities about the results of investigations.
- Attempt to obtain mailing addresses from all complainants that do not wish to remain anonymous.

Health Services' Action: Partial corrective action taken.

Health Services has addressed two of the four bulleted recommendations by instituting a quality assurance process for its complaint investigations. Specifically, Health Services' quality assurance process includes peer reviews to ensure that complainants receive timely notification at the initiation and conclusion of investigations. Further, this process includes reviewing the quality of the investigations performed, such as ensuring that its staff properly investigate complaints and issue citations that are adequately supported by the evidence.

Although Health Services has established a goal of completing its investigations within 40 days following the start of its reviews and evaluates how long investigations actually take as part of its quality assurance process, it has not established target time frames for facility evaluators, supervisors, and support staff to complete key stages in the complaint investigation process. Without such timelines, Health Services will continue to have difficulty in holding staff accountable for the timely completion of their work. Health Services reports that it disagrees with this particular aspect of our recommendation, explaining that establishing target time frames for its staff and tracking their performance would create an incredible, unfunded workload request. Finally, although Health Services' one-year response indicated that its quality assurance process includes steps to review whether its staff attempt to obtain the mailing addresses of complainants that do not wish to remain anonymous, we found no evidence of this in our review of its quality assurance reports.

Finding #4: Health Services may have understated the priority levels of complaints received and the severity levels of deficiencies identified during recertification surveys.

We found that Health Services may not have correctly prioritized complaints it received against skilled nursing facilities. For 12 of the 35 complaints we reviewed, Health Services may have understated the priority of complaints that, according to requirements, would have warranted more urgent investigations. We also found that Health Services may have understated the severity of the deficiencies it identified for nine of the 35 recertification surveys we reviewed. When Health Services does not classify deficiencies at a sufficiently severe level, the enforcement actions Health Services imposes on skilled nursing facilities may not be adequate, and facility stakeholders may form misperceptions about the quality of care offered at those facilities.

We recommended that Health Services ensure that staff correctly and consistently prioritize complaints and categorize the deficient practices of skilled nursing facilities.

Health Services' Action: Corrective action taken.

Health Services' new quality assurance program includes reviewing randomly selected complaint investigations to ensure, among other things, that complaints are appropriately prioritized and that complaint dispositions are appropriate.

Finding #5: Health Services has failed to meet state requirements for providing public access to information on skilled nursing facilities.

To enhance the quality and public accessibility of information on long-term care facilities, the Legislature passed Assembly Bill 893 (Chapter 430, Statutes of 1999), which required Health Services to provide the public with an on-line inquiry system accessible through a toll-free telephone number and the Internet. This inquiry system must provide information to consumers regarding a skilled nursing facility of their choice, including its location and owner, number of units or beds, and information on state citations assessed. Our audit found that Health Services has been unable to fully implement this system nearly five years after the Legislature's deadline of July 1, 2002. Health Services' management asserted that budget shortfalls in fiscal years 2003–04 and 2004–05 have hampered its efforts to implement the Internet-based system.

We recommended that Health Services continue in its efforts to implement an Internet-based inquiry system and take steps to ensure that the data it plans to provide through the system are accurate.

Health Services' Action: Corrective action taken.

Health Services reports that it launched the Health Facilities Consumer Information System (HFCIS) on January 23, 2008. Our review of this system confirmed that users are able to find a variety of information on skilled nursing facilities, including locations and owners; the number of units or beds; and summary information on complaints, state-enforcement actions, and survey deficiencies.

Finding #6: The system Health Services uses to track complaint investigations is governed by weak application controls.

Health Services complaint-tracking system is one module in the Automated Survey Processing Environment (ASPEN), a database developed and maintained by the Centers for Medicare and Medicaid Services (CMS). Health Services' district offices enter complaint investigation and federal recertification survey data into ASPEN for all facilities within California. Our audit found that the complaint-tracking system has weak application controls that preclude Health Services from preventing erroneous data from being entered into the system or detecting data errors or omissions within the system. We also found that district office data entry staff are not consistently using the complaint-tracking system to record data regarding complaint investigations. For example, data entry staff record two different events in the field designed to capture the on-site investigation completion date. Some data entry staff record the date that the on-site investigation ended, while others record the date when the facility evaluators have determined the type of enforcement action to take. In addition, we found instances in which various dates in the complaint-tracking system conflicted with the normal sequence of events that occurs when Health Services investigates a complaint. For example, 677 of the 17,042 records in the system's population of complaints that were prioritized at either the immediate-jeopardy or non-immediate-jeopardy level and were received between July 1, 2004, and April 14, 2006, have entries indicating that some step in the investigation process occurred before the complaint was recorded as received.

To improve the accuracy of complaint data used to monitor its workload and staff performance, we recommended that Health Services develop strong application controls to ensure that its data are accurate, complete, and consistent. This process should include validating the data entered into key data fields, ensuring that key data fields are complete, and training staff to ensure consistent input into key data fields, such as the field designed to capture the date on which the investigation was completed.

Health Services' Action: Corrective action taken.

Health Services reports that it has developed standard performance measures for each district office. One of the performance measures requires, on a quarterly basis, random checks by the support staff supervisor to ensure the accuracy of data input as well as complaint files. Our review of Health Services' quality assurance program confirmed that it evaluates whether the information noted in the complaint file agrees with its data system. Finally, Health Services reports that it has begun a recurring training program where it reminds staff of data input and accuracy procedures.

Finding #7: Health Services could enhance the value of its recertification surveys by making its visits less predictable.

Federal regulations prescribe the frequency with which Health Services must conduct its recertification surveys of skilled nursing facilities, requiring a survey no later than 15 months after a facility's prior survey, with an average of 12 months between all of its recertification surveys of skilled nursing facilities statewide. In interpreting these regulations, the CMS actually allows states more generous time frames of 15.9 months between recertification surveys and a statewide average survey interval of 12.9 months. As of June 2006 Health Services' survey interval averaged 12.2 months, and only one survey had occurred more than 15.9 months after the facility's last survey.

Although Health Services has been able to meet recertification survey frequency requirements statewide, it could improve the randomness with which it schedules the surveys. According to CMS, "states have a responsibility for keeping surveys unannounced and their timing unpredictable. This gives the state agency doing the surveying greater ability to obtain valid information." Our own analysis indicates that some district offices may have performed better than others in managing their workloads and varying the timing of their recertification surveys. For example, most recertification surveys conducted within the jurisdiction of the Daly City district office occurred near the end of the 15.9-month federal deadline, allowing little room for variability. In contrast, the Chico district office was less predictable in its scheduling of surveys because it did not concentrate its activity immediately before a known deadline.

To reduce the predictability of its federal recertification surveys, we recommended that Health Services institute a practice of conducting surveys throughout the entire survey cycle, ensuring that each facility has a greater probability of being selected at any given time.

Health Services' Action: Pending.

Health Services' six-month response indicated that it had planned to use the CMS ASPEN system to help schedule recertification surveys in a way that will reduce their predictability. However, Health Services' one-year response indicated that it has not yet been able to use the ASPEN system as planned due to its focus on implementing the HFCIS and delays with a federal contractor that maintains the ASPEN scheduling system. In addition, Health Services did not specify when it expects to implement the scheduling system.

Finding #8: Health Services has weak controls for disbursing certain funds from the Health Facilities Citation Penalties Account (citation account).

We generally found that Health Services' controls over the expenditure of funds from the citation account were weak. Allowable uses of citation account funds are prescribed within state law and include paying for the costs of ensuring the continued operation of a skilled nursing facility pending its correction of cited deficiencies or closure, including the appointment of temporary management or receivership, in the event that revenues from the facility are insufficient. Our review of citation account expenditures revealed that Health Services relied on high-level forecasts of expected revenues and expenses submitted in e-mails by temporary management companies as a basis to request funding. Given the magnitude of some of

these payments—we noted one instance in which a single payment exceeded $700,000—we would have expected Health Services to eventually request evidence beyond the e-mails to gain some assurance that the payments made were necessary.

In addition, Health Services provided more than $10.5 million to one temporary management company and had only one other approved temporary management company available for use. With such a small pool of qualified and available temporary management companies, Health Services may have less ability to employ such firms as a means of effecting change in underperforming skilled nursing facilities and has less assurance that it is getting a competitive price for these services. Finally, our review found that Health Services did not maintain adequate support for $581,000 in citation account funds that it used to purchase computers for its licensing and certification division.

To ensure it can adequately justify the expenses it charges to the citation account, we recommended that Health Services take steps to gain assurance from temporary management companies that the funds they received were necessary. This should include reviewing the support behind temporary management companies' e-mails requesting payments. In addition, Health Services should take steps to expand its pool of temporary management companies to ensure that it has sufficient numbers of temporary management companies available and receives competitive prices. Finally, when Health Services charges general support items to the citation account, it should be able to document its rationale for determining the amounts charged.

Health Services' Action: Pending.

Health Services reports that it has drafted new procedures for appointing temporary managers. These draft procedures define the roles and responsibilities of Health Services' staff and the temporary management company. In addition, the draft procedures include the reporting responsibilities and financial processes, such as requesting payment for services. Health Services anticipates finalizing its new procedures by the end of July 2008, and soliciting new applications for prospective temporary management companies in August 2008, renewing this process every 12 to 18 months.

Finding #9: Staffing shortages hamper Health Services' enforcement efforts, and filling its vacant positions remains difficult.

Health Services cited staffing shortages as the cause of many of its oversight problems. We believe that Health Services' explanation has some merit. Our review of the staffing levels within the Field Operations Branch (branch) of the Licensing and Certification Division indicated that securing adequate staffing has been a problem. In the fiscal year 2005–06 budget, the Legislature approved funding for 485 positions within the branch, of which 397 were facility evaluator positions. During the same year, the branch reported it was able to fill 426 of these approved positions, of which 347 were facility evaluators. Most of these facility evaluators are registered nurses, accounting for 78 percent of the 397 health facility evaluator positions authorized in fiscal year 2005–06. Annual vacancy rates for these positions averaged about 16 percent between fiscal year 2002–03 and 2005–06 but have declined slightly each year since fiscal year 2003–04. Health Services primarily focuses on hiring candidates that are registered nurses; however, a nursing shortage and higher salaries elsewhere make filling these positions problematic.

To fill its authorized positions and manage its federal and state workloads, we recommended that Health Services consider working with the Department of Personnel Administration (DPA) to adjust the salaries of its staff to make them more competitive with those of other state agencies seeking similarly qualified candidates. In addition, Health Services may want to consider hiring qualified candidates who are not registered nurses. Finally, if these options prove unsuccessful, Health Services should develop additional strategies, such as temporarily reallocating its staff from district offices that are less burdened by their workloads to those facing the highest workloads.

Health Services' Action: Pending.

Health Services reports that it has received a preliminary report on the employee classification study from its contractor, Cooperative Personnel Services. Health Services has reviewed this report and expects to submit its proposals to DPA in August 2008. In addition, Health Services reports that it has renegotiated, but not yet executed, a new contract with Los Angeles County. Health Services asserts that a provision of this new contract allows for the contractor's staff to perform work outside of the county upon a written request from Health Services.

Department of Social Services

Investigations of Improper Activities by State Employees, July 2007 Through December 2007

INVESTIGATION I2006-1040 (REPORT I2008-1), APRIL 2008

Investigative Highlight . . .

The Department of Social Services wasted $14,714 in state and federal funds.

Department of Social Services' response as of September 2008

We investigated and substantiated an allegation that the Department of Social Services (Social Services) violated state contracting policy and wasted state and federal funds by paying $14,714 for improper overhead costs.

Finding: Social Services failed to scrutinize invoices and wasted state and federal funds by paying unnecessary overhead costs totaling $14,714.

Social Services wasted state and federal funds when it improperly paid for overhead costs that violated a state policy. According to the policy, state agencies must ensure that overhead fees are reasonable; thus, the agencies may pay overhead charges only on the first $25,000 for each subcontract. However, in seven of the nine contracts we reviewed for conference-planning services from 2004 through 2007, Social Services did not limit payments for overhead costs to the first $25,000 of subcontracts, but instead paid overhead costs on the entire subcontract amounts when the subcontracts exceeded $25,000. As a result, Social Services made $14,714 in improper payments, constituting a waste of state and federal funds. Social Services apparently made these improper payments because it failed to scrutinize invoices and did not monitor these contracts adequately for compliance with state policy. In addition, we found that if Social Services proceeds with four additional contracts for upcoming conferences, it likely will waste an additional $13,000 in state and federal funds.

Social Services' Action: Partial corrective action taken.

At the time of our report, Social Services stated that it had revised its standard contract language to cite the state policy that limits the application of overhead charges on subcontracts. Social Services also reported that it planned to similarly amend the contracts for its upcoming conferences. In addition, Social Services told us that it had requested more detailed budgets from its contractor to better distinguish the services provided by subcontractors. Further, Social Services stated that it planned to develop guidelines that would assist staff in the appropriate application of indirect cost rates and identify subcontracts during contract development. Social Services informed us in May 2008 that the exclusion from its standard contract language of a provision implementing the state policy that limits charges for overhead costs to the first $25,000 of subcontracts was an administrative oversight and that it did not intend to take any disciplinary action against any of its employees. In September 2008 Social Services reported that it had recouped $13,171 in overpayments from the contractor. In addition, Social Services indicated that the remaining $1,543 was not improper because it determined that one of the subcontract

line items greater than $25,000 contained in the contractor's invoice was for multiple subcontracts, which were each less than $25,000. Finally, Social Services told us that the contractor had revised its budget detail to facilitate the identification of subcontractors.

Sex Offender Placement

State Laws Are Not Always Clear, and No One Formally Assesses the Impact Sex Offender Placement Has on Local Communities

REPORT NUMBER 2007-115, APRIL 2008

Department of Justice's and Department of Corrections and Rehabilitation's responses as of October 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the State's process for placing sex offenders in residential facilities. Specifically, the audit committee asked that the bureau determine residency options for sex offenders on parole, identify the departments responsible for licensing such facilities, and quantify the number of sex offenders in various facilities. It also requested that the bureau review the departments' policies and procedures for licensing facilities and for identifying, evaluating, placing, and tracking sex offenders in local communities.

Finding #1: State laws for licensing residential facilities contain no specific provision for housing sex offenders.

State laws that govern the licensure of residential facilities do not contain specific rules or prohibitions for housing sex offenders. Two state departments are typically responsible for licensing facilities that could house six or fewer persons, including sex offenders. The Department of Social Services (Social Services) licenses community care residential facilities, and the Department of Alcohol and Drug Programs (Alcohol and Drug) licenses residential alcohol and substance abuse treatment facilities. Neither state laws nor departmental policies require consideration of the criminal background of the clients the licensees plan to serve. Further, these two departments are not required to, nor do they, track whether individuals residing at these facilities are registered sex offenders. Additionally, while the database of the Department of Justice (Justice) contains the addresses of registered sex offenders, it is not currently required to, nor does it, indicate whether or not the address is a licensed facility. We attempted to determine the number of sex offenders residing at licensed facilities by comparing the databases from the two licensing departments containing the addresses of such facilities to Justice's database. Because of the variations of the same address included in the databases maintained by Social Services, Alcohol and Drug, and Justice, we were unable to determine the precise number of facilities that housed sex offenders. Nevertheless, our comparison showed that at least 352 facilities appeared to house a total of 562 sex offenders as of December 13, 2007. We also found 49 instances in which the registered addresses in Justice's database for sex offenders were the same as the official addresses of facilities licensed by Social Services that serve children, such as family day care homes and foster family homes.

We recommended that if the Legislature is interested in identifying all sex offenders living in licensed residential facilities, it require Justice, Social Services, and Alcohol and Drug to coordinate with one another and

Audit Highlights . . .

Our review of the placement of sex offenders in communities found that:

» *The Department of Justice's (Justice) database contained more than 59,000 registered sex offenders living in California communities. Of these, 8,000 are supervised and monitored by the Department of Corrections and Rehabilitation (Corrections) until they complete their parole.*

» *State laws and regulations and departmental policies do not require that licensing departments consider the criminal background of potential clients, including registered sex offenders, that the licensed facilities plan to serve.*

» *State law does not generally allow sex offenders on parole to reside with other sex offenders in a single family dwelling that is not what it terms a "residential facility;" however, in several instances two or more sex offenders on parole were residing in the same hotel room.*

» *The registered addresses in Justice's database for 49 sex offenders were the same as the official addresses of facilities licensed by the Department of Social Services that serve children.*

» *Although state law does not prohibit two or more sex offenders from residing at the same "residential facility," it does not clearly define whether residential facilities include those that do not require a license, such as sober living facilities.*

» *State law is also unclear whether the residence restriction applies to juvenile sex offenders; we found several instances in which Corrections placed juvenile sex offender parolees at the same location.*

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» *Local law enforcement agencies generally told us they have not performed formal assessments of the impact sex offenders have on their resources and communities.*

» *State laws generally do not require the departments or their contractors that place registered sex offenders to consider the impact on local communities when making placement decisions.*

develop an approach that would allow them to generate such information on an as needed basis. For example, with the assistance of Social Services and Alcohol and Drug, Justice could assign a unique identifier to each registered address in its database, such as the license number issued by the respective licensing department, which would allow it to track the number of sex offenders living together in licensed facilities.

To ensure that registered adult sex offenders are not residing in licensed facilities that serve children, we also recommended that Justice provide Social Services with the appropriate identifying information to enable Social Services to investigate those instances in which the registered addresses of sex offenders were the same as child care or foster care facilities. Further, if necessary, Justice and Social Services should seek statutory changes that would permit Justice to release identifying information to Social Services so that it can investigate any matches.

Legislative Action: Legislation proposed.

Assembly Bill 2593 was introduced to require the Department of Social Services to implement some of these recommendations. The bill did not pass during the 2007—08 Regular Session.

Justice's Action: Corrective action taken.

Justice stated that it has actively worked with Social Services to ensure that registered adult sex offenders are not residing in licensed facilities that serve children. It further stated that it continues to make available to Social Services the appropriate identifying information to enable Social Services to investigate those instances in which the registered addresses of sex offenders were the same as child care or foster facilities. Additionally, Justice indicated that it determined a statutory change was not necessary in order for it to share the names and addresses of persons in the sex offender database with Social Services law enforcement officers. Further, Justice noted that it negotiated an interagency agreement with Social Services, whereby Justice will implement certain protocols that will allow Social Services' peace officers to promptly investigate any instance in which the address of a registered sex offender is the same as a licensed facility. According to Justice, the interagency agreement is with Social Services for its final approval and execution.

Social Services' Action: Corrective action taken.

Social Services stated that it has investigated the 49 instances we identified in our report in which the registered addresses in Justice's database for sex offenders were the same as the official addresses of facilities licensed by Social Services that serve children. Social Services stated that it took appropriate actions to address those that were in violation of the terms and conditions of their licensure. Further, as recommended, Social Services indicated it sponsored an assembly bill that, among other things, would have provided the explicit authority for Justice to share its registered sex offender database with Social Services; however, the bill did not pass. Although the legislation was not successful, Social Services indicated it has continued to perform comparisons of the addresses of sex offenders listed on Megan's list with those

of licensed children's facilities. Finally, Social Services also noted that it is finalizing an interagency agreement with Justice that will enable periodic automated matches of Justice's sex offender database with addresses of facilities licensed by Social Services.

Finding #2: State law is unclear as to whether more than one adult or juvenile sex offender may reside at certain types of facilities.

State law is not always clear as to whether a sex offender on parole may reside with another sex offender in certain types of facilities. Although most sex offenders may live with other sex offenders, the California Penal Code states that an individual released on parole after being incarcerated in state prison for a sexual offense generally may not reside with another sex offender in a single family dwelling during the period of parole, except in a residential facility. We found several instances in which two or more sex offender parolees were listed as living in the same room of a hotel by reviewing addresses in a database of adult parolees maintained by the Department of Corrections and Rehabilitation (Corrections). Although the law is unclear as to whether a single room within a hotel is considered a single-family dwelling, Corrections has interpreted the law as such; therefore, its policies do not allow a sex offender on parole to reside with another sex offender in the same room within a hotel. When we informed Corrections' staff of this policy violation, they indicated that they plan to review all residences of paroled sex offenders to ensure compliance. Nevertheless, we believe the law is unclear on this matter.

This law also is not clear as to whether a sex offender on parole may reside with another sex offender at a residential facility that does not require a license, such as a sober living facility. We identified several instances in which two or more adult sex offenders on parole were residing at the same sober living facility. It is also unclear whether this restriction applies to juvenile offenders. We found several instances in which Corrections placed more than one juvenile sex offender parolee at the same location, such as a group home, that does not require a license, because it does not believe the residence restriction imposed by this statute applies to juveniles.

We recommended that the Legislature consider amending the law that places limits on the number of paroled sex offenders who may reside at the same single-family dwelling to clearly define a single-family dwelling and a residential facility. Further, we recommended that the Legislature specify whether this statute applies to juvenile sex offenders.

We also recommended that Corrections continue to monitor the addresses of paroled sex offenders to ensure that they are not residing with other sex offenders, including those not on parole, in the same unit of a multifamily dwelling.

Legislative Action: Unknown.

Corrections' Action: Corrective action taken.

Corrections stated that it completed an audit of all adult sex offender parolees and it continues to monitor any situation of alleged noncompliance with state laws and its policies. It also noted that it issued a policy memorandum to appropriate parole staff to clarify residence restrictions for sex offenders. Further, it requires parole agents in its Juvenile Division to confirm with local law enforcement that no other registered sex offenders are living in a proposed placement.

Finding #3: The database used by Correction's Juvenile Division to track juvenile parolees is incomplete.

When we attempted to identify the number of juvenile sex offenders residing in licensed and unlicensed facilities by using the database that Correction's Juvenile Division uses to track its juvenile parolees, we found that the database was incomplete. More specifically, the Juvenile Division's database does not identify whether the person is registered as a sex offender. Therefore, to identify the sex offenders who are parolees under the Juvenile Division's supervision, we attempted to use Social Security

numbers to identify the sex offenders by comparing the data to Justice's sex offender registry. However, of 2,559 juvenile offenders on active parole contained in the database, 22 percent were missing Social Security numbers and over 6 percent were missing criminal investigation and identification numbers. As a result, we may not have identified all juvenile offenders who were also sex offenders by matching their Social Security numbers or criminal investigation and identification numbers with those in the database from Justice. The Juvenile Division's policies state that Social Security numbers are required for identification and to assist juvenile offenders in obtaining employment and benefits. Moreover, a director in the Juvenile Division told us that the criminal investigation and identification numbers are required in order to conduct warrant and historical checks on a timely basis. According to the director, the division is currently working to ensure that the missing information is entered into its database for all juvenile offenders.

We recommended that Corrections' Juvenile Division update its database to include the Social Security numbers and criminal investigation and identification numbers for all juvenile offenders under its jurisdiction.

Corrections' Action: Pending.

Corrections noted that it issued a memorandum requiring supervisors to review the Juvenile Division's database to determine which parolees are missing criminal investigation and identification numbers. It indicated that it plans to complete this process by December 30, 2008.

Finding #4: Corrections adequately supervised its sex offender parolees but did not always follow its policies.

Our review of 20 adult and 20 juvenile sex offender parolees found that Corrections' parole agents generally supervised them in accordance with department policies. However, in 15 of the 20 adult cases and one juvenile case, Corrections could not provide evidence that it informed local law enforcement agencies of the impending release of the parolee into their jurisdiction as required by its policies, was late in informing them, or did not inform them of a change in parole release date. Further, in two of the 20 adult cases and one juvenile case, Corrections did not ensure that the parolee registered with local law enforcement within five working days as required. Finally, Corrections did not always monitor juvenile parolees as required by its policies.

We recommended that Corrections ensure that its parole regions provide timely notification of the release of all parolees to the applicable law enforcement agencies and that its parole agents review all registration receipts to make certain that all parolees required to register as sex offenders do so within five working days of moving into a local jurisdiction. We further recommended that the Juvenile Division's parole agents monitor juvenile parolees as required and maintain all documents to support its monitoring efforts.

Corrections' Action: Partial corrective action taken.

Corrections stated that its Division of Adult Parole Operations issued a policy reiterating registration requirements pursuant to various state laws. Further, it noted that the Division of Adult Parole Operations issued a separate policy directing staff to provide enhanced notification to law enforcement agencies, in addition to that already provided in accordance with laws.

Corrections stated that its Juvenile Division plans to provide training to all support staff to reinforce the policy related to providing timely notification of the release of all parolees to the applicable law enforcement agencies. Further, the director of Juvenile Parole Operations issued a memorandum reminding all parole staff of the notification requirements. Additionally, Corrections indicated that the assistant supervising parole agent within its Juvenile Division will conduct, at a minimum, quarterly reviews with the agent of record to verify the registration receipt and the copy of such receipt is in the field file. To ensure that the Juvenile Division's parole agents monitor juvenile parolees as required and maintain all documents to support its monitoring efforts, according to Corrections, its Juvenile Division provided refresher training to all field parole agents regarding contact standards for various cases. Corrections also indicated that it plans to provide training to the agents of record in the Juvenile Division to document the contacts and to place the documentation in the field file.

Safely Surrendered Baby Law

Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact

REPORT NUMBER 2007-124, APRIL 2008

Department of Social Services' response as of October 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the Department of Social Services' (Social Services) administration of the Safely Surrendered Baby Law (safe-surrender law). The Legislature, responding to a growing number of reports about the deaths of abandoned babies in California, enacted the safe-surrender law, which became effective in January 2001. The law provides a lifesaving alternative to distressed individuals who are unwilling or unable to care for a newborn by allowing a parent or other person having lawful custody of a baby 72 hours old or younger to surrender the baby confidentially and legally to staff at a hospital or other designated safe-surrender site. The audit committee asked us to identify funding sources and review expenditures for the safe-surrender program since 2001 and determine how much has been used for public awareness, printing and distribution of materials, and for personnel. We were also asked to determine how Social Services sets its annual goals, examine its process for determining which outreach and public awareness strategies are the most effective, and identify its plans for future and enhanced outreach to increase the public awareness of the law. In addition, the audit committee asked us to gather information regarding safely surrendered and abandoned babies and determine whether the public outreach efforts appear to be appropriately targeted in light of this information.

Finding #1: The safe-surrender law lacks an administering agency and consistent funding for its implementation.

The safe-surrender law is not as effective as it might be because it does not give state agencies rigorous, ongoing responsibilities for publicizing the law's benefits, and the State has not funded the administration or promotion of a safe-surrender program. Before 2006 the law simply required Social Services, the state agency primarily responsible for implementing the law, to report annually to the Legislature on the law's impact. Since 2006 state agencies have had virtually no legal obligations under the safe-surrender law. Social Services' only involvement is compiling information that counties must submit when their designated sites accept surrendered babies, and since 2002 it has not attempted to obtain funds to further implement and publicize the safe-surrender law. The Legislature did pass two bills that, among other things, would have required Social Services to conduct a media campaign to increase public awareness of the safe-surrender law, but Governor Davis and Governor Schwarzenegger vetoed those bills. Nonetheless, in late 2001, at the request of then-Governor Davis, Social Services used approximately $800,000 from its State Children's Trust Fund (trust fund) and obtained $1 million from the California Children and Families Commission (First 5 California) to conduct a two-phase public awareness campaign.

Audit Highlights . . .

Our review of the State's implementation of the Safely Surrendered Baby Law (safe-surrender law) revealed the following:

- *The safe-surrender law does not impose on any state agency sufficient requirements to publicize its availability, thus potentially reducing the law's effectiveness.*
- *The State's failure to provide consistent funding for promoting the law may further reduce its effectiveness.*
- *The Department of Social Services' (Social Services) initial efforts to publicize the safe-surrender law exceeded its statutory obligations; however, it has not developed any further goals for conducting additional activities.*
- *After the Legislature amended the safe-surrender law to provide greater protection to individuals who surrender a child, Social Services supplied counties with erroneous guidance on managing confidential data on these individuals.*
- *Safe-surrender sites included identifying information on individuals who surrendered babies—a violation of state law—in more than 9 percent of the cases since the amendment took effect.*
- *At least 77 children may not have access later in life to information on their birth parents that they may have a legal right to view because, according to Social Services, counties have incorrectly classified them as surrendered.*

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» *Likely as the natural result of the safe-surrender process and the act of abandoning a child, which do not lend themselves to robust data collection, we learned very little about the mothers of surrendered and abandoned babies from our review of the caseworker narratives.*

» *Several counties have developed interesting approaches to increasing public awareness about the safe-surrender law.*

If it would like Social Services or other agencies to promote awareness of the safe-surrender law, we recommend that the Legislature consider amending the law to do the following:

- Specify the agency that should administer a safe-surrender program, with responsibilities that include ongoing outreach and monitoring efforts.
- Require continued annual reporting to the Legislature on the law's impact.
- Consider providing or identifying funding that will support efforts to promote awareness of the law.

To support future efforts related to the safe-surrender law, including continuing outreach and improving the quality of the State's statistics, we recommended that Social Services consider using a portion of existing funds, such as those available in its trust fund, and should consider renewing its partnership with First 5 California, which Social Services can legally use for such efforts.

Legislative Action: None.

Social Services' Action: Partial corrective action taken.

Social Services stated it will continue to provide funding for outreach related to the safe-surrender law to the extent that funding from the trust fund is available. Further, Social Services reported that a safe-surrender law outreach committee was formed as part of a workgroup, and is tasked with developing outreach activities related to raising public awareness about the law. Social Services indicated that one recommendation from the subcommittee is to submit a funding proposal to First 5 California.

Finding #2: Social Services' lack of further plans to publicize the safe-surrender law may limit its effectiveness.

Because the State has not funded a program that would publicize the safe-surrender law and its benefits, Social Services has not actively publicized the law since concluding the mass-media portion of its awareness campaign in December 2003. Further, Social Services presumes that counties are actively promoting the law and that increases in the number of abandoned babies would provide the necessary warning for it to adjust its practices. However, our audit indicated that Social Services' assumptions about the counties' programs for and its statistics about the safe-surrender law may be incorrect.

Social Services' staff stated that although the department will update its information on the safe-surrender law if it changes, it does not plan to actively promote the law. Moreover, Social Services' administrators do not believe that an official safe-surrender program exists because the Legislature has not created or funded such a program.

We believe that Social Services' decision not to set long-term goals for or actively promote the safe-surrender law will probably limit the law's effectiveness. Indeed, some individuals who are unaware of the law may abandon rather than safely surrender babies born to mothers who may not be able to care for them. In justifying its position, Social Services' management explained that the department has fulfilled all of its legal requirements. In addition, management indicated that counties have ongoing public awareness efforts and that Social Services' statistics do not indicate an "alarming increase" in the number of abandoned babies. Although we agree that state law does not presently require it to take any further action, Social Services' assumption that counties are continuing to market the safe-surrender law is not well founded, and its statistics on abandoned babies are incomplete. For instance, for calendar years 2003 through 2006, Social Services reported a total of five deceased abandoned babies found throughout the State, and it reported no deceased abandoned babies for 2005. Our limited review of other data suggests that the actual number of deceased abandoned babies may be much higher. Specifically, the Inter-Agency Council on Child Abuse and Neglect reported that in Los Angeles County alone, 24 deceased abandoned babies were found during the same four-year period. In addition, a database that the Department of Public Health (Public Health) maintains to monitor the deaths of children and the causes of those deaths contains information on six deceased abandoned infants, found across California in 2005, who we determined were one year old or younger. Additionally, Social Services' position suggesting that it will not conduct additional activities related to the safe-surrender law unless the number of abandoned babies increases significantly is not in keeping with the mission of the Office of Child Abuse Prevention.

We recommended that Social Services work with Public Health and county agencies to gain access to the most accurate and complete statistics on abandoned babies to ensure that it is aware of and can appropriately react to changes in the number of abandoned babies.

Social Services' Action: Pending.

Social Services stated that as part of the tasks being addressed by the safe-surrender law workgroup, a subcommittee was formed to address data issues. The subcommittee includes representatives from Social Services, Public Health, and county agencies. According to Social Services, efforts are underway to address the following:

- Clarification regarding the manner in which data for surrendered and abandoned babies is extracted from the Child Welfare Services/Case Management System (CWS/CMS).
- Clarification regarding the issuance of a Certificate of Finding, which does not list the birth parents' names, in lieu of a birth certificate for surrendered babies.
- Public Health and Social Services' data sharing related to safely surrendered and abandoned babies.

Social Services will also continue to partner with Public Health and county agencies to ensure the accuracy of the data.

Finding #3: Safe-surrender sites are violating state law by disclosing confidential information on individuals who surrender babies.

Social Services' guidance on the management of confidential data is contrary to the Legislature's intent for the safe-surrender law and, combined with the safe-surrender sites' violation of the prohibition against providing confidential data to county agencies, may adversely affect one of the safe-surrender law's ultimate goals—the adoption of surrendered infants.

Effective January 2004 the Legislature amended the safe-surrender law to protect personal identifying information contained in the medical questionnaire on persons who surrender babies. In August 2004 Social Services issued an information notice to all counties that gave instructions on entering data about safely surrendered babies into the CWS/CMS. Among other things, the instructions stated that

if the parent(s) verbally provided their names, the counties should enter the names into the CWS/CMS because the parent(s) has waived their privilege of confidentiality. Conversely, if a parent reveals their name on the medical background questionnaire, their name should not be entered in the CWS/CMS.

According to our legal counsel, the instructions provided by Social Services appear to contradict state law. Specifically, the safe-surrender law states that any personal identifying information that pertains to a parent or individual who surrenders a child is confidential and shall be redacted from any medical information provided to the county agency. In fact, the law unambiguously prohibits the disclosure of identifying information on the person who surrenders a baby by a safe-surrender site—even to county agencies. Further, we believe that it is unlikely that a parent surrendering a child would know that verbally mentioning her or his name could constitute a waiver of the privilege of confidentiality. Moreover, our legal counsel asserts that the safe-surrender law does not provide that a person verbally providing personal information waives his or her right to confidentiality.

Despite the law's clear prohibition of the disclosure of identifying information by safe-surrender sites, we found that county documents in the CWS/CMS created both before and after Social Services provided this guidance contained personal information on parents of surrendered babies. Our review of caseworker narratives for all 218 babies surrendered since 2001 identified the names, phone numbers, or addresses of individuals who surrendered children in 24 cases, including 16 (9 percent) of the 176 cases occurring since January 2004 when the Legislature strengthened the protection given such information. Each of these cases reflects a violation of the safe-surrender law. Individuals who otherwise would use the safe-surrender law might be discouraged from doing so if they were aware of the frequent violation of one of the safe-surrender law's key features—confidentiality.

We recommended that Social Services clarify the circumstances under which the safe-surrender sites and counties must protect the identifying information on the individual who surrenders an infant. At a minimum, Social Services should revoke its erroneous guidance on the waiver of the privilege of confidentiality by individuals who safely surrender babies.

Social Services' Action: Pending.

According to Social Services, the workgroup will draft a new All County Information Notice to correct the erroneous CWS/CMS data entry instructions relative to surrendering an individual's confidentiality. Additionally, Social Services stated that a subcommittee was formed to begin drafting instructions specific to each type of safe surrender site, as well as child welfare service agencies. According to Social Services, the instructions will clarify each agency's responsibility to keep the surrendering individual's personal information confidential.

Finding #4: Counties are not correctly classifying babies as either safely surrendered or abandoned, which affects the decision of whether to disclose confidential information.

Based on Social Services own review, many counties are not correctly classifying babies as safely surrendered or abandoned in the CWS/CMS. A misclassification can affect access to confidential data on individuals who have relinquished their children. For example, children improperly classified as safely surrendered may not be allowed access to information on their parents even though they have the legal right to review the information. Although its staff are aware of the possible consequences of such misclassifications, Social Services has made only limited attempts to correct the problem. According to an official at Social Services, it has not changed the data in the CWS/CMS that department staff believe are misclassified, because Social Services views the data as county property. Moreover, Social Services has not required county agencies to correct such mistakes, because its management believes that the department lacks the authority to do so.

The large number of babies whose cases Social Services believes are misclassified appears to arise, at least in part, because of the misapplication of or confusion over guidelines Social Services issued to the counties. We found that Social Services' own criteria for determining whether cases qualify as safe surrenders have changed over time; however, it has not adequately followed up with the counties to ensure that they correctly apply the current criteria.

Another element prompting Social Services to disagree, for reporting purposes, with the way county agencies classify cases involving surrendered babies centers on the parent's mention of adoption. During our review of cases that it considered to be misclassified as safely surrendered, we noted that Social Services appears not to consider a baby as surrendered if the mother merely mentions that adoption is her ultimate goal for the baby, even if she does not sign the necessary adoption forms. Specifically, since 2001, Social Services has disagreed with the classification of 36 cases that counties deemed to be safe surrenders because the documentation prepared by the counties included some evidence that the parent had mentioned adoption. We agree with Social Services' action in 13 of these instances because the caseworker narratives explicitly state that the mother signed paperwork to voluntarily relinquish her child for adoption. However, for the remaining 23 cases, there was no evidence that a parent completed the paperwork required for adoption. In fact, in some of these 23 cases, there was evidence that the mother may have intended to safely surrender the baby.

Legal access to certain information on parents may be compromised because county agencies have inappropriately labeled some babies as surrendered and mistakenly categorized other babies as abandoned. Social Services has identified at least 77 cases in which babies classified as surrendered should have received another classification. These 77 cases represent more than 26 percent of the surrendered babies reported in the CWS/CMS from January 2001 to December 2007. The misclassifications may limit those children's future access to information about their parents. Moreover, the misclassification of cases as safe surrenders may hinder the potential criminal investigation of individuals who abandon babies.

Additionally, the counties' incorrect labeling of abandoned babies as safe surrenders may have negative effects. We found five instances in which counties classified babies found alone in and around hospitals as safely surrendered, although those cases appear to be examples of unsafe infant abandonment. The classification of such babies as safely surrendered may mean that counties are not pursuing criminal investigations of the individuals who left those babies in unsafe situations.

Social Services' staff have also found cases of infants labeled as abandoned in the CWS/CMS who they believe met the safe-surrender criteria, meaning that the parents of those children may not be given the protection they are entitled to under the safe-surrender law. Based on their review of caseworker narratives for children whom county agencies have coded as abandoned in the CWS/CMS, Social Services' staff have identified two cases that county agencies should have classified as safe surrenders instead of abandonments. Further, we reviewed a sample of narratives for 40 babies one year old or younger who were classified as abandoned in the CWS/CMS and identified one additional case that could have been classified as safely surrendered, given the lack of clarity on the definition. If a county agency codes a baby's case file as abandoned when a parent actually surrendered the baby, and if the county then uses the coding in the CWS/CMS to determine which data it must protect, the child may later be able to inappropriately access the information on his or her family that the parents believed was confidential. Ultimately, depending on how a county agency classifies a child in the CWS/CMS, a child may have more or less access to information on his or her birth parents than the law allows.

We recommended that Social Services clarify the definition of safe surrender, and then disseminate and monitor its use among county and state agencies. Additionally, Social Services should require counties to correct records that Social Services' staff believe are erroneous because counties have misclassified babies as either surrendered or abandoned. Because Social Services does not believe it presently has the authority to do so, Social Services should seek legislation to obtain this authority.

Social Services' Action: Pending.

Social Services stated that the safe-surrender law workgroup formed a subcommittee to develop a clear, consistent definition of the safe-surrender law to be utilized by all appropriate agencies. This subcommittee created a draft definition that clarifies the circumstances in which a baby is considered surrendered and presented it to the full workgroup for their review. Revisions to the definition are currently underway and the final draft will be reviewed at the next full workgroup meeting. Steps for disseminating the definition to the appropriate agencies will be discussed at that time.

Social Services also stated that its staff encourages counties to follow the established CWS/CMS data deletion process to make the necessary changes to correct inaccurate data related to surrendered or abandoned babies. Social Services anticipates that as safe surrender sites and county child welfare agencies better understand their role in the surrender process, inappropriate information will not be entered into CWS/CMS. The workgroup will continue to develop solutions to this issue.

Finding #5: The majority of surrendered babies may not have access to key medical information later in life.

Our review of caseworker narratives for all safely surrendered infants in California found that 72 percent of the babies surrendered since the law's enactment may not have access to vital information on their families' medical histories because of the difficulty that safe-surrender sites have in obtaining this information in medical questionnaires or by some other means. Safe-surrender sites must provide, or make a good faith effort to provide, a medical questionnaire to the individual who surrenders a baby. The individual may complete the medical questionnaire at the time of the surrender, anonymously submit it later in an envelope provided for that purpose, or decline to fill out the form. The low number of completed medical questionnaires and the minimal intake of medical information by other means suggest that many surrendered babies may not benefit from having knowledge of their families' medical histories.

To provide surrendered babies and their health care providers as much information on their medical histories as possible, we recommended that Social Services consider ways to improve the availability of medical information.

Social Services' Action: Pending.

According to Social Services, in an effort to address this recommendation, the safe surrender workgroup formed a subcommittee that is reviewing the current version of the medical questionnaire provided to surrendering individuals. This subcommittee is also planning to address protocols for surrender sites, which will include the requirement to provide, or make a good faith effort to provide, the medical questionnaire to the surrendering individual. However, because completing the questionnaire is voluntary on the part of the surrendering individual, developing methods of obtaining this information will continue to be a challenge.

Finding #6: Some counties have developed useful models and materials to raise awareness about the law.

Although county efforts to publicize the safe-surrender law vary, some counties have developed interesting products and employed innovative techniques to implement and publicize the safe-surrender law. Los Angeles County appears to have undertaken the most comprehensive and sustained effort, including forming two task forces to help it achieve better results. For instance, according to a representative from Los Angeles County, as a result of one of the task force's recommendations, the county spent more than $500,000 on an outreach campaign. Other local governments, such as San Joaquin and San Bernardino counties, have also employed novel methods to

inform the public about the safe-surrender law, including using nonprofit organizations to spearhead efforts and producing an award-winning short film on the safe-surrender law. These efforts by local entities furnish a valuable service and help to make up for the State's limited involvement in publicizing and further implementing the safe-surrender law.

We recommended that Social Services work with the counties to leverage existing models and tools currently in use in California, such as translated materials and existing middle and high school curricula, to continue raising the public's awareness of the safe-surrender law in the most cost-effective manner.

Social Services' Action: Pending.

According to Social Services, a safe-surrender law outreach subcommittee has been tasked with developing outreach activities related to raising public awareness about the law. The subcommittee members represent Public Health, nonprofit agencies, county partners and hospitals, as well as Social Services. Social Services stated that the subcommittee has already gathered and reviewed materials brought by committee members and will consider conducting a survey of counties to gather additional information.

Regarding middle- and high-school curricula, Social Services stated that it has no authority to approve and distribute such materials. However, as it is made aware of educational materials for use in schools, Social Services will provide contact information to those who request it.