DEPARTMENT OF FINANCE
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May 25, 2010

Mark B. Horton, M.D., M.S.P.H, Director
California Department of Public Health
1615 Capitol Avenue, MS 0500
P.O. Box 997377
Sacramento, CA 95899-7377

Dear Dr. Horton:

Final Report—California Department of Public Health, 2008-09 Review of Fiscal Processes and Funds of the Every Woman Counts Program

The Department of Finance, Office of State Audits and Evaluations (Finance), has completed its review of the fiscal processes and funds related to the Every Woman Counts Program at the California Department of Public Health (CDPH). This evaluation was performed in accordance with Interagency Agreement 09-86143.

CDPH's response to the reported observations and our evaluation of the response are incorporated into this final report.

In accordance with Finance's policy of increased transparency, this report will be placed on our website. Additionally, pursuant to Executive Order S-20-09, please post this report in its entirety to the Reporting Government Transparency website at http://www.reportingtransparency.ca.gov/ within five working days of this transmittal.

We appreciate the assistance and cooperation of CDPH's staff. If you have any questions, please contact Susan M. Botkin, Manager, or Alexis Calleance, Supervisor, at (916) 322-2985.

Sincerely,

Original signed by:

David Botelho, CPA
Chief, Office of State Audits and Evaluations

cc: On following page

cc: Mr. Peter Barth, Assistant Secretary, California Health and Human Services Agency
Mr. Jose Ortiz, Acting Chief Deputy Director of Operations, California Department of Public Health
Mr. Kevin Reilly, Chief Deputy Director of Policy and Programs, California Department of Public Health
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Ms. Karen Petruzzi, Audit Coordinator, California Department of Public Health

A Special Report

California Department of Public Health
Fiscal Review of the
Every Woman Counts Program

Prepared By:
Office of State Audits and Evaluations
Department of Finance

104265027

May 2010

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Final reports are available on our website at http://www.dof.ca.gov

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EXECUTIVE SUMMARY

The California Department of Public Health (CDPH) Cancer Detection Program: Every Woman Counts (Program) receives $51.62 million to provide free clinical breast exams, and mammograms to California's underserved women.

In response to legislative and other stakeholders' concerns over the Program, the CDPH requested the Department of Finance, Office of State Audits and Evaluations (Finance), review CDPH's fiscal processes involved in the receipt of funding for the Program and related expenditures. Additionally, CDPH requested recommendations be provided to streamline and improve revenue and expenditure processes.

The review confirmed that CDPH does not have adequate processes in place to monitor or project current and/or future obligations of resources, and the most far-reaching and mission critical weaknesses are Program governance, decreasing revenues, and increasing Program expenditures. The following observations of fiscal processes and our review of best practices were identified, and the proposed recommendations, if implemented would improve CDPH's fiscal oversight of the Program.

Program Governance—Governance over the Program is fragmented and decentralized. Moreover, interdepartmental barriers between CDPH and the Department of Health Care Services (DHCS) have impaired CDPH's ability to centrally govern and make mission-critical changes needed to improve operations. The review found that:

- Caseload figures are inaccurate.
- Duplicate beneficiaries exist within the current claims system.
- Based on the number of identified duplicate beneficiaries, the Program has been assessed $218,000 in duplicate billings for Case Management Services (CMS) fees.
- Communication and coordination between CDPH and DHCS is poor.
- There is no single individual or unit with oversight responsibility for all aspects of the Program.

It is recommended that CDPH and DHCS work together to implement a system of assigning each beneficiary a unique identifier and/or implement controls to prevent duplicate beneficiaries from being input to the system. Doing so would prevent or mitigate opportunities for duplicate billings of CMS fees by Primary Care Providers (PCP). Additionally, it is recommended both CDPH and DHCS as well as internal units within CDPH improve governance processes to ensure effective communication, coordination, and management of the Program.

Revenue—Program funding is received from two sources of state tobacco tax as well as federal monies. The review found that:

- Tobacco tax revenues are declining.
- The continued reduction of revenues may be detrimental to the sustainability of the Program as resources may not be available to meet the increase in the demands for services.

Expenditures—Program expenditures consist of clinical claim direct expenditures as well as indirect support costs. Overall, expenditures show an increasing trend. The following observations were identified:

- Direct expenditures for CMS fees have been increasing at a faster rate than other direct expenditures, thereby reducing funding available to provide services to beneficiaries.
- CMS fees represent $8.98 million in fiscal year 2008-09, or 17 percent of total Program funding.
- Four out of five states contacted do not pay CMS fees to PCPs.
- No procedures are in place to estimate or review denied claims that may obligate current or future resources.
- Funding is over obligated for the Breast Cancer Control Account (Fund 0009).

It is recommended that CDPH review the necessity of issuing CMS fees to PCPs and evaluate whether or not other delivery systems would allow for efficiencies in the reporting process, thereby reducing Program expenditures. Additionally, CDPH should conduct a study analyzing the impact of denied claims to funding and the basis for claim denials. If applicable, CDPH should issue clarification and/or training to PCPs to reduce the number of claims denied.

Accounting and Reporting—Additional observations were identified related to accounting and reporting:

- Fund 0009 fund condition statements presented in the Governor's Budget were not supported by CDPH's year-end financial statements.
- Cash Balances were not properly recorded for Fund 0009.

It is recommended that CDPH implement policies and procedures to ensure fund condition statements are accurately prepared and supported. Ensure amount reported in the 2009-10 Fund 0009 beginning balance is accurately stated, and retain supporting documentation for financial reports.

BACKGROUND, SCOPE, AND METHODOLOGY

BACKGROUND

The California Department of Public Health (CDPH) is dedicated to optimizing the health and well-being of the people in California. CDPH funds needed cancer screening to eligible low-income women who are screened by the cancer detection program Every Woman Counts Program (Program). Women eligible for the Program must be age 40 or older (cervical cancer screening is provided to women 25 and older), and have an income at or below 200 percent of the federal poverty level.

In fiscal year 2008-09, CDPH was appropriated $51.62 million; funded by both state and federal monies. Specifically, the funding sources for the Program are the following:

- Tobacco tax revenues[1] appropriated to the 0009 Breast Cancer Control Account.
- Proposition 99 tobacco tax revenues appropriated to the 0236 Unallocated Fund.
- Federal grant funding appropriated to the 0890 Federal Trust Fund.

Effective January 1, 2010, CDPH's Cancer Detection Section suspended all new enrollments for breast cancer screening services until July 2, 2010, and changed the eligibility age for breast cancer screening services to 50 years of age and over. CDPH reported the cause for the reduction in services is due to declining tobacco tax revenues and increasing caseload causing the demand for services to exceed available funding. In 2008-09 a $9.3 million budget augmentation was approved to address the Program's reported deficit.

As a result of the policy change to suspend all new enrollments of breast cancer screening services, changes in eligibility requirements, and reports of a budgetary shortfall, concerns have been raised by state legislators, local agencies, and other stakeholders about CDPH's ability to efficiently manage this Program.

Further complicating the operations of the Program is the unique relationship between CDPH and the Department of Health Care Services (DHCS). Although, CDPH has primary responsibility for the Program, it relies heavily on the administrative services provided by DHCS and its claims processing agent in connection with processing claims from primary care providers.

See Appendix A for a glossary of acronyms and terms discussed throughout this report.

SCOPE

Pursuant to an interagency agreement with CDPH, the Department of Finance, Office of State Audits and Evaluations (Finance) conducted a review of CDPH's recording, monitoring, and reporting of revenues and expenditure claims, and identified methods to streamline and improve

[1] See Appendix A for a definition of the different tobacco tax revenues received by the Program.

these processes for the Program. The objectives included a review and evaluation of the following:

- CDPH's fiscal oversight over the Program.
- The funding and income streams for the Program.
- CDPH's method for the collection, recording, and projecting future revenues.
- Claims authorization and payment processes.
- Cost drivers and expenditure levels for the Program.
- Methodology of recording and estimating expenditures for the Program.
- 0009 Breast Cancer Control Account cash balance and related fund condition statements.
- For the aforementioned areas identify activities subject to improvement and provide recommendations.

Our scope did not include an assessment of the accuracy of revenue and expenditure data or an inspection of supporting documentation. Further, this review did not assess or evaluate the efficiency or effectiveness of the Program with respect to service or quality of care.

METHODOLOGY

To evaluate CDPH's fiscal processes over the Program, the following procedures were performed:

- Documented and gained an understanding of CDPH's Program revenues and expenditures through interviews of CDPH staff and review of relevant documents.
- Reviewed a sample of revenue receipts and supporting accounting reports.
- Gained an understanding of CDPH's processes for monitoring and reconciling revenue.
- Conducted an analysis of revenue trends.
- Gained an understanding of expenditure claims and cost drivers for the Program through interviews of CDPH staff and review of data provided by DHCS.
- Identified increases in expenditure categories by preparing a trend analysis and review of claims data obtained from DHCS.
- Reviewed a sample of claims and related reports.
- Contacted other states to identify best practices utilized by states with similar programs.
- Prepared a trend analysis of the 0009 Breast Cancer Control Account and gained an understanding of significant fluctuations of account groups for the fund.
- Evaluated CDPH's oversight of the Program.

Because CDPH is dependent on DHCS for its claims processing, we reviewed the programmatic and fiscal processes performed at DHCS. DHCS utilizes the Medi-Cal system to process claims submitted by primary care providers billable to the Program. Therefore, it was critical to review the role DHCS plays in the claims payment process. Interviews were conducted of DHCS staff to gain an understanding of DHCS' role. Furthermore, claims data was provided by DHCS that was used to review direct Program expenditures.

In order to meet our objectives we relied on interviews and inquiry of CDPH and DHCS staff. We did not evaluate the documents and reports received from CDPH and DHCS for validity; however, limited analysis of the information provided was performed. Our review and analysis of CDPH's fiscal processes was limited to the Program.

Recommendations were developed based on our review of documentation made available to us, our observations, and interviews with management and key staff directly responsible for the fiscal processes of the Program. The review was conducted during the period January 2010 through March 2010.

A review was performed of CDPH's fiscal processes[2] over the Every Woman Counts Program (Program) revenues and expenditures. Opportunities for improvement were indentified in the following areas: governance, revenues and expenditures, and accounting and reporting. Except where noted all recommendations pertain to CDPH.

Program Governance

Governance is critical to ensuring strategic direction and fiscal operations are sound, effective, and responsible. Clear performance goals and measures, communication, monitoring, and evaluation of results are all desired outcomes of effective governance. Governance establishes the tone and foundation for all of an organization's activities.

Governance over the Program is fragmented and decentralized. Fiscal infrastructure and oversight is not in place to ensure efficient revenue and expenditure processes, specifically as it pertains to claims processing and caseload projections. Internal and external barriers between CDPH and DHCS have impaired CDPH's ability to centrally govern and make mission-critical changes needed to improve operations. The following weaknesses were identified during a review of CDPH's and DHCS' governance processes:

OBSERVATION 1: Caseload Figures Are Inaccurate

The caseload figures of beneficiaries reported by CDPH are inaccurate. The processing system allows for Primary Care Providers (PCPs) to override the database creating duplicate beneficiaries within the database[3]. Additionally, the database allows for individual beneficiaries to be added a variety of ways creating multiple files for a single beneficiary. For example, the processing system cannot differentiate between two women with the same name and birth date. From a preliminary query of the database 4,350 exact duplicates currently exist in the database related specifically to beneficiaries with the same name and birth date.

As result, PCPs may have been issued duplicate payment for case management fees at a rate of $50 annually per beneficiary. Based on the number of identified duplicate beneficiaries, the Program may have been assessed $218,000 in duplicate billings in the current fiscal year.

It should be noted that as caseload figures are inaccurate, information generated and resulting decisions based on caseload are unreliable.

[2] See Appendices B and C for flowcharts outlining CDPH's fiscal process over the Every Woman Counts Program.
[3] See Appendix C, specifically legend item A for an illustration of the breakdown within the claims process.

Caseload Comparison

The Program has reported caseload information that is adjusted by its internal Evaluation Research Unit (Unit). For fiscal years 2004-05 through 2007-08 the Unit's adjusted caseload is less than the caseload obtained from DHCS. An objective for adjusting caseload is to remove duplicate beneficiaries, therefore it is logical for adjusted caseload to be less than data reported by DHCS. However, in fiscal year 2008-09 the Unit increased caseload by 5,006 beneficiaries as compared to caseload reported by DHCS, which is not consistent with their methodology. Furthermore, when compared to the calculated[4] caseload significant variances were identified between what DHCS reported and the Units caseload (see the table below for a comparison of caseload).

	Caseload Figures Comparison					
Reported/Calculated By	**FY 04/05**	**FY 05/06**	**FY 06/07**	**FY 07/08**	**FY 08/09**	**Total**
CDPH EWC Evaluation Research Unit	222,000	241,000	249,000	270,000	311,000	**1,293,000**
DHCS Information Technology Management Branch	240,541	257,601	267,461	282,195	305,994	**1,353,792**
Calculated[4]	130,152	142,481	154,940	158,559	179,761	**765,893**

Recommendation

- Implement a system assigning a unique identifier to each beneficiary, or implement controls to prevent duplicate beneficiaries from being input, to effectively monitor Program progress and compliance with statutory reporting requirements.

OBSERVATION 2: Governance Over Program Processes and Systems is Ineffective

A key factor is the bifurcation of management of the claims payment process between CDPH and DHCS[5]; each department has different functions and responsibilities. For example, PCP claims are submitted and paid by DHCS. DHCS invoices CDPH for the PCP claims paid; however, CDPH does not evaluate the validity of claim payments and has no direct oversight of this process. Specifically, during interviews CDPH staff stated they believed unallowable costs were being billed to the Program for family planning and other services. However, through interviews and inquiry of DHCS staff, the questions were resolved. It was determined that these costs are valid; however, due to the set-up of the claims processing system, they appeared unallowable. CDPH states that avenues for researching invoices for unallowable costs are not available.

Additionally, CDPH believed DHCS invoiced $400,000 in questioned claims. Similarly, we were informed that no viable research methods exist to determine the basis of the invoiced amounts. Through inquiry of DHCS staff, it was discovered that the $400,000 in expenditures were valid. Particularly, the PCP claims supporting the expenditures were improperly denied by the claims processing system. Upon DHCS' realization of the error, the system was corrected and the

[4] See Glossary for definition of calculated caseload.
[5] See Appendix C, specifically legend item B for an illustration of the breakdown within the claims process.

denied claims paid, thereby generating $400,000 of valid expenditures that were invoiced to CDPH.

Further instances of decentralized and ineffective Program management were discovered internally within CDPH. Upon review of the year-end financial reports for fiscal years 2006-07 through 2008-09, decreases in liability accounts were identified. However, CDPH could not support the basis for the decreases. It came to our attention that the Program unit staff are responsible for tracking these accounts. However, upon further investigation, this trend could not be substantiated because supporting documentation was not retained by CDPH. Additionally, due to staff turnover, current CDPH staff are not aware of the specific transactions.

Recommendations

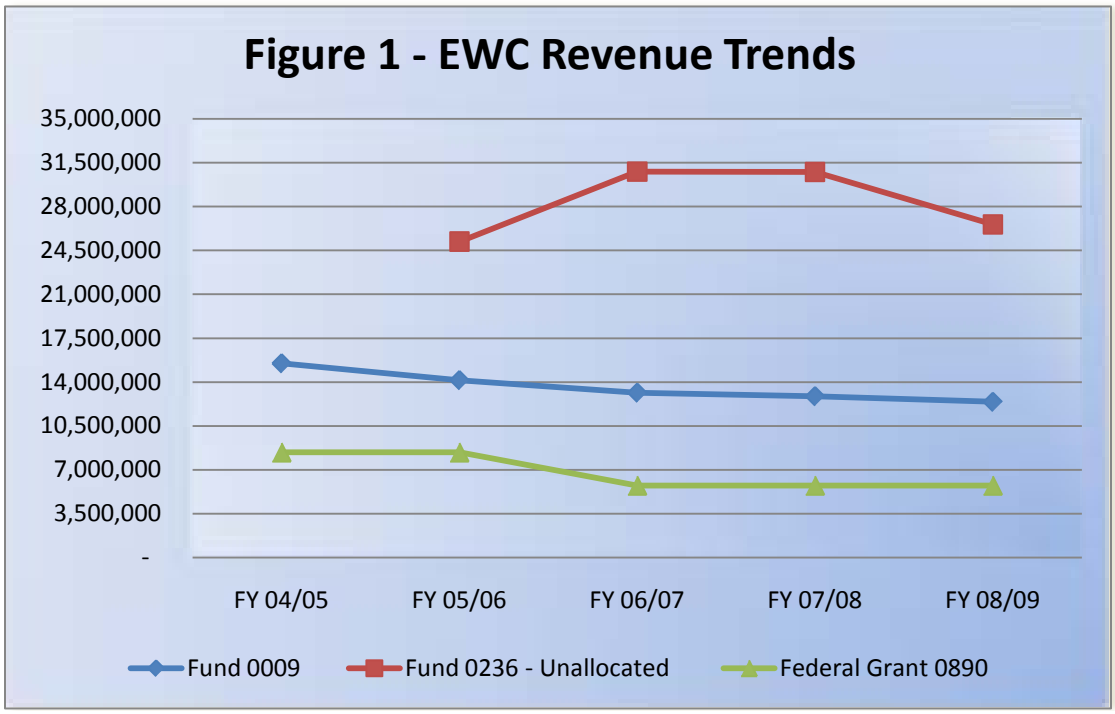
- Improve communication between CDPH and DHCS. This communication should include timely notification of any issues that jointly impact both departments' daily operations. Develop a process that allows for monitoring and timely resolution of billing disputes.
- Improve management oversight to ensure efficiency and effectiveness of Program operations.
- Cross-train staff to ensure duties can be completed in the absence of staff or in the event of staff turnover.
- Retain documentation supporting changes to account balances.

Revenue

The Program receives revenue from state and federal funding sources[6]. State monies received from both the Breast Cancer Control Account (Fund 0009) and the Unallocated Account (Fund 0236) are collected by the State Board of Equalization. The Program also receives federal funding deposited to the Federal Trust Fund (Fund 0890). We reviewed the fiscal processes and tested a sample of revenue receipts. Overall, CDPH's processes for the recording, reconciling and monitoring of Program revenues appear to be adequate; however, the following observations were identified:

[6] See Appendix B for a flowchart displaying CDPH's revenue process over the Program.

OBSERVATION 3: Funding Levels of the Program Are in Jeopardy



As depicted in the chart above tobacco tax and federal awards are decreasing. Of the three funding sources, the largest, Fund 0236 has seen the most significant decrease. Specifically, funding in 2007-08 was $30.7 million whereas in 2008-09, funding dropped to $26.5 million. This decrease of $4.2 million represents a 13.7 percent decrease in the 0236 Fund. Continuing declining revenues may be detrimental to the sustainability of the Program. As demand for services increase and revenues continue to decrease, CDPH may not be able to fund services to women in need.

Expenditures

Program expenditures consist of direct clinical claims and indirect support costs. We reviewed CDPH's processes for the recording, monitoring and projecting of the direct clinical claims and noted the following observations:

OBSERVATION 4: Direct Expenditures Are Increasing

The two highest cost drivers are mammogram screenings and CMS fees[7]. Mammogram screenings are the initial methods utilized to detect and screen for cancer. CMS fees are charged by the PCP's to follow-up with beneficiaries and report data as required by state and federal mandates.

Between fiscal years 2004-05 and 2008-09, direct Program expenditures excluding CMS fees have increased approximately 20 percent, whereas CMS fees have increased approximately 38 percent during this same time. Specifically, in fiscal year 2008-09 CMS fees were $8.98 million representing approximately 17 percent of the total Program funding of

[7] See Appendix C for a flowchart of CDPH's expenditure process and Appendix D for the top-ten cost drivers by procedure codes for fiscal year 2004-05 through fiscal year 2008-09.

$51.62 million. CMS fees represent 27.6 percent of the total top-ten direct costs for the Program. Additionally, of the five states contacted regarding best practices, four states (Texas, Illinois, New York, and Florida) stated they do not pay a CMS fee to their PCPs.

Recommendation

- Evaluate the necessity of issuing CMS fees to PCPs and conduct a study to determine if more economical methods of data collection are available to the Program. Any cost savings could potentially allow CDPH to provide services to additional beneficiaries.

OBSERVATION 5: No Procedures Are In Place To Review And Monitor Denied Claims

CDPH does not have procedures in place to estimate or review denied claims that may obligate current or future resources. Denied claims represent amounts invoiced from PCPs for unallowable procedures or invoices containing technical errors. PCPs have six months from the date of denial to correct the error, if appropriate, and resubmit the claim for full payment. In fiscal year 2008-09 approximately 64 percent of total dollars claimed were denied. Because CDPH has no method of projecting the amount of denied claims which will be resubmitted and subsequently paid, it is unclear what amount of Program resources will be required for future claims. Furthermore, year-end accruals cannot be accurately estimated if true obligations are unknown, thereby misstating year-end financial statements.

Recommendations

- Implement policies and procedures to accurately project current and future Program expenditures.
- Determine causes for denied claims and implement processes to reduce the number of denied claims. Provide training or issue clarifying guidance to PCPs.
- Implement a system for monitoring denied claims and the impact to current and future resources.

OBSERVATION 6: Funding May Be Insufficient For Current And Projected Expenditure Levels

As of February 28, 2010, the cash balance of Fund 0009 was $17.3 million. Of that amount, current obligations of the fund are $18.2 million. This will result in a fund deficiency of $827,726 if existing fund obligations are paid. However, CDPH reports that of the current obligations, only $12.97 million are payable in the current year and the remaining obligations are to be paid in subsequent years. It believes the fund will be supplemented by revenue not yet received for the current year. Conversely, our review of fund revenue revealed decreases in revenue trends. Specifically, revenues decreased from $15.3 million in fiscal year 2004-05 to $11.9 million in 2008-09. This decline represents the steady decrease of tobacco tax revenues collected by the state. If current trends of declining revenues and increases to fund obligations continue, Fund 0009 will face a deficiency. As existing revenues continue to decrease, the Program will need to seek alternative sources of funding to maintain the existing level of service.

Accounting and Reporting Matters

Additional observations were identified during our review related to the accounting and budgetary reporting aspects of the Program.

OBSERVATION 7: Unsupported Fund Condition Statements

Our review disclosed material variances and insufficient support for the reported amounts in the Fund 0009 fund condition statements (FCS), as of June 30, 2009. The FCS, as reported in the Governor's Budget for fiscal years 2007-08 and 2008-09 were not supported by CDPH's year-end records. For example, a prior-year adjustment in the amount of $11.02 million was posted to the 2008-09 beginning fund balance. Sufficient documentation supporting this adjustment was not maintained by CDPH. Furthermore, a comparison of the ending fund balance reported in CDPH's year-end reports to the FCS ending balance in the Governor's Budget revealed the Governor's Budget balance is overstated by approximately $8.6 million. Specifically, the FCS reflects an ending fund balance of $13.8 million, whereas, CDPH's year-end accounting records show the fund balance as $5.2 million. The basis for the variances could not be supported or explained by CDPH.

Recommendations

- Implement policies and procedures to ensure the fund condition statements are accurately prepared and supported.
- Research and resolve the basis for the above-mentioned variances. Additionally, if applicable, calculate and post a prior year-adjustment to correctly state the 2009-10 beginning fund balance to be reported in the 2011-12 Governor's Budget.

OBSERVATION 8: Cash Balances Were Not Recorded

During the review of CDPH's account balances, we identified $15.3 million in cash that had not been recorded in the Fund 0009 accounting records as of June 30, 2009. Upon inquiry we were informed that the accounting records were not properly transferred from the former California Department of Health Services when CDPH was established in July 2007. As a result, the cash was not recorded. CDPH subsequently recorded the cash to the accounting records. While this amount did not affect the ending fund balance for this shared fund, proper recording is necessary for an accurate estimate of future needs.

APPENDIX A

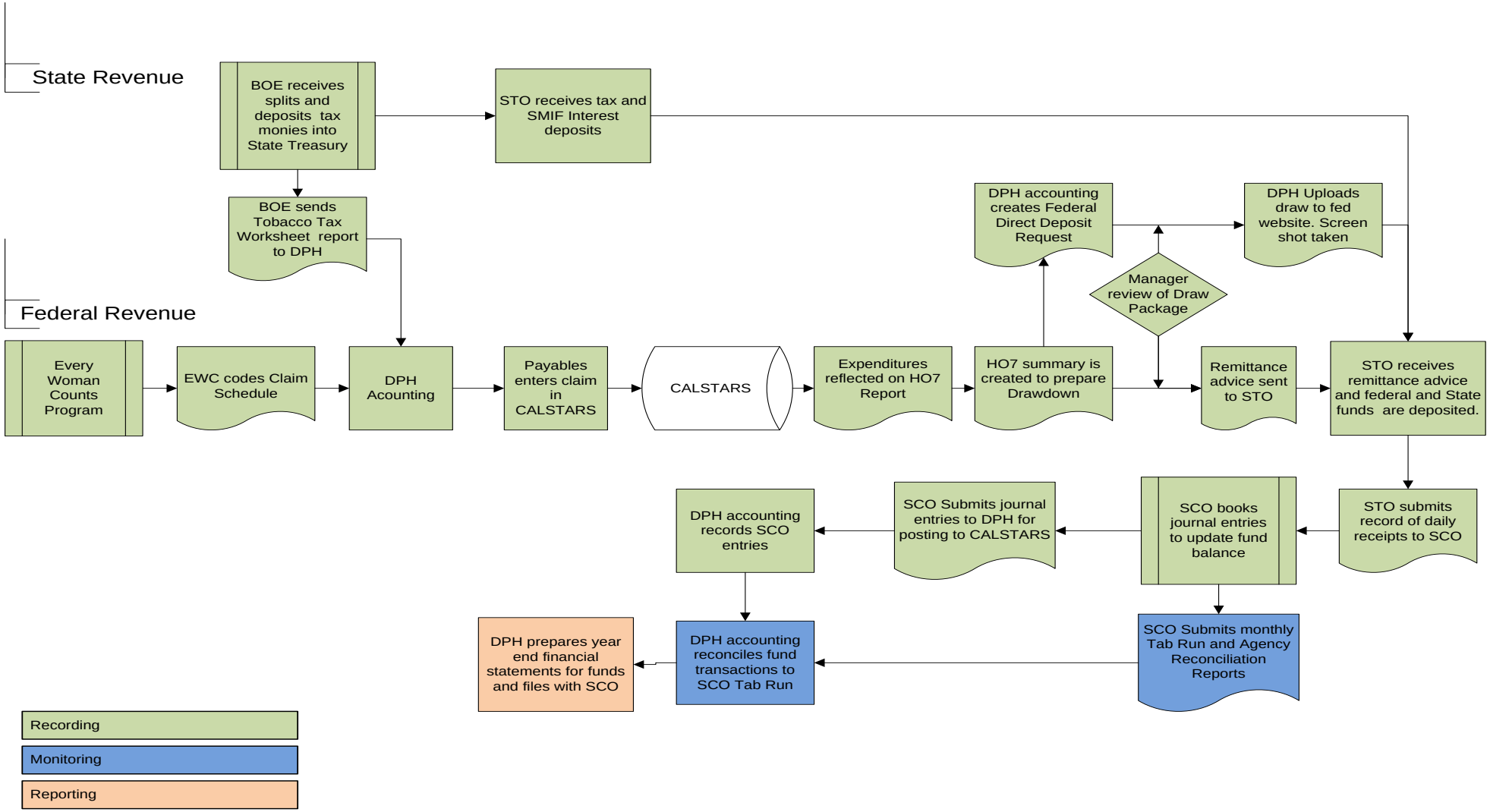
Glossary of Acronyms and Terms

Term	Definition
Beneficiary	**Beneficiary:** Women who are 50 years or older (25 or older for cervical screening), low income, and do not have any other means of receiving breast or cervical cancer screening are entitled to free services from the Program.
Board of Equalization	**Board of Equalization:** The BOE collects California state sales and use tax, as well as fuel, alcohol, and tobacco taxes and fees that provide revenue for state government and essential funding for counties, cities, and special districts.
Calculated Caseload	**Calculated Caseload:** Derived from data obtained by DHCS' Information Technology Management Branch. Specifically, Caseload Management Service expenditures as reported by EWC were divided by the allowable fee claimed by Primary Care Providers per beneficiary per year to arrive at the estimated beneficiaries in the system.
CALSTARS	**California State Accounting and Reporting System:** CALSTARS provides CDPH an automated organization and Program cost accounting system to account and report revenues and expenditures.
Case Management Fees	**Case Management Fees:** PCPs are allowed to charge $50 per beneficiary, per calendar year for completing the required case management services.
Case Management Services	**Case Management Services:** CMS are provided by PCPs to follow-up on beneficiaries to ensure they receive proper follow-up treatment or screenings as appropriate. CMS data related to the follow-up procedures and final diagnosis is electronically reported to the Program through a web based portal known as DETEC.
Caseload	**Caseload:** The total population of the Program active beneficiaries who have received services provided by the Program.
CDC	**Centers for Disease Control:** CDC is the federal agency that provides expertise, information and tools to individuals and communities regarding disease prevention and health promotion. The Program is partially funded from federal funding granted by CDC. As such, CDPH is required to comply with federal program mandates.
CDPH	**California Department of Public Health:** CDPH is dedicated to optimizing the health and well-being of the people in California. CDPH is responsible for the Program and fiscal oversight of the Program.
Claim	**Claim:** A claim is a request for reimbursement by PCPs for services provided to eligible beneficiaries. Each claim represents one clinical visit, but one claim can consist of multiple services performed.

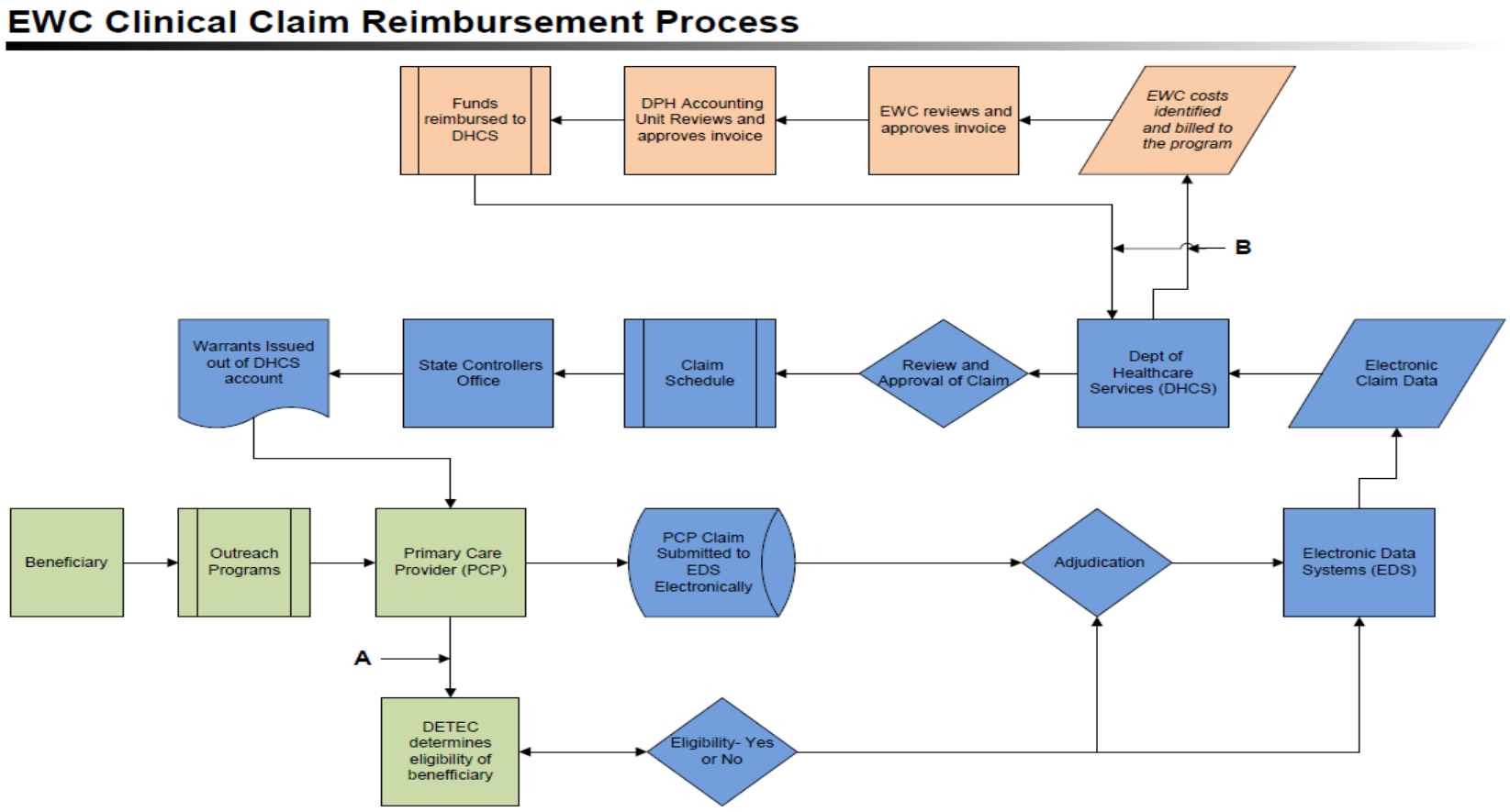
Claim Schedule	**Claim Schedule:** The state uses a variety of vendor payment methods. One method is to submit **claim schedules** to the State Controller's Office (SCO) for payment. A unit within DHCS creates the claim schedule based on all approved claims submitted by the PCPs. DHCS reviews and approves the claim schedule and forwards it to SCO for payment. The payments are cleared through the DHCS general fund clearing account.
Cost Driver	**Cost Driver:** A cost driver is an activity that causes a cost to be incurred. The cost drivers for the Program are direct expenditures for clinical procedures performed by the PCPs.
DETEC	**DETEC:** Is a web-portal utilized by primary care providers to enroll eligible beneficiaries in the claims processing system.
DHCS	**Department of Health Care Services:** DHCS' mission is to preserve and improve the health status of all Californians. DHCS works closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income residents and persons with disabilities. DHCS is the liaison between the PCP claims processing system and CDPH.
EDS	**Electronic Data Systems:** EDS (Recently acquired by Hewlett-Packard) houses the database and claims processing system used to adjudicate PCP claims for the Program services on behalf of CDPH. This database is overseen by DHCS who is responsible for programming and monitoring the system to ensure the reliability and accuracy of claims processed.
EWC	**Every Women Counts:** The Program provides free clinical breast exams, mammograms, pelvic exams and Pap tests to California's underserved women. These women are age 50 and older (cervical cancer screening is provided to women 25 and older), and have an income at or below 200 percent of the federal poverty level.
Expenditure	**Expenditures:** The Program incurs both direct and indirect expenditures. Direct expenditures include clinical claims, public outreach and CMS fees. Indirect Expenditures included salaries and wages for Program employees and other miscellaneous Program overhead charges. This review of the fiscal processes of the Program focused on the direct clinical claim expenditures.
Fund 0009	**Fund 0009 Breast Cancer Control Account:** Fund 0009 resources are used for early breast cancer detection services. Fund 0009 sources are tobacco tax revenues collected by BOE and transferred to CDPH. This fund is shared between CDPH and DHCS to support Program activities.
Fund 0236	**Fund 0236 Unallocated Account, Cigarette and Tobacco Products Surtax Fund:** Fund 0236 is a special revenue fund that receives 25 percent of the Cigarette and Tobacco Products Surtax. A portion of Fund 0236 is used to support the Program.
Fund 0890	**Fund 0890 Federal Trust Fund:** Fund 0890 is used to deposit and track all moneys received by the state from the federal government where the expenditure is administered through or under the direction of any state agency. The purpose of this fund is to provide better accountability of the receipts and expenditures of federal funds received by the state. A portion of this fund supports the Program.

Invoice	**Invoice:** DHCS pays for all of the approved PCP claims out of its general fund clearing account. DHCS then submits an invoice to CDPH seeking reimbursement. The invoices are submitted to CDPH on a weekly basis.
PCP	**Primary Care Provider:** A PCP is the approved health care clinic granted authority to perform early cancer detection procedures for beneficiaries. The PCP has authorization to submit claims for approved procedures performed.
Proposition 99	**Proposition 99:** Proposition 99 is an initiative statute which appeared on the November 8, 1988 California general election ballot, as the Tobacco Tax and Health Protection Act. Its primary effect is to impose a 25-cent per pack state excise tax on the sale of tobacco cigarettes within California. Tobacco tax revenue is the main funding source of the Program.
Revenue	**Revenue:** Program revenue is derived from Tobacco Tax collected by the BOE and funds received through federal grants. Tobacco tax revenues are transferred to CDPH and appear as Transfers-In on budgetary and accounting documents.
SCO	**State Controller's Office:** The SCO maintains uniform and systematic control accounts of all receipts, disbursements, and balances in CDPH's funds. The SCO issues payments to the PCP's on behalf of CDPH.
STO	**State Treasurer's Office:** The STO provides banking services for state government.
Stakeholders	**Stakeholders:** Stakeholders include beneficiaries, family members of beneficiaries, advocates, local public health directors, community agencies, PCPs, state agencies, state legislators, and federal agencies.

Flowchart of Revenue Process



Flowchart of Expenditure Process



Legend
A- See Observation 1 for detailed description of Process breakdown
B- See Observation 2 for detailed description of Process breakdown

APPENDIX D

Clinical Claims Cost Drivers by Category

Major Cost Drivers						
Top procedure codes paid (by $)	**FY 04/05**	**FY 05/06**	**FY 06/07**	**FY 07/08**	**FY 08/09**	**% Change**
76092 - MAMMOGRAM, SCREENING	$9,566,670	$10,167,459	$10,613,594	$9,923,286	$11,314,886	18.27%
99358 - CASE MANAGEMENT SERVICES-PCP	6,507,619	7,124,026	7,746,989	7,927,970	8,988,047	38.12%
76091 - MAMMOGRAPHY; BILATERAL	2,421,134	2,408,222	1,971,314	N/A	N/A	N/A
99213 - OFFICE VISIT, EST., LEVEL 3	1,723,141	1,844,911	2,029,042	2,137,343	2,452,780	42.34%
99202 - OFFICE VISIT, NEW, LEVEL 2	1,474,144	1,387,475	1,247,548	1,202,803	1,288,527	-12.59%
76090 - MAMMOGRAPHY; UNILATERAL	1,176,420	1,264,930	1,113,699	N/A	N/A	N/A
77056 - MAMMOGRAM, BOTH BREASTS	N/A	N/A	N/A	1,593,381	2,300,661	N/A
76645 - US EXAM, BREAST(S)	1,166,354	1,288,523	1,404,403	1,556,267	1,788,385	53.33%
99214 - OFFICE VISIT, EST., LEVEL 4	1,064,791	1,367,688	1,495,833	1,721,471	2,017,765	89.50%
99204 - OFFICE VISIT, NEW, LEVEL 4	825,730	880,385	839,910	N/A	1,199,398	45.25%
99203 - OFFICE VISIT, NEW, LEVEL 3	N/A	656,268	731,872	860,154	1,129,809	72.16%
Total	**$25,926,003**	**$28,389,887**	**$29,194,204**	**$26,922,675**	**$32,480,258**	**25.28%**

Source: Department of Health Care Services, Fiscal Intermediary – Information Technology Management Branch

Legend:

N/A – Data for years with a "N/A" (not applicable) represent years where costs for these procedures were not within the top-ten cost categories. While costs may have been incurred for these procedure codes, they were not within the top ten categories.

DEPARTMENT RESPONSE

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

MAY 24 2010

David Botelho, Chief
Department of Finance
Office of Audits and Evaluations
300 Capitol Mall, Suite 801
Sacramento, CA 95814

Dear Mr. Botelho:

The California Department of Public Health (CDPH) has prepared its response to the California Department of Finance draft report entitled, "Draft Report: California Department of Public Health, 2008-09 Review of Fiscal Processes and Funds of the Every Woman Counts Program." The CDPH appreciates the opportunity to provide the Department of Finance with responses to the draft report.

Please contact Karen Petruzzi, CDPH Audit Coordinator, at (916) 650-0266, should you have any questions.

Sincerely,

Original signed by:

Mark B Horton, MD, MSPH
Director

Enclosure

OBSERVATION 1: Caseload Figures Are Inaccurate

Recommendation

- Implement a system assigning a unique identifier to each beneficiary, or implement controls to prevent duplicate beneficiaries from being input, to effectively monitor Program progress and compliance with statutory reporting requirements.

CDPH Response (Program):

CDPH agrees that the assignment of a unique identifier to each beneficiary would allow appropriate controls to be in place to prevent duplicate beneficiaries and to effectively monitor Program progress and compliance with reporting requirements. In Fiscal Year (FY) 2006-07 CDPH's predecessor Department CDHS determined that the Program was not authorized to collect and use social security numbers as a unique identifier to help eliminate duplicate beneficiaries. Currently Program uses probabilistic matching of usable data to determine if duplicates exist. No later than August 31, 2010, Program will begin to evaluate the feasibility of collecting social security numbers or another method that will provide a unique identifier for the *CDP: EWC* clients.

OBSERVATION 2: Governance Over Program Processes and Systems is Ineffective

Recommendations

- Improve communication between CDPH and DHCS. This communication should include timely notification of any issues that jointly impact both departments' daily operations. Develop a process that allows for monitoring and timely resolution of billing disputes.
- Improve management oversight to ensure efficiency and effectiveness of Program operations.
- Cross-train staff to ensure duties can be completed in the absence of staff or in the event of staff turnover.
- Retain documentation supporting changes to account balances.

CDPH Response (Program & Accounting):

CDPH agrees that communication between CDPH and DHCS should be improved. In December 2009 Program began meeting with DHCS monthly for the purpose of discussing daily operations, billing disputes, contract amendments, etc. CDPH staff and Program management will continue these regular meetings.

CDPH agrees that improvement is needed in management oversight to ensure efficiency and effectiveness of Program operations. In July 2009, Program began

monthly meetings with CDPH budgets and accounting staff to discuss and identify action items to improve the efficiency and effectiveness of Program operations.

CDPH agrees that Program staff should be cross-trained to ensure duties can be completed in the absence of staff or in the event of staff turnover. Program recognized this need last year and established a new fiscal unit, including hiring of a staff person in the Administration Division, Accounting Section. The fiscal unit consists of enough positions to allow for cross-training. The hiring process was completed in December 2009. Cross-training of current staff and ongoing procedures for cross-training new staff should be completed in December 2010.

CDPH partially agrees that documentation to support changes to account balances is not retained. Program was able to show support documentation for expenditures, however, due to staff turnover, new staff were unable to find documentation supporting prior adjusting entries to the temporary pass-through account. Program has initiated internal procedures for regular account reconciliation as well as retention of support documentation.

OBSERVATION 3: Funding Levels of the Program Are in Jeopardy

CDPH Response:

CDPH agrees with Observation 3. The primary funding for the program is from tobacco taxes, which is a declining fund source. Program has been challenged by decreasing revenues and increasing caseload and expenditures as identified in Observation 4.

OBSERVATION 4: Direct Expenditures Are Increasing

Recommendation

- Evaluate the necessity of issuing CMS fees to PCPs and conduct a study to determine if more economical methods of data collection are available to the Program. Any cost savings could potentially allow CDPH to provide services to additional beneficiaries.

CDPH Response (Program):

CDPH agrees that any cost savings could potentially allow services to be provided to additional beneficiaries and has begun to identify these savings that will allow Program to live within its budget and at the same time begin to allow new enrollments. On March 18, 2010, Program held a meeting with Stakeholders to discuss a number of potential cost saving methods such as implementing a two-tiered case management fee structure or providing mammograms every other year. These cost savings methods are included in the Administration's May revision budget proposal.

OBSERVATION 5: No Procedures are in Place to Review and Monitor Denied Claims

Recommendations

- Implement policies and procedures to accurately project current and future Program expenditures.
- Determine causes for denied claims and implement processes to reduce the number of denied claims. Provide training or issue clarifying guidance to PCPs.
- Implement a system for monitoring denied claims and the impact to current and future resources.

CDPH Response (Program):

CDPH disagrees that policies and procedures to accurately project current and future Program expenditures have not been implemented. Program expenditures other than clinical claim costs do not require forecasting, they are budgeted and predictable. Program tracks clinical claim costs on a weekly basis and keeps a record of several years of past clinical claim costs. Currently Program uses actual clinical claim costs from current and past years to forecast future expenditures. Based on past trends the Program has determined that funds will not be overspent for FY 08-09 as well as FY 09-10. Program used this method to forecast clinical claims costs in FY 08-09 and in the first half of FY 09-10.

Program faces numerous challenges in obtaining all of the necessary data needed to more accurately account for caseload and predict caseload growth as identified in Observations 1, 2, 3, and 4 and is working on methods to more accurately project expenditures.

CDPH agrees that the cause for denied claims and implementation of processes to reduce the number of denied claims is needed. Program will work with DHCS to obtain usable data that was unavailable in the past to see if this is a viable resource to determine if a process to reduce the number of denied claims is feasible.

CDPH disagrees that training and issuing clarifying guidance to Program primary care providers (PCPs) is not occurring. Currently training is performed by Program to the approximately 900 PCPs by the clinical staff at the Regional Contractor level. However, the Regional Contractors are not obligated to train the approximately 3,000 referral providers which also submit claims for payment and could be one of the sources of the denied claims. The referral providers are informed of the billing process via Medi-Cal bulletins and trainings, and through the fiscal intermediary representatives.

CDPH agrees that a system for monitoring denied claims and the impact to current and future resources is needed. Program currently uses the same fiscal intermediary as DHCS to adjudicate claims through an interagency agreement. The claims processed for Program represent less than 1% of the workload for the fiscal intermediary. Program is unable to effectuate the changes needed and obtain usable data that is necessary to analyze the impact of the denied claims. Program recognizes that there might be a strong business case to contract directly with a fiscal intermediary to better serve its purposes and has begun the process to assess the feasibility of having a separate adjudication contract by FY 2012-13.

OBSERVATION 6: Funding May Be Insufficient For Current and Projected Expenditure Levels

CDPH Response:

CDPH agrees with Observation 6. To live within the budget, Program is actively working with staff from the CDPH Administration Division and the Department of Finance in developing accurate fund condition statements, tracking and monitoring expenditures and revenues, and working with stakeholders in the development of future programmatic priorities and cost saving methods in order to best serve target populations. However, CDPH anticipates that this will remain a problem as long as demand for services exceeds the available resources.

OBSERVATION 7: Unsupported Fund Condition Statements

Recommendations

- Implement policies and procedures to ensure the fund condition statements are accurately prepared and supported.
- Research and resolve the basis for the above-mentioned variances. Additionally, if applicable, calculate and post a prior year-adjustment to correctly state the 2009-10 beginning fund balance to be reported in the 2011-12 Governor's Budget.

CDPH Response (Budgets):

CDPH agrees with the recommendations cited in Observation 7. CDPH Budgets will enhance our policies and procedures and conduct staff training to ensure that fund condition statements are accurately prepared and supported by the CDPH final financial statements by September 30, 2010. If applicable, CDPH Budget will calculate and post a prior year-adjustment to correctly state the 2009-10 adjusted beginning balance to be reported in the 2011-12 Governor's Budget.

OBSERVATION 8: Cash Balances Were Not Recorded

CDPH Response:

CDPH agrees with Observation 8. Due to an oversight when CDPH split from Department of Health Services (now DHCS) on July 1, 2007, the one time transferring of the cash balance from DHCS to CDPH did not occur. This oversight was discovered and the cash balance was posted to the CDPH Accounting records in November 2009.

EVALUATION OF RESPONSE

The Department of Finance, Office of State Audits and Evaluations (Finance) reviewed the California Department of Public Health's (CDPH) response to the draft report.

CDPH concurred with Observations 1, 3, 6, 7 and 8. CDPH partially agrees with Observation 2 and disagrees with Observation 5.

Where CDPH disagrees with reported observations and conditions in its response, the following comments are provided:

OBSERVATION 2: Governance Over Program Processes And Systems is Ineffective

CDPH states, "Program was able to show support documentation for expenditures…" CDPH misinterpreted the observation; Finance does not suggest program expenditures were not supported and documentation was not retained. To clarify, the observation identified, that CDPH could not provide supporting documentation for specific adjusting entries. CDPH subsequently stated, "new staff were unable to find documentation supporting prior adjusting entries…Program has initiated internal procedures for regular account reconciliation as well as retention of support documentation." Finance commends CDPH on implementing procedures to prevent future occurrences and reiterates the recommendation, to retain documentation supporting changes to account balances.

OBSERVATION 5: No Procedures Are in Place to Review And Monitor Denied Claims

Finance's recommendation to implement policies and procedures to accurately project current and future Program expenditures, relates specifically to CDPH's denied claims. While we agree, CDPH projects future expenditures based upon approved clinical claims, no consideration of denied claims is included in these projections. Given the significant percentage of denied claims (approximately 64 percent of total dollars claimed) we believe CDPH should obtain this data and include it in the projection calculations. CDPH subsequently agreed to this observation by stating, "CDPH agrees that a system for monitoring denied claims and the impact to current and future resources is needed." Finance reiterates the recommendation to implement a system for monitoring denied claims and the impact to current and future resources.

CDPH states:

> "Currently training is performed by Program to the approximately 900 PCPs by the clinical staff at the Regional Contractor level. However, the Regional Contractors are not obligated to train the approximately, 3,000 referral providers which also submit claims for payment and could be one of the sources of the denied claims. The referral providers are informed of the billing process via Medi-Cal bulletins and trainings…"

CDPH has primary oversight and responsibility for providing training and guidance to all Program providers. The majority of providers submitting claims are referral providers, consequently, we recommend CDPH review the training and guidance offered to all providers and implement improvements to these processes to reduce the number of denied claims.

Furthermore, CDPH states, "Program is unable to effectuate the changes needed and obtain usable data that is necessary to analyze the impact of the denied claims." We disagree. During this review, denied claims data was obtained and was made readily available from the Department of Health Care Services (DHCS). CDPH and DHCS should jointly establish a process to make such claims data routinely available to CDPH. In order to improve program efficiency and effectiveness, Finance reiterates the recommendation, from Observation 2, that CDPH and DHCS improve communication.

For the reasons stated above, Finance's reported observations and recommendations remain unchanged in the report. However, the title of Observation 5 has been revised to better describe the subject matter as requested by CDPH.