EL DORADO COUNTY GRAND JURY
2007-2008

FINAL REPORT
Part III

June 2008

Grand Jury
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El Dorado County Grand Jury 2007-2008
June 2008

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NOTICE TO RESPONDENTS

California Penal Code § 933.05 mandates specific requirements for responding to grand jury reports. This information is intended to help you in your responses to avoid unnecessary and time-consuming repetitive actions. Those responses which do not fully comply with Penal Code requirements, including explanations and time frames where required, will not be accepted and will be returned to respondents for corrections.

RESPONSE TO FINDINGS

The responding person or entity shall indicate one of the following:

1. *The respondent agrees with the finding.*
2. *The respondent disagrees wholly or in part with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reason therefore.*

RESPONSE TO RECOMMENDATIONS

The responding person or entity shall report one of the following actions:

1. *The recommendation has been implemented, with a summary regarding the implemented action.*
2. *The recommendation has not yet been implemented, but will be implemented in the future, with a timeframe for implementation.**
3. *The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or head of an agency of department being investigated or reviewed. This timeframe shall not exceed six months from the date of publication of the grand jury report. ***
4. *The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefore.*

* The time frame needs to be specific and reasonable.

** At the conclusion of this analysis, the recommendation must be responded to as required by items 1, 2, or 4.

RESPONSE: TIME, WHERE AND TO WHOM

The Penal Code identifies two different response times, depending upon the classification of the respondent (see below), and includes where and to whom the response is directed. Day one begins with the date of the Final Report.

1. **Public Agency:**

   The governing body of any public agency (also refers to department) must respond within ninety (90) days. The response must be addressed to the Presiding Judge of the El Dorado County Superior Court.

   Examples: Governing body of a public agency, Board of Supervisors, Directors of Districts

2. **Elective Officer or Agency Head:**

   All elected officers or heads of agencies/departments are required to respond within sixty (60) days to the Presiding Judge of the Superior Court, with a copy provided to the Board of Supervisors.

   Examples: Sheriff, Auditor/Controller, Recorder, Surveyor, Tax/Treasurer, County Superintendent of Schools

FAILURE TO RESPOND

Failure to respond to a grand jury report is in violation of California Penal Code §933.05 and is subject to further action.

EL DORADO COUNTY GRAND JURY 2007-2008

Use of El Dorado County Vehicles

Case No. 07-030

REASON FOR REPORT

The El Dorado County Grand Jury received complaints regarding the use of County-owned vehicles designated as "take-home" vehicles. There was also media attention to the subject matter. Specifically, these complaints questioned why some County employees were assigned permanent and overnight retention of County-owned vehicles when they seemingly did not qualify under the requirements specified in the Board of Supervisors (BOS) Policy #D-4 for Vehicle Use, Standards, Procurement and Disposal, adopted 12/22/87 and revised 6/20/06. After initial review of the complaints the Grand Jury determined there was sufficient cause to investigate the use of County-owned vehicles.

BACKGROUND

The County owns 542 vehicles, although only 475 are specifically managed by Fleet Management. These vehicles range from passenger cars to heavy-duty vehicles for use by our Department of Transportation (DOT). Currently 83 vehicles in this fleet are assigned to individual employees of the County and are driven to and from their respective residences.

The Board Of Supervisors Policy #D-4 sets forth rules regarding the use and operation of vehicles while on official County business; the assignment, use, operation, procurement and disposal of County-owned vehicles, and the methods used by the County to meet business transportation needs of County employees.

The County's Fleet Management Unit in the Department of General Services operates a vehicle pool and coordinates department requests for leased, rented, or purchased vehicles to make them available to County departments. Where appropriate, County vehicles are assigned to specific County departments and managed by Fleet Management.

County department heads are responsible for ensuring compliance with all provisions of the BOS Policy and maintaining and monitoring vehicle usage logs.

METHODOLOGY

The Grand Jury gathered data from many sources. Personnel were interviewed from the Chief Administrative Office (CAO), Auditor-Controller's Office and General Services.

Documents Reviewed:

- Board of Supervisors Policy #D-4 For Vehicle Use, Standards, Procurement and Disposal adopted 12/22/87 and revised 6/20/06
- Fleet Rates Spreadsheet Draft (08/09)
- General Services – Fleet Management Draft Vehicle Cost Estimates Fiscal Year 08/09 Budget
- General Services – Fleet Management Vehicle Rate Reduced Calculations Fiscal Year 07/08
- Take Home Vehicles 2007 Spreadsheet

FINDINGS

In accordance with the California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings:

1. BOS Policy #D-4 is not being followed. Paragraph B.2 titled "Vehicle Use" requires the CAO's Office to review permanent assignment and overnight retention of County-owned vehicles on an annual basis and to continue or rescind authorization. Interviews with the CAO's office revealed that this has not been done for several years.

2. Paragraph B.2.a of the policy specifies that an employee who is responsible for responding to emergency situations related to public health or safety and protection of property on a 24-hour basis may be assigned a vehicle for on-call duty. However, paragraph B.2.b is subject to interpretation and allows any County employee that can demonstrate to the Board of Supervisors that it is in the best interest of the County for that employee to be assigned permanent and overnight retention of a County-owned vehicle.

3. The purchase of County vehicle fuel is a budget item within various County departments, and **is not** a component of the Fleet Management process. This is a significant County expense and estimated to be over 1.6 million dollars next year and represents nearly 40% of total fleet costs.

4. Fuel purchases for County vehicles are not centrally managed or controlled. The County's primary fuel vendor possesses very sophisticated reporting capabilities and would be able to provide excellent tools in an effort to better manage fuel purchases.

5. The 50 vehicles identified as "Department 99" or department owned are not managed by Fleet Management, so the efficiency of operating those vehicles (which represent nearly 10% of the County total) is difficult to determine.

6. County fleet costs for 2008-2009 are estimated to be 4.2 million dollars, with projected total miles at over 5.4 million. These costs represent a cost to the County of 77.2 cents for every mile driven. As a point of reference, the rate the County reimburses employees to drive their own vehicles on County business is 50.5 cents per mile, or 26.7 cents per mile *less* than the County spends on its own vehicles. We do recognize that the County per mile cost is an average of ALL vehicles, including some heavy duty vehicles.

7. In reviewing the take-home vehicle list many of the assignments are not for "health and safety" or on-call status use. Take-home vehicles are driven 21% more miles per year, per vehicle when compared to the balance of the Fleet managed vehicles. One reason is that take-home vehicles include "commute" miles.

8. Potential cost savings to the County exist in two areas:

    a. The conversion of miles driven in County-owned vehicles to private vehicle reimbursement would save 26.7 cents per mile. If a 10% reduction were achieved, the County would save an estimated $145,278 annually.
    b. A 10% reduction of total County vehicle miles driven would yield a 77.2 cent per mile savings, estimated to be $419,862 annually.

9. Our investigation indicated that Fleet Management is performing their function well.

RECOMMENDATIONS

1. The CAO to complete the required annual review of permanent assignment and overnight retention for County-owned vehicles for each County department by the end of this calendar year. Those assignments that cannot be justified should be rescinded.

2. Paragraph B.2 in the County vehicle policy should provide a clear definition of what constitutes "in the best interest of the County" for assigning take-home vehicles when the vehicle is not used for the public health and safety of citizens or does not meet the on-call qualification.

3. The purchase of fuel for County vehicles should be consolidated under Fleet Management so that all vehicle cost accounting and oversight is managed under a single program.

4. The management of "Department 99" vehicles should be consolidated under the Fleet Management process to insure that effective oversight and efficiency is achieved.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05.

PROJECTED 2008-2009 COUNTY VEHICLE MILES AND RELATED COSTS

TOTAL FLEET MILES: **5,437,318**

		COST / MILE
ALL COSTS LESS FUEL:	**$2,560,397**	**47.1 ¢**
FUEL COST (407,806 gals.):	**$1,638,224**	**30.1 ¢**
TOTAL COUNTY COST:	**$4,198,621**	**77.2 ¢**
COUNTY PRIVATE VEHICLE REIMBURSEMENT RATE:		**50.5 ¢**
SPREAD BETWEEN COUNTY PER MILE COST AND REIMBURSEMENT RATE:		**26.7 ¢**

POTENTIAL ANNUAL SAVINGS:

> EACH 10% REDUCTION IN OVERALL MILES DRIVEN = **$ 419,862**

> EACH 10% CONVERSION FROM COUNTY TO PRIVATE VEHICLE = **$ 145,278**

Vehicle Categories	Count	% of Fleet Managed Vehicles	Miles	% of Miles	Miles/Vehicle
"Take-Home" Vehicles:	83	17.5%	1,112,350	20.5%	13,402
All Other Fleet-Managed Vehicles:	392	82.5%	4,324,968	79.5%	11,033
Total Fleet Managed Vehicles:	**475**	100%	5,437,318	100%	11,447
"Department 99" Vehicles:	50				
Inactive Vehicles:	17				
Total County Owned Vehicles:	**542**				

NOTE: costs and miles for the 50 "Department 99" vehicles are not included, as they are not managed by Fleet Mgmnt.

EL DORADO COUNTY GRAND JURY 2007-2008

Emergency Permits in the Development Services Department

Case No. GJ 07- 027

REASON FOR REPORT

The Grand Jury became aware of lengthy delays in the permit process for the reconstruction of damaged buildings.

BACKGROUND

Fires, floods, earthquakes and other unexpected damage to buildings can cause great hardship to occupants and owners. Often a business must cease or curtail operations and homeowners must find temporary lodging until building repair or reconstruction is completed. Expediting reconstruction is in the interest of building owners and occupants, as well as the community. However, unlike most construction contractors, building occupants and owners struck by fire or other emergencies are usually not familiar with the rigorous County construction permit and inspection regulations.

The El Dorado County Board of Supervisors commissioned a study of private development review processes conducted by the County, principally within the Development Services Department. Results were presented in a document and power point presentation, "Permits Evaluation and Recommended Tasks Report," March 25, 2008. This report was aimed at changes that would facilitate private commercial development in the County. While it made several recommendations regarding the Development Services Department, it omitted any discussion of the Department's response to emergency repair and reconstruction of damaged buildings.

METHODOLOGY

The Grand Jury investigated the County Development Services Department's process for emergency permits. The Grand Jury interviewed several individuals and reviewed many documents.

People Interviewed:

- El Dorado County Assistant Chief Administrative Officer (interim)
- El Dorado County building contractors and business owners

- El Dorado County Development Services Department personnel
- Fire Protection District personnel

Documents Reviewed:

- "Angora Fire Reconstruction Expedited Process," El Dorado County Development Services Department
- Building Permit Application (form), El Dorado County Development Services Department
- Contractor's Project Notes for the re-building of a damaged business
- "Fire Damage Rapid Response Permit Process," with charts, El Dorado County Development Services Department
- "Permits Evaluation & Recommended Tasks Report," March 25, 2008, Assistant Chief Administrative Officer, El Dorado County (interim)
- "Scheduling of Permits for Reconstruction of a Fire Damaged Building," El Dorado County Development Services Department

FINDINGS

In accordance with the California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings:

1. The need for a rapid response to expedite repair and reconstruction of damaged buildings is recognized in a Development Services Department's document, "Fire Damage Rapid Response Permit Process." Grand Jury interviews provided anecdotal evidence that this process takes much longer than necessary.

2. The building construction inspection steps received little criticism. Most of the problems were deemed to occur in the permit process. Owners of damaged buildings often don't have the knowledge and experience that developers have in navigating through the complicated process. They usually require guidance on how to proceed, both at the beginning and along the way to the completion of the permit process. Several persons within the Development Services Department, including outside officials such as fire marshals, are usually involved in a series of sequential steps. There is no evidence of an overall coordinator to actually obtain rapid response. Other than a red cover sheet ("red tag") placed on the document package, there was no evidence of a systemic rapid response process. The Development Services Department has been characterized as insufficiently energetic in expediting permits under emergency response conditions.

3. Reconstruction of damaged buildings to meet current codes required by State law leads to confusion between owners and the Development Services Department regarding the necessary reconstruction plans and re-submittals. This leads to delays.

4. The Grand Jury found some evidence that contractors feared reprisal if they made complaints about the permit process.

RECOMMENDATIONS

1. The County Board of Supervisors should direct the three Development Services Branch Managers (Placerville, El Dorado Hills and South Lake Tahoe) to be master coordinators of rapid response to all building emergencies that occur in their areas. In this capacity, their duties should include expediting all activities related to repair and reconstruction by:

    - Close supervision of all involved Department employees
    - Aggressive coordination with fire marshals and other government officials outside the Department
    - Actively advising the owners and occupants of damaged buildings throughout permitting and inspection, from beginning to completion of building repair and reconstruction

2. A dated events log should be kept on each emergency response by the Branch Managers. These logs, with relevant comments, should be reported monthly to the Director of the Development Services Department.

3. Rapid response to emergency repair and reconstruction should be a consideration in evaluating job performance of Branch Managers within the Development Services Department.

4. The (new) Director of the Development Services Department should establish an "open door" policy in order to hear complaints from building owners and contractors on a strictly confidential basis and make it clear to the construction community that this policy has been adopted.

RESPONSE

Responses to this report are required in accordance with the California Penal Code §933.05.

EL DORADO COUNTY GRAND JURY 2007-2008

Garden Valley Fire Protection District

Case No. GJ 07- 020

REASON FOR REPORT

The El Dorado County Grand Jury received a complaint requesting that the Grand Jury investigate the selection and hiring of a payroll consultant by the Garden Valley Fire Protection District (GVFPD). In the course of the investigation the Grand Jury looked into the operations and responsibilities of the Garden Valley Fire Protection District Board of Directors, the position of Fire Chief and administrative staff.

BACKGROUND

"The Garden Valley Fire Protection District, a combination paid and volunteer staffed department is an "all risk" agency providing fire protection, rescue and initial response medical aid to a population of approximately 7,500. The District consists of an area of approximately 60 square miles of unincorporated area on the Georgetown Divide in northern El Dorado County . . ." (Garden Valley Fire Protection District website)

The District's Board of Directors consists of five members. These are non-compensated positions. There are approximately 25 members of the Fire Department, of which 12 are volunteers.

METHODOLOGY

The Grand Jury utilized sworn testimony, information gathered from interviews and the review of documentation consisting of reports and written statements.

People Interviewed:

- El Dorado County Auditor-Controller
- GVFPD personnel and employees

Documents Reviewed:

- GVFPD financial documentation
- GVFPD web page
- Internal emails, memos and correspondence, guides, and manuals
- Various written information including newspaper articles and notes provided by complainant and witnesses

RESULTS OF INVESTIGATION

During the time frame of 2005-2007, GVFPD Board of Directors and the two prior Fire Chiefs revealed a high degree of palpable dysfunction and bouts of acrimony among themselves. The common theme by most members of the Board of Directors and a former Chief was to proclaim ignorance of policies, procedures and ultimate responsibility of the events which resulted in the questionable hiring of a payroll consultant.

The Board of Directors was negligent in carrying out their fiduciary duties relative to proper oversight of Fire Chief(s) and the GVFPD employees. The Board as a whole did not demonstrate a clear understanding of the budgetary and fiscal controls that were their responsibilities.

The Fire Chief(s) neglected to properly oversee administrative and personnel issues. Their lack of oversight was directly responsible for the atmosphere that allowed the breakdown of proper budgetary and fiscal controls. Additionally, such failures of supervision prompted administrative personnel to act independently of the Board and the Chief(s) controls over budgetary and administrative policies.

FINDINGS

In accordance with the California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it was addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings:

1. For over three decades, payroll, accounting and accounts payable services were provided by the El Dorado County Auditor-Controller's office at no cost to the District. The GVFPD Board of Directors decided to withdraw the GVFPD funds from the County Auditor-Controller. This decision doesn't appear to be based on any viable alternative to the services that were being performed by the County. Furthermore, GVFPD did not offer a rational explanation to the Auditor-Controller's office as to why the funds were withdrawn. The GVFPD recently decided to go back into the El Dorado Auditor-Controller's program and work with the Auditor's office to re-establish fiscal oversight. The overall cost to GVFPD withdrawing from the Auditor-Controller's office and eventually returning to the County has yet to be determined.

2. The GVFPD Board of Directors was negligent in their fiduciary responsibilities to the citizens of the District by their failure to properly oversee the operation of the Department. Lack of control with hiring procedures resulted in the District contracting with a person (to perform District financial transactions) who had previously plead guilty to grand theft and selling securities without a license. Additionally, this consultant misrepresented his qualifications but was not immediately terminated when this information was provided to the District. Contract agreements for financial services were not formalized in writing nor approved by the Board.

3. The Fire Chief is ultimately responsible for the supervision and oversight of Fire District personnel. The previous Fire Chief(s) were negligent in their oversight of the administration and personnel issues which led to conflicts within the Department. Former Fire Chief(s) allowed administrative personnel to develop a pattern of insubordination and bypass the chain of command. By not addressing these affronts to the Fire Chiefs' authority, administrative personnel were allowed to operate with impunity affecting the good order and function of the Fire District.

4. Financial obligations were/are delinquent and inaccurate, including both payroll and billing to United States Forest Service (USFS). The result of these actions could cost the District thousands of dollars in repayment and expenses.

5. The contract with USFS for the All Risk Team was poorly managed. Problems include inaccurate record keeping, incorrect payments to employees and mishandling of Government funds.

6. The financial controls and budgetary process in GVFPD that were found to be deficient are now in the process of being corrected by the current Board of Directors and Fire Chief.

RECOMMENDATIONS

1. The GVFPD Board of Directors need to clearly understand their responsibilities and have adequate budgetary and financial knowledge while engaging in District business. If the individual directors are deficient in those skill sets, it is their responsibility to become proficient enough to serve the District effectively, or resign.

2. The District Fire Chief must fully understand the duties of the position. Included in those duties is the proper oversight and supervision of all personnel within the Fire District. The Chief must be able to quickly recognize and deal with personnel and administrative issues that may lead to financial or operational problems.

3. The GVFPD Board of Directors should participate in the educational programs offered through the California Special District Association.

4. County Auditor to provide a final report with findings of fact regarding financial standing of the GVFPD with the recommendation that checks and balances be put in place.

5. The Grand Jury strongly recommends that the GVFPD seriously consider the recommendation of the 2007-2008 Grand Jury Final Report Part II concerning the consolidation of fire districts.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05.

EL DORADO COUNTY GRAND JURY 2007-2008

Hillwood Community Services District

Case No. GJ 07-020

REASON FOR REPORT

The El Dorado County Grand Jury received a complaint from a citizen/resident of the Hillwood Community Services District (HCSD). The citizen requested the Grand Jury investigate the Board of Directors of the HCSD regarding various actions taken by the Board, including violation of California Government Codes and the collection of monies for the purpose of establishing a Road Improvement Group (RIG) within the HCSD. The Grand Jury has also had communication with the El Dorado County Auditor-Controller concerning Community Service Districts (CSD) in the county and the problems associated with managing and operating CSDs within the requirements of the Government Code.

BACKGROUND

The fifteen (15) single purpose road districts in El Dorado County and other multiple purpose CSDs provide road maintenance as part of their various defined services. These CSDs are characterized as being governed by a board of directors (usually volunteers) with defined boundaries, are a form of government and provide services and facilities depending on the size and scope of the CSD. These districts are usually in rural communities and formed following development of a land parcel or sub-division. Each CSD is independent.

Hillwood is a single purpose CSD that maintains approximately six miles of roads. HCSD contains over 160 residential parcels within 390 acres and serves 273 registered voters. The District is located in the Shingle Springs area of El Dorado County. The district was formed to maintain roadways that connect two public roads, French Creek Road and South Shingle Road. The HCSD is geographically divided by topography with the northwestern area identified in this report as Monarch-Woodside. The

Monarch-Woodside area is within the boundaries and under the governance of HCSD. Road repairs and maintenance are based on the amount of available funding and the extent of damage to the roads. The HCSD Board of Directors makes these decisions.

There is a specific group of residents in the Monarch-Woodside area of HCSD who have been trying to form a RIG for the express purpose of improving and maintaining certain portions of HCSD roads in the Monarch-Woodside area. This specific group of residents wants to encumber their property with additional taxes to be collected by the County to improve their roads. These new taxes would be in addition to the taxes already collected to maintain all roads in the HCSD.

METHODOLOGY

The Grand Jury gathered data from many sources including the El Dorado County Auditor-Controller, California Special Districts Association, Local Agency Formation Commission (LAFCO), Community Association Institute and previous investigations into CSDs from prior year's grand juries.

People Interviewed:

- Complainant
- El Dorado County Auditor-Controller
- Hillwood CSD Residents and Directors
- Local Agency Formation Commission (LAFCO)

Documents Reviewed:

- California Special Districts Association Documents
- El Dorado LAFCO, December 2007 Final Municipal Service Review
- Hillwood CSD documents and correspondence

FINDINGS

In accordance with California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings:

1. The Grand Jury found no intentional wrongdoing on the part of the HCSD Board of Directors.

2. The information gathered revealed that the monies generated by taxes for road repair in the HCSD are insufficient to meet the needs of the District.

3. The HCSD Board is within its discretion to allow Monarch-Woodside to become a "zone" or RIG under the HCSD. Their position is supported by California Government Code §61140 and LAFCO.

4. There is a prevailing lack of trust by some residents in the HCSD that was clearly demonstrated when residents were interviewed by the Grand Jury. Most residents are not involved in the operation of HCSD and do not support any tax increases to pay for improving roads. Combined with insufficient funds to meet HCSD road needs, there exists a contentious environment that continues to create turmoil among residents. These conditions do not create an environment where good governance and involved citizens can resolve issues that arise in the normal course of a CSD.

RECOMMENDATIONS

1. The HCSD should create a newsletter, website or other form of communication to help keep all residents informed of HCSD needs and proposed action(s) by the Board of Directors, to include activity by Monarch-Woodside RIG.

2. The 2007-2008 Grand Jury Final Report Part-I released March 2008, "Assisting Road Repair Community Service Districts," made the following recommendations:
    a. The County Department of Transportation should invite road repair district directors to its annual training sessions for Zones of Benefit Advisory Committee members.
    b. The County should publish the "Zone of Benefit Advisory Committee Manual" and make it available, free of charge, to every road repair district director. As soon as possible, this Manual should also be provided through the internet.

    If these two recommendations are accepted by the Department of Transportation, we recommend that HCSD avail themselves to these resources.

3. To address the prevailing lack of trust in the Hillwood CSD that dates back over thirty years, the Grand Jury recommends that the Board of Directors inform residents of the powers and duties of the Board, and advise residents that there is a remedy called direct democracy in the form of initiative, referendum and recall. This gives power to citizens to propose items directly to the Board through notice, petition and election. A referendum gives citizens a direct vote in District matters and recall powers allow residents to remove members from office before the next election.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05.

EL DORADO COUNTY GRAND JURY 2007-2008

Audit of
Human Services and Mental Health Medi-Cal Revenues
Case No. GJ 07-006

BACKGROUND

During the past five years, the Grand Jury has received several requests for action relating to the poor internal administrative controls in the County Departments of Human Services (DHS) and Mental Health. The Grand Jury seated in 2005-2006 had an outside audit performed by qualified, respected, and seasoned consultants with expertise in the Mental Health and Medi-Cal Programs. The audit determined that both departments lacked necessary internal controls. Specifically in the administrative areas of time-keeping, completing reports, clients receiving incorrect information, and the programs administrated were not in compliance with State and/or Federal laws. The major areas of concern were the financial billing, time keeping, accurate report documentation, and recouping funds from the State of California.

A follow-up study was performed by the 2006-2007 Grand Jury and although both departments had made improvements, still more needed to be done. (See Grand Jury reports from 2005-2006 and 2006-2007.)

In 2007, the Sacramento Bee reported the Attorney General and the Director of DHS provided an estimate that the State's Medi-Cal Program was losing up to one billion dollars annually due to fraudulent activities. The Grand Jury received a less then satisfactory response into its inquiry to both the County Departments of Mental Health and Human Services about the status of its billing and financial reimbursement of clients' services.

METHODOLOGY

The 2006-2007 Grand Jury voted to allocate funds to perform an audit of the financial billing practices of both County departments in the Medi-Cal programs. The audit was initiated in 2006-2007, but was not complete by the end of the jury's term requiring the audit to be terminated. After a thorough analysis, the 2007-2008 Grand Jury voted to resume the audit with Harvey Rose Associates, LLC, adjusting the audit scope to include questionable programs in DHS and Mental Health Departments.

FINDINGS

1. El Dorado County faces a severe budget crisis and the findings in the Audit Report provide evidence that the County could be at risk of losing up to **$541,420**. If the State requested the money be refunded, it would have to come from the County's general fund. The potential losses are due to administrative errors and omissions, poor policy communications and procedures, and questionable management in the Human Services Public Guardian Program. Conversely, the Human Services Linkages Program was found to be well managed.

2. The Grand Jury acknowledges the difficulty in administering and implementing mental health and human service programs. County staff is concerned and takes pride in caring for our citizens; however, there is room for improvement.

3. The Grand Jury and the Auditor encountered multiple impediments in obtaining the necessary legally authorized and court-ordered records from DHS. Even with repeated County Counsel intervention, the Auditor, with the court-order, did not receive requested client case record information, including requested assessments in effect during the review period, pertinent to the performance of a comprehensive compliance audit. Only during the June 9, 2008 exit conference, did DHS acquiesce to allow the Auditor and grand jurors a chance to physically inspect the records, just six days before the audit was to be submitted to the Grand Jury. The Auditor gave DHS every possible opportunity to comply. After the exit conference, DHS did provide the Auditor with additional information requested. A subsequent letter from the Assistant Director of DHS to the Grand Jury dated June 13, 2008, extended a late invitation encouraging jurors to review the electronic records. The invitation was received in the Grand Jury after the audit review period and the closure of the investigation.

   The impediments the Auditor experienced in acquiring information was in direct contrast with the Department of Mental Health. The Grand Jury commends the Department of Mental Health for their positive attitude and desire to improve customer service and providing information requested by the Auditor while still maintaining client confidentiality.

4. The results of the investigation and information from previous Grand Juries indicate that closer oversight of the leadership in the DHS by the Board of Supervisors is required.

5. During the exit conference, the Auditor presented to DHS a copy of State regulations pertaining to Targeted Case Management and written comprehensive Individualized Service Plans. DHS stated they did not know of the regulation, had never received proper training by the State, and therefore, did not comply with the regulation.

RECOMMENDATIONS

1. The Grand Jury agrees with the Audit findings and urges the Board of Supervisors to direct management in the Departments of Human Services and Mental Health to implement all the audit recommendations.

2. The Board of Supervisors should direct the development of a comprehensive written policy and procedure for departments on "How To" process requests for confidential records from auditors and court orders.

3. Next year's Grand Jury should determine if DHS provided to the Auditor the documents requested in the court-order.

4. Department of Health Services should actively engage in a process with the State of California to resolve any discrepancies in training when that training conflicts with statutes and program regulations. Resolutions should be well documented, communicated, and readily retrievable.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05.

EL DORADO COUNTY GRAND JURY 2007-2008

El Dorado County Procurement Department

Case No. GJ 07-019

REASON FOR REPORT

The El Dorado County Grand Jury received a complaint regarding poor customer service levels delivered by the County Procurement and Contracts Division of the Chief Administrative Office (Purchasing Department). There was sufficient concern to warrant the Grand Jury investigating the allegations and determining if some corrective recommendations would surface.

BACKGROUND

County Procurement Policy #C-17 states, "The County Purchasing Department is responsible for the procurement of services, supplies, materials, goods, furnishings, equipment, and other personal property for the County and its offices unless otherwise excepted by ordinance or these policies." The Purchasing Department is also responsible for providing leadership, guidance and assistance to departments in all procurement related matters, including interpreting and applying County policies and procedures related to procurement of goods and services. The department is expected to provide a high degree of customer service.

The Purchasing Department is staffed with seven people: a department manager, three buyers (of which one position is currently vacant), one analyst (concentrating primarily on contracts), and two administrative support personnel. This county decentralizes the purchasing function as it relates to contracts. There are currently seven additional employees engaged in the contract process within the departments of transportation, environmental health and public health.

METHODOLOGY

The Grand Jury gathered data through interviews with county personnel, as well as reviewing written county documents.

El Dorado County Personnel Interviewed:

- Auditor/Controller
- Chief Administrative Officer
- Information Technology Department Manager
- Office of Emergency Services Manager
- Procurement Department Analyst
- Procurement Department Buyer
- Procurement Department Manager

Documents Reviewed:

- Document titled "Procurement and Contracts Division Workflow Analysis and Recommendations" dated 10-31-2007
- Document titled "Purchasing Issues" from Purchasing/Fiscal Staff meeting 1-30-2008
- Documented procurement problems from various county sources
- El Dorado County Procurement Policy C-17, adopted 10-11-2006; revised 3-20-07
- Several papers regarding procurement issues from various County sources

FINDINGS

In accordance with California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings.

1. Interviews with County personnel indicate a very poor internal and external customer service level for the purchasing function in the County. This is evidenced by late billings and payments, as well as excessive time to process contracts and bids.

2. A package put together by the Purchasing Department in October of 2007 titled "Procurement and Contracts Division Workflow Analysis and Recommendations" (PCDWAR) was reviewed. This document was prepared for the Chief Administrative Officer (CAO), and some of the recommendations in the document were presented to the Board of Supervisors (BOS). The main thrust of the recommendations was to increase staffing levels, with a few substantive process change recommendations. These recommendations were based on a comparison to Placer County's procurement processes and staffing. Comparing El Dorado County to Placer County is not a valid comparison as Placer County has four additional cities (six vs. two) making Placer County's procurement functions and needs greatly different.

3. This PCDWAR package contained detailed process flow charts for each major segment in the procurement process. The processes are long, complex, and heavily "paper-based." There are also lead-time charts in the package, but

nothing to tell the reader if these processes and lead times are typical in the context of other county governments, private industry, or any measure of meeting expected levels of service to user departments.

4. The current purchasing process involves a time period for County Counsel and Risk Management to review all contracts. The lag times built in for those reviews appear excessive, especially if it is a renewal of an existing contract.

5. When a purchase order or contract needs to be changed, the current process necessitates virtually going back to the beginning of the process, adding excessive time delays.

6. It is recognized by the purchasing department, and the CAO, that the purchasing data management system, Advanced Purchasing Inventory Computer System, is out of date and inadequate to facilitate faster turnaround times for processing change orders. However, there is no plan or budget to affect an upgrade to this software program.

7. Although the problems within the purchasing function are recognized and acknowledged by both the CAO and the purchasing department, there are no definitive plans to fix the problems.

RECOMMENDATION

1. The Grand Jury recommends that a task force be formed comprised of expert end users and outside vendors, charging them with the responsibility of streamlining the procurement process and improving the customer service level to all internal departments and external vendors. This end user task force should include members from all major County functions. The BOS should champion this process and assign one of the Supervisors to oversee the progress of this task force, with a monthly update from the leader of this task force to him/her and the CAO. We recommend that this task force start with a "blank page," and identify an appropriate flow process, effective computer systems' support and lead times that best serve the needs of the County and outside vendors. Significant progress has already been made in identifying the current process, but the challenge to the team is to identify what changes should be made to improve the procurement process.

2. The completed task force report should be written and submitted to the BOS with all recommended changes no later than the end of fiscal year 2008-2009.

3. No additions to personnel should occur until such time as a full review of the procurement process is completed.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05

EL DORADO COUNTY GRAND JURY 2007-2008

South Lake Tahoe Police Department

Case No. GJ 07-003

REASON FOR REPORT

The El Dorado County Grand Jury received several complaints from citizens of South Lake Tahoe. The complaints centered on the verbally abusive behavior and menacing actions of the South Lake Tahoe Chief of Police. Investigation of these complaints uncovered additional information which prompted the Grand Jury to look further into his managerial and behavioral issues.

BACKGROUND

The City of South Lake Tahoe was incorporated November 10, 1965. The formation of the South Lake Tahoe Police Department (SLTPD) occurred on July 1, 1967. SLTPD has to date had seven police chiefs. The current police chief was sworn in as the Chief of Police in 2006.

The SLTPD has approximately 42 sworn positions and 12 civilian support personnel. The Police Department patrols approximately 13 square miles, of which five miles include the waters of Lake Tahoe. The City of South Lake Tahoe's permanent population is approximately 24,000 people, increasing to 150,000 during major holidays.

The SLTPD in 1991-1992 was faced with a crisis of a divisive department, low morale and a feeling of helplessness on the part of many who wanted to make the situation better. The Department united under the realization that in order to “fix” what was broken, everyone of the SLTPD personnel from the civilian employees to the Chief of Police needed to "roll up their sleeves", put their egos on hold, and do what was right for the SLTPD and more importantly, what was right for the citizens of South Lake Tahoe.

METHODOLOGY

The Grand Jury utilized sworn testimony, information gathered from interviews and the review of documentation consisting of reports and written statements. The Grand Jury also received legal advice from the El Dorado County District Attorney's Office and the El Dorado County Counsel's Office.

People Interviewed:

- City of South Lake Tahoe Citizens
- City of South Lake Tahoe Officials
- Consultants
- El Dorado County Counsel Officials
- El Dorado County District Attorney's Office Personnel

Documents Reviewed:

- SLTPD Web Page
- Survey
- Written documentation including newspaper articles, faxes, notes, manuals, emails, and correspondence

FINDINGS

In accordance with California Penal Code §933 and §933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2007-2008 El Dorado County Grand Jury has arrived at the following findings:

1. The Grand Jury interviewed several citizens of South Lake Tahoe who reported an altercation that occurred in September 2006. While having breakfast in a South Lake Tahoe restaurant, one citizen stated that he was approached by the Chief of Police who began to verbally accost and loudly berate him in front of two acquaintances. The citizen did not know what provoked the verbal tirade and felt the Chief of Police must have confused him with someone else. The citizen stated the loud disturbance in the restaurant that was witnessed by patrons and staff alike, caused the citizen to be fearful for his safety.

2. The Chief of Police, by losing his temper in public and verbally berating a citizen of South Lake Tahoe in a public restaurant, acted in an inappropriate manner and displayed conduct unbecoming a police officer. All citizens of South Lake Tahoe should have an expectation of being treated fairly in a professional and dignified manner by **ALL** members of the SLTPD.

3. In the course of this investigation, the Grand Jury also learned of serious concerns among the employees of the South Lake Tahoe Police Department on the state of the morale and cynicism that exists in the Department.

4. Although the Police Department is managed through a Participative Management Team (PMT) which was initiated in 1991-1992, the program has deteriorated over time and is currently ineffective. PMT is designed to allow all employees to participate in the decision making process of the Department. The Police Department leadership hired a consultant with the purpose of assisting the PMT process.

5. The evidence received by the Grand Jury paints a picture of a Department in crisis. Many of the statements made by members of the SLTPD and information gathered through documents can only be classified as troubling.

    - A majority of the sworn officers and supervisors believe promotions within the SLTPD are given to people who are not deserving
    - Almost all sworn officers and supervisors believe they are not rewarded for there efforts in achieving Departmental goals
    - The vast majority of sworn officers, supervisors and management agreed that the SLTPD employees do not have confidence in senior leadership
    - A majority of supervisors and sworn officers do not believe Management understands the importance of maintaining employee self-esteem
    - A large majority of sworn officers and supervisors fear reprisals if they openly exchange opinions and ideas
    - Almost all management, supervisors and sworn officers believe cynicism is widespread in the SLTPD

6. The Chief recognized the Police Department had many problems, and initiated the review knowing it may be unfavorable. The Grand Jury acknowledges his proactive efforts in requesting outside professional advice.

RECOMMENDATIONS

1. The Grand Jury recommends the SLTPD leadership attend Strategic Management, Leadership, Coaching & Mentoring, Business Management, Anger Management, and Human Skills Development Training.

2. The City Council and City Manager should take proactive measures in administering oversight of the Police Department. The City Council and the City Manager should assure the formalization of the Police Department oversight is established and fully implemented. The Grand Jury recommends the Chief of Police meet with the City Manager on a monthly basis to give a "State of the Department" update to include performance measurements.

3. The Grand Jury recommends the Chief of Police prepare a written three and five year Strategic Plan. A copy of that plan should be published and available to the public.

4. The City Manager, City Council and the Chief of Police should collectively agree on the type of organizational structure for the South Lake Tahoe Police Department.

5. It is recommended that the SLTPD "revitalize" a form of Participative Management Team. If SLTPD agrees to continue with that program, then the management team needs to be trained in the PMT process to completely utilize the full benefits of the program. Additionally, the employees of the SLTPD must actively participate in the PMT to generate the desired results.

6. The SLTPD's Strategic Plan should address clearly defined performance measures that include at a minimum the following areas of concern:

    - Confidence in Senior Management
    - Cynicism
    - Morale
    - Visions and Values of the Department

7. The Chief of Police should present a written progress report to the City Council and City Manager annually for public review.

8. The City Manager and City Council should maintain an active presence in tracking the Strategic Plan progress.

9. The Chief's annual performance evaluation should include the progress of the goals set in the Strategic Plan.

RESPONSES

Response(s) to this report is required in accordance with California Penal Code §933.05.

EL DORADO COUNTY GRAND JURY 2007-2008

Victim Restitution

GJ 07-014

REASON FOR REPORT

The Grand Jury elected to investigate the County's Victim Restitution activity to determine if El Dorado County is effectively and efficiently managing victim restitution.

BACKGROUND

The successful 1998 ballot initiative, known as the California State Constitutional "Victims' Bill of Rights," created a new **Constitutional Right** for all victims of crime to receive restitution from their offender.

> *"It is the unequivocal intention of the People of the State of California that all persons who suffer losses as a result of criminal activity shall have the right to restitution from the persons convicted of crimes for the losses they suffer."*

The State of California Victims Compensation and Governmental Claims Board (VCGC) assists victims of **violent** crimes. Victims of **non-violent** crimes must rely mostly on the County to assist with ensuring that their right to restitution is realized.

METHODOLOGY

The Grand Jury heard sworn testimony, information gathered from interviews and the review of documentation consisting of reports, written statements, and observation of court restitution proceedings.

The investigation focused on:

1. Processes and preparation necessary to attain and amend court orders of restitution
2. Court ordered restitution collection

3. Disbursement of payments
4. Enforcement of the court restitution order including financial reviews when offenders fail to consistently pay their restitution

Additionally, the investigation reviewed the efficiency and effectiveness of the following County restitution processes:

- Educating and supporting victims on restitution from the moment the crime is reported through the life of the restitution order
- Monitoring the offender's payment progress on existing restitution orders
- Determining if the County has a centralized and comprehensive county-wide restitution accounting system
- The collection and administration of restitution including:
  a. Administrative fees
  b. Financial reviews
  c. Fines
  d. Interest
  e. Restitution orders payable to the victim(s)
- Disbursing restitution to the victim and reimbursement to the California State VCGC Board

People Interviewed:

- Alameda County Deputy District Attorney Restitution Specialist
- California Department of Corrections and Rehabilitation, Restitution Program Manager
- El Dorado County:
  Assistant Court Executive Officer
  Chief Probation Officer and staff members
  District Attorney
  Fiscal Administrative Manager
  Public Defender
  Sheriff
  Sheriff's Team of Active Retirees (STAR)
  Superior Court Judges
  Treasurer-Tax Collector
  Victim Witness Program Coordinator

Documents Reviewed:

- Alameda County Restitution Program Policy and Procedures
- Alameda County Superior Courthouse-Oakland Corpus Restitution Court Calendar
- Applicable California Restitution Statutes
- California Constitution, Victims' Bill of Rights
- California Department of Corrections and Rehabilitation State Restitution Program Audit from 2002 and 2004

- California State Controller's Audit Report on Alameda Restitution Fines and Court Ordered Restitution, February 25, 2004
- California Victim Compensation and Governmental Claims Board Restitution Policy and Procedures
- El Dorado County District Attorney Victim Witness Program, Restitution Policy and Procedures
- El Dorado County Probation Department Restitution Policy and Procedures

FINDINGS

1. The County's Restitution activity process is not centralized.

2. The County and City jails have no procedure to collect victims' restitution from inmates.

3. There is insufficient follow-up with victims to obtain information as to their actual losses. This information is necessary to support the issuance of a victim restitution order by the court. According to the 2002 State Department of Corrections and Rehabilitation Restitution Audit, approximately 11% of offenders in the California State Prison system sentenced from El Dorado County have a court order to pay restitution to the victim(s).

4. Attaining timely victim information, including losses, is essential. The Probation Department is responsible for determining victim losses if the offender is sentenced to probation, which may be well after the crime is reported.

5. The District Attorney's Office of Victim Services is cognizant of the rights of victims and provides valuable services to victims of crime in El Dorado County. However, insufficient funding severely limits the services the District Attorney is able to provide.

6. When offenders are sentenced to State prison, or a juvenile facility, all outstanding restitution ordered for all cases is transferred to the Department of Corrections for collections. The State of California is only able to disburse 25% of victim restitution collected to victims because victim information is unavailable. It is imperative that victim information is included in the case records file accompanying the offender when sentenced to State prison.

7. Although the Probation Department is diligent and successful in their efforts to collect and disburse restitution from those offenders on probation obtaining the victim information when the crime is reported and communicating that information to the appropriate collection and disbursing entities is lacking.

8. Victims of misdemeanor crimes do not have their restitution orders actively collected by the County.

9. The restitution administration fee is currently being collected in an inefficient manner and occasionally at a rate higher than authorized by State statute. The current practice of the County is to collect the restitution administrative fee after the court-ordered amount is satisfied. The Grand Jury is aware of the justification for this method; however, research indicates the method of collecting administrative costs as payments are received improves the Restitution Program's ability to increase collections in future years.

RECOMMENDATIONS

1. The District Attorney should convene a team of restitution activity experts to analyze the feasibility and methodology that will best enhance restitution activities. The Alameda County Restitution Program Managers, the Alameda County District Attorney, the El Dorado County Superior Court, and the STAR volunteers are supportive to formalizing and improving the County's Restitution program.

2. Increase victim services under the District's Attorney's Victim Witness Program, utilizing the assistance of the STAR Program (volunteers). Increased services should include:

    - Early contact with **all** victims of crime to provide comprehensive county–wide information on the restitution program
    - Obtain and confirm current victim losses and addresses and a process for victims to keep address information current and have that information passed on to the State when appropriate.

    Victim contact by the District Attorney's Office will increase the success of identifying victim losses and information needed to request a Court Order in an amount commensurate with the loss, rather than an amount "to be determined." Collection cannot commence on orders to be determined where no dollar amount is stated.

3. In conjunction with the entities involved in restitution process, the El Dorado County District Attorney should adopt a more aggressive approach to the collection and enforcement of restitution that includes actively collecting restitution resulting from misdemeanor crimes. Delinquent accounts need to be identified and brought before the Superior Court. Alameda County has received statewide recognition as a leader in restitution enforcement with several counties in California successfully utilizing Alameda County's Restitution Enforcement Program as a model.

4. To offset operational costs collect the administration fee, authorized by State statute, as payments are received.

5. The Sheriff should analyze the feasibility of collecting restitution from offenders in the County jails, prior to depositing cash received into the offender's trust account. Hold offenders accountable until final payment is made regardless if the offender is in jail, on formal/informal probation, or work release programs.

6. A team or restitution experts should develop a comprehensive restitution and accounting system that tracks information from the date the crime is reported to the release of the offender from County jurisdiction. Also the system should track accurate records including the offender(s) name, case number, payment history, and link the offender(s) to the appropriate victim(s). Lastly, the system should interface with State systems.

Audit of El Dorado County's Medi-Cal Revenues Generated by the Departments of Human Services and Mental Health

Prepared for:
FY 2007-08 El Dorado County Grand Jury

By:

Harvey M. Rose Associates, LLC
June 2008

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HMR

June 18, 2008

Ms. Rosemary Mulligan, Foreperson
Members, FY 2007-08 El Dorado County Grand Jury
P.O. Box 472
Placerville, CA 95667

Dear Foreperson Mulligan and Members of the FY 2007-08 El Dorado County Grand Jury:

Harvey M. Rose Associates, LLC is pleased to submit this Audit of El Dorado County's Medi-Cal Revenues Generated by the Departments of Human Services and Mental Health.

Consistent with the results of a risk assessment conducted as part of this audit and direction from the Grand Jury, the audit focused on Medi-Cal billing and revenues for Adult Outpatient services provided by the Department of Mental Health and the Targeted Case Management program at the Department of Human Services.

We found that, to varying degrees, opportunities for improvement exist in the program areas reviewed for improved compliance with Medi-Cal and Targeted Case Management documentation requirements to ensure that the County maximizes its Medi-Cal revenues and minimizes Medi-Cal reimbursements disallowances.

This report contains findings in each program areas and documentation of potential losses to the County resulting from lack of compliance with Medi-Cal and Targeted Case Management requirements. There are eight recommendations presented in this report that, when implemented, will result in improved accountability and management of the Medi-Cal billing process in the two departments reviewed.

This audit was prepared in compliance with the work program submitted to and approved by the FY 2007-08 El Dorado County Grand Jury with one exception. It was necessary to obtain a court order to access Department of Human Services records. This had an impact on the state of records reviewed and interactions with that department, as discussed in detail in this report.

Thank you for selecting Harvey M. Rose Associates, LLC to conduct this audit. We are available at any time to respond to questions you may have about this audit and report.

Respectfully submitted,

Fred Brousseau
Project Manager

Table of Contents

Executive Summary

Harvey M. Rose Associates, LLC was retained by the FY 2007-08 El Dorado County to conduct an audit of El Dorado County's Medi-Cal revenues generated by the Departments of Human Services and Mental Health. To determine how limited audit hours could best be utilized given the potential breadth of the audit topic, a review of all programs receiving Medi-Cal revenues in the two subject departments was conducted. Based on those reviews, and with the Grand Jury's approval, the following programs were selected for more detailed review, including auditing a sample of client case records to ensure proper documentation was in place to support the amounts billed. The programs selected were:

- Adult Outpatient Services, Department of Mental Health
- Targeted Case Management, Department of Human Services (administered through the Public Guardian's Office and the Linkages program)

Other programs considered were the Department of Mental Health's Psychiatric Health Facility, Adult Day Rehabilitation program and Children's Services. Other Medi-Cal revenue generating programs considered at the Department of Human Services were the Multipurpose Senior Services Program and Medi-Cal Administrative Activities.

The following are the findings and recommendations contained in this audit report.

Section 1: Overview of Department of Mental Health programs selected for review: No findings or recommendations.

Section 2: Department of Mental Health's Medi-Cal Billing and Documentation

- Review of a sample of Department of Mental Health client files showed that an estimated 15.1 percent of the amount claimed for Medi-Cal reimbursement for adult outpatient services were not documented in accordance with Medi-Cal regulations and could potentially be disallowed. However, the State allows mental health departments to first attempt to correct documentation problems found before a final disallowance amount is determined. Based on the Department's rate of documentation correction, the percentage of claimed amounts subject to disallowance would be reduced to 8.8 percent and thus represents a risk of reimbursement disallowance by the State of approximately $165,643 for Fiscal Year 2006-2007 for adult outpatient services only.

- The Department of Mental Health expressed concern that the sample size used for this audit was too small and could not be considered representative of all Department clients' charts. The Department conducted its own review of a larger sample of client records and found that 18.8 percent of adult outpatient claims, a

comparable though slightly higher rate than the 15.1 percent found in the audit sample, were potentially disallowable.

- It should be noted that previous audits for Medi-Cal billing requirement compliance by the Department's Utilization Review/Quality Control division found much higher potential rates of disallowance as recently as 2006. It appears that the Department's internal audit efforts and staff training on documentation requirements since then has resulted in improved compliance and a reduced, though still present, risk of disallowance by the State.

- Review of the sample files revealed records of eligible services provided to Medi-Cal beneficiaries for which there was no corresponding Medi-Cal claim. The value of these services amounted to 12.1 percent of the value of all adult outpatient Medi-Cal claims reviewed. If these same results are applied to the Department's outpatient services for comparable adults, the Department has not billed Medi-Cal for an estimated $228,030 worth of eligible services provided in Fiscal Year 2006-2007. The Department reports new procedures in place to avoid unbilled services and that approximately 86 percent of the amount identified as unbilled has now been billed.

Based on the above findings, the following is recommended:

The Director of the Department of Mental Health should:

2.1 Direct the Department's Utilization Management/Quality Improvement Coordinator to continue to focus Department manager training efforts on ensuring that complete progress notes, complete assessments, and complete client plans are in every case file to minimize the risk of Medi-Cal disallowances for the Department and that all eligible services provided are included in Medi-Cal claims.

2.2 Direct the Utilization Review Coordinator to include reviews for unbilled services as part of the Department's routine Quality Improvement audits and to report the results of these audits quarterly to the Director.

2.3 Set goals for each Program Manager that make them accountable for eliminating the number of potential Medi-Cal disallowances and unbilled services in their program areas, measurement and achievement of which should be captured through the Department's regularly performed Quality Improvement audits.

The Board of Supervisors should:

2.4 Direct the Director of Mental Health to annually report to the Board and Chief Administrative Officer the results of the Department's Quality Improvement audits and success in reducing potential Medi-Cal disallowances and unbilled services.

Section 3: Overview of Department of Human Services programs selected for review: No findings or recommendations.

Section 4: Department of Human Services Targeted Case Management Medi-Cal Billing

- Client billing records for a sample of Department of Human Services Targeted Case Management clients were reviewed to determine compliance with program requirements necessary for Medi-Cal reimbursement. The Targeted Case Management program is operated through the Department of Human Services' Public Guardian and Linkages programs.

- Most of the Targeted Case Management records reviewed for Public Guardian clients were found non-compliant with one or more aspects of Program regulations. If this pattern holds true for all Public Guardian clients, a good portion of the Department's Medi-Cal revenues for this program are at risk of being disallowed for non-compliance with Targeted Case Management regulations. On the other hand, records reviewed for Linkages program clients were found to be substantially compliant. These records were more thorough and structured consistent with Targeted Case Management requirements. Some areas of the Linkages program billing records, however, were found to be non-compliant with program requirements or determinations of compliance could not be made because of the form in which case file records were provided by DHS.

- This audit of Targeted Case Management program Medi-Cal billing records was impaired by the documentation provided by the Department of Human Services in that: 1) the case file documents provided could not be positively identified as those of the clients randomly selected for review because client identification numbers from the Department's client master lists were blacked out by the Department on case file documents and replaced with handwritten numbers; 2) documentation provided did not allow for verification of whether or not claims were submitted for Medi-Cal reimbursement for the cases reviewed; 3) case file documents were so extensively redacted in some cases that it was not possible to verify compliance with some program regulations; and, (4) Assessment and Individual Client Service Plan documents provided by the Department for a number of clients were prepared after the Periodic Reviews provided so it was not possible to determine if service plans and objectives in effect at the time of the Periodic Reviews had been assessed by the case managers.

- Given the rate of non-compliance found with the sample Targeted Case Management records reviewed, the Department of Human Services is at risk of Medi-Cal disallowances of up to $147,747 for Fiscal Year 2006-2007 if the sample results apply to all Medi-Cal beneficiary program clients. To the extent that deficiencies found can be corrected to the State's satisfaction, this amount would be reduced.

Based on the above findings, the following is recommended:

The Director of Human Services should:

4.1 Direct Public Guardian Office management to establish written policies and procedures and documentation requirements that are consistent with Targeted Case Management program requirements and regulations, to include: inclusion in Individual Client Services Plans of client issues identified in Assessments; inclusion of specific actions and services in Individual Client Services Plans; and, specific discussion in Periodic Reviews of client progress in meeting service objectives and needs identified in previous Assessments and Service Plans.

4.2 Direct Linkages program management to direct staff to include frequency and duration of activities and services in their Individual Client Services Plans.

4.3 Direct the Department's TCM Coordinator to conduct periodic spot audits of Public Guardian and Linkages program Medi-Cal beneficiary client case records to ensure that they are compliant with TCM requirements and report the results in writing to the Director every six months.

4.4 Establish protocols for periodic reviews and audits of TCM and other Medi-Cal program case records by oversight agents such as the County Auditor-Controller, the Chief Administrative Officer and future Grand Juries that will allow for unimpaired audits of Medi-Cal programs by providing all documents needed to assess program compliance while still protecting client privacy.

Introduction

Harvey M. Rose Associates, LLC was retained by the FY 2007-08 El Dorado County Grand Jury to conduct an audit of the County's Medi-Cal revenues generated by the Departments of Human Services and Mental Health. Both departments receive Medi-Cal revenues for certain of their services. The purposes of the audit were to:

- Assess the adequacy of the two departments' Medi-Cal record keeping and billing policies and procedures and their compliance with State requirements;
- Analyze the two departments' Medi-Cal record-keeping practices relative to their policies and procedures and pertinent State requirements;
- Assess the timeliness and accuracy of claims to the State;
- Assess the two departments' accuracy and completeness of Medi-Cal related time and service record-keeping and billing.
- Assess the risk of current time and service record-keeping practices affecting the County General Fund or other sources by: under-claiming eligible costs; over-claiming eligible costs, which later have to be repaid to the State or federal government; and, allowing payments to contractors in excess of actual services provided.
- Evaluate policies and procedures to ensure that all patients who receive County indigent mental health and other services are screened for Medi-Cal eligibility to minimize County General Fund costs and are receiving all services they need and for which they are eligible.
- Evaluate the County's and two departments' management accountability systems and practices to ensure that Medi-Cal revenues are maximized and State claim errors are minimized.

Audit Methods

Methods used to conduct this audit included the following:

- Interviews were conducted with directors, program managers and key staff at the Department of Human Services and the Department of Mental Health.
- All programs at the two departments receiving Medi-Cal revenues were identified and assessed to determine the nature and costs of the services, the revenues received and to obtain an overview of the systems in place to identify and bill for all eligible costs.
- Pertinent State and federal regulations were reviewed and used for comparison to actual encounters.
- Program budgets, cost reports, time studies and supporting documentation were obtained and reviewed for all programs to determine the basis of their Medi-Cal rates charged to the State.

- A risk assessment was conducted of the program areas where more detailed review of Medi-Cal records would be most useful. The results were presented to the Grand Jury and programs were selected for more detailed review.
- Samples of client records for Medi-Cal invoiced services were reviewed for the selected programs in both departments: Adult and Children's Outpatient Services for the Department of Mental Health and the Targeted Case Management program administered through the Public Guardian's Office and the Linkages program at the Department of Human Services.
- A draft report containing findings, conclusions and recommendations stemming from the above steps was prepared and provided to the two departments for their review. Following their review and receipt of their comments through exit conferences, some changes were made based on their input and the final report was transmitted to the FY 2007-08 El Dorado County Grand Jury.

Audit Process Issues

Due to the Department of Human Services' refusal to provide access to Targeted Case Management case records due to concerns about client confidentiality, it was necessary for a court order to be obtained to allow access to the records for audit purposes. A court order was issued to this effect on February 20, 2008 specifying documents that would be provided and classes of documents that could be requested.

The court order did not provide for blanket access to Department records, access to the Department's computer system or any sources that might provide client names or allow for client identification. All records provided by the Department were to have client information such as name and Social Security number redacted though a unique identification number from each client's records was to remain visible in the records so that it could be matched to a corresponding client master list to ensure that we were provided the randomly selected case records.

The required unique identification numbers were not included in the computer generated records as requested but were instead handwritten on each document. This reduced the assurance that the auditors received the randomly selected records requested.

The arrangement in the court order did allow for provision of the needed records but the extent of Departmental redaction efforts exceeded name and Social Security number. Much of the content of progress reports and client service plans was blacked out, reducing the extent to which case record compliance with all Targeted Case Management requirements could be evaluated. In spite of this impediment, it was still possible to determine compliance with most program requirements.

Initially all Targeted Case Management records provided by the Department of Human Services had supervisor signatures redacted so it was not possible to determine if the Department was complying with the Program requirement that supervisors sign Client

Service Plans. After the exit conference with the Department, a subsequent set of records was provided showing the signatures.

The purpose and scope of the audit never changed and there was no impact on timing related to change in purpose. The factor most affecting audit timing was the weeks it took for the Department of Human Services to provide the requested records.

The audit was not a review for Medi-Cal fraud though certainly if evidence of fraud were found in the review, it would have been reported. The purpose of the audit from the start was to review billing procedures and revenue collection for selected programs in the Departments of Human Services and Mental Health. A number of programs were considered, and two programs were selected. The Department's Medi-Cal eligibility function was not considered for this audit though information was collected about the function at the outset of the audit to gain understanding about how Medi-Cal beneficiaries enter the system and how that may affect billing and reimbursement to the County.

Efforts to obtain access to the Department of Mental Health records had no impediments. A confidentiality waiver was signed by the audit team, as has been our experience in other jurisdictions where confidential records need to be reviewed as part of an audit, and access to records was provided within days. Names and Social Security numbers were redacted for all records removed from the Department.

1. Selection of Mental Health Department Program for Detailed Review

The El Dorado County Department of Mental Health provides specialty mental health services to County residents including beneficiaries enrolled in the Medi-Cal managed mental health care program. Services provided include adult inpatient, adult outpatient, adult day rehabilitation and children's outpatient services. Children's outpatient services are also provided through contract providers though they are not included in the scope of this audit.

The Department's Fiscal Year 2006-2007 expenditure budget was approximately $15.6 million and approximately $6 million was budgeted in Medi-Cal revenues. Table 1.1 presents the distribution of Fiscal Year 2006-2007 Medi-Cal billings and caseload for each Mental Health program.

Table 1.1
Medi-Cal Billings and Caseload
By Department of Mental Health Program
Fiscal Year 2006-2007

Services	Average Caseload Per Month	Medi-Cal Billings
Adult Inpatient	8	$998,487.54
Adult Outpatient	1,173	$1,882,305.81
Adult Day Rehab	159	$353,314.36
Children Outpatient	408	$2,081,795.45
Administrative Services	n/a	$416,605.85
Subtotal	*n/a*	*$5,732,509.01*
Special program Medi-Cal	n/a	$277,626.45
Total Medi-Cal billings	**1,748**	**$6,010,135.46**

Sources: "2006/2007 Billings & Revenue by Source Code," Finance, Mental Health Department, March 6, 2008. "Reporting Unit Caseload Summary Statistics," Finance, Utilization Review consultation, Mental Health Department, January 23, 2008.

Selection of Medi-Cal Services for Audit

To select Department programs for more detailed investigation of record keeping and Medi-Cal billing practices, a risk assessment of Medi-Cal reimbursed services was conducted and the results presented to the Fiscal Year 2007-2008 Grand Jury. The Grand Jury agreed with the conclusions of this risk assessment and authorized a more detailed audit of the Department's Medi-Cal billing records and processes for Adult and Children's Outpatient services.

Attributes of Medi-Cal services for this risk assessment included billings, caseload (open, unique cases), billings and recent audits conducted. Although administrative services are not programmatic, they were included in recognition of their portion of total Medi-Cal claims. Because administrative services are billed at as a percentage of total claims, they carry the same risk as all Medi-Cal services combined, but were not assigned a ranking.

As shown on Table 1.1, the Department's Medi-Cal billings are concentrated in Adult and Children's Outpatient services. Caseload is primarily concentrated in Adult Outpatient services. The smaller number of clients in Children's Outpatient services reflects the nature of children's services which often involves more encounters per client than in adult services.

The Department's Utilization Review/Quality Improvement division conducts ongoing audits of the Department's Medi-Cal billing. The Division's audit results from the period from July 2006 through December 2006 indicated that adult outpatient services had a significantly higher rate of potential Medi-Cal disallowances than children's outpatient services. For example, the Utilization Review 2nd Quarter Summary of Chart Audits found that 91 percent of adult outpatient charts, or client files, required a Plan of Correction to address failures to comply with Medi-Cal standards of documentation, such as missing client signatures or assessments. These failures to comply with documentation standards represented approximately 47 percent of the total claims. By comparison, the percentage of claims failing to comply with Medi-Cal standards in child populations in County operating and County contracted programs was 7 percent of the total claims. On average, adult outpatient services had disallowment rates ranging from 23 to 66 percent of claims, whereas children outpatient services had disallowment rates ranging from 0.56 to 13 percent of claims.

The risk assessment coupled with the Department's Utilization Review findings pointed to adult outpatient services as having the great risk of disallowment over all other Medi-Cal services the County provides to beneficiaries. Hence, it was decided, with Grand Jury approval, to concentrate the audit focus on adult outpatient services. Inclusion of a smaller sample of claims for Western Slope Children's Services was also added to the audit due to the lack of a recent audit of this program area by the Department Utilization Review division.

State Requirements for Provision of Medi-Cal Services

The County provides specialty mental health services to eligible Medi-Cal beneficiaries and is responsible for the authorization and payment of all medically necessary services in accordance with Federal and state requirements. Compliance with those requirements is attested to by the County's certification that the claims meet all applicable requirements when submitting the Department's monthly claim for Medi-Cal reimbursement to the State. Should documentation fail to substantiate claims, the full claim amount is disallowed, or "recouped" to the State.

State Documentation Requirements

Documentation must establish, first and foremost, that the beneficiary meets the diagnosis,[1] impairment,[2] and intervention related criteria.[3] This establishes the requirement for medical necessity for a beneficiary, which is recorded in an individual assessment and client plan. Documentation must also substantiate services, which are recorded in progress notes. Compliance with medical necessity and other state documentation requirements was tested by noting satisfactory documentation of the following items in client files for selected claims:

1) Assessment.
2) Client Plan that:
   (a) was based on the Assessment,
   (b) was annually updated, and
   (c) contained signatures of the clinician providing service or representative and the beneficiary.
3) Progress notes that:
   (a) documented medical necessity,
   (b) were written within 24 hours of service delivery,
   (c) were legible,
   (d) contained legible signatures of clinicians, and
   (e) claimed the correct amount of time documented.

While this is discretionary, the State allows for auditors' judgment of documentation as a justification for disallowment, or "recoupment," in the California Code of Regulations. Such reasons for recoupment include: judgment that "[d]ocumentation in the chart *does not establish* that the focus of the proposed intervention is to address the condition identified in the California Code of Regulations [*italics added*]"[4]; or "[t][he progress note indicates that the service provided was solely for… socialization that consists of generalized group activities that do not provide *systematic individualized feedback to the*

[1] California Code of Regulations, Title 9, Chapter 11, Sections 1830.205(b)(1)(A-R).
[2] California Code of Regulations, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C) and 1830.210(a)(3).
[3] California Code of Regulations, Title 9, Chapter 11, Sections 1830.205(b)(3)(A) and 1830.205(b)(3)(B)(1),(2), and (3).
[4] California Code of Regulations, Title 9, Chapter 11, Sections 1830.205(b)(2)(A),(B),(C).

specific targeted behaviors".[5] The Department's Utilization Review division has boiled down state documentation requirements to include the Client Plan **G**oal, staff person's **I**nterventions, client's **R**esponse to the interventions, and a **P**lan detailing next steps, or GIRP. The aim of GIRP is to address narrative documentation standards, such as those highlighted above, that require discretionary judgment.

State Utilization Management Program Requirements: Utilization Review

The Department's Utilization Review program satisfies the state requirement for a Utilization Management Program that is responsible for assuring compliance with access and authorization, monitoring standards for authorization decisions, and is revised as appropriate annually.[6] The Utilization Review Division's training program and materials are consistent with State requirements.

Billing Process Issues

The County, among eleven counties[7] collectively known as the "California Regional Mental Health System Coalition Joint Powers Authority" ("JPA") entered into a System Agreement with Netsmart New York, Inc. on June 27, 2006 to purchase and implement Avatar, a software program that would replace the billing and documentation system to process and substantiate claims, including Medi-Cal claims.

The County is currently transitioning from a legacy system to a new system. The new system, Avatar, is intended to replace both the legacy billing and system, Echo, and legacy documentation system, iTrack, with a unified, integrated system for automated billing and documentation.

At the time of the audit, the County had completed implementation of the billing functionality. The County had successfully used Avatar to generate the Medi-Cal billing from February 2007 onwards, and had not yet begun implementing the documentation functionality. Hence, in its transitional state, the County currently uses Avatar, the new system, for billing functionality and iTrack, the legacy system, for documentation functionality.

[5] California Code of Regulations, Title 9, Chapter 11, Sections 1840.312(a),(b),(c), and (d).
[6] California Code of Regulations, Title 9, Chapter 11, Sections 1810.440(b).
[7] The Agreement is made by and among the Counties: Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Inyo, Modoc, Mono, San Benito, and Shasta.

2. Department of Mental Health's Medi-Cal Billing and Documentation

- **Review of a sample of Department of Mental Health client files showed that an estimated 15.1 percent of the amount claimed for Medi-Cal reimbursement for adult outpatient services were not documented in accordance with Medi-Cal regulations and could potentially be disallowed. However, the State allows mental health departments to first attempt to correct documentation problems found before a final disallowance amount is determined. Based on the Department's rate of documentation correction, the percentage of claimed amounts subject to disallowance would be reduced to 8.8 percent and thus represents a risk of reimbursement disallowance by the State of approximately $165,643 for Fiscal Year 2006-2007 for adult outpatient services only.**

- **The Department of Mental Health expressed concern that the sample size used for this audit was too small and could not be considered representative of all Department clients' charts. The Department conducted its own review of a larger sample of client records and found that 18.8 percent of adult outpatient claims, a comparable though slightly higher rate than the 15.1 percent found in the audit sample, were potentially disallowable.**

- **It should be noted that previous audits for Medi-Cal billing requirement compliance by the Department's Utilization Review/Quality Control division found much higher potential rates of disallowance as recently as 2006. It appears that the Department's internal audit efforts and staff training on documentation requirements since then has resulted in improved compliance and a reduced, though still present, risk of disallowance by the State.**

- **Review of the sample files revealed records of eligible services provided to Medi-Cal beneficiaries for which there was no corresponding Medi-Cal claim. The value of these services amounted to 12.1 percent of the value of all adult outpatient Medi-Cal claims reviewed. If these same results are applied to the Department's outpatient services for comparable adults, the Department has not billed Medi-Cal for an estimated $228,030 worth of eligible services provided in Fiscal Year 2006-2007. The Department reports new procedures in place to avoid unbilled services and that approximately 86 percent of the amount identified as unbilled has now been billed.**

To test the Department of Mental Health's compliance with Medi-Cal documentation requirements, a randomly selected sample of client billing records for Western Slope,

Mallard and South Lake Tahoe Adult and Western Slope Children outpatient clients were audited. Documentation for a number of Medi-Cal claims were found non-compliant with Medi-Cal requirements, meaning that the amounts reimbursed for those services are at risk of being recouped by the State if the same files are subject to a State audit. In addition, records were found in the sample files for eligible services provided to Medi-Cal beneficiaries for which there were no corresponding Medi-Cal claims, meaning that reimbursements to which the County was entitled had not been recovered.

Sample Population

Table 2.1 presents a summary of the number of clients and claims randomly selected for review for each segment of the Department of Mental Health's (DMH) client population and Department sites. The number of clients is the number of beneficiaries and the number of claims is the number of billed claims included in the sample. The number of claims exceeds the number of clients because clients often receive multiple services in a billing period.

Table 2.1
Sample Clients and Claims Reviewed
By Department Client Group and Location

Sample Populations and Sites	# Clients	# Claims	Ratio of Claims to Clients
Western Slope Adult	9	31	3.4
Mallard Adult	10	41	4.1
South Lake Tahoe Adult	14	43	3.1
Western Slope Children	4	30	7.5
Total	**37**	**145**	**3.9**

Source: Harvey M. Rose Associates, LLC audit sample

Sampling Methodology

The sampling methodology for Mental Health Medi-Cal claims included a random selection of Department claims and case file documentation for adult and children outpatient clients eligible for Medi-Cal reimbursement from the State. Random numbers were assigned to all of the Department's Medi-Cal beneficiary outpatient clients and a group of 52 clients were selected for potential review, of which 37 were actually reviewed, representing 145 claims.

For the Western Slope Adult, Western Slope Children, and Mallard Adult samples, the methodology consisted of verifying all billing and documentation (client file information) for selected clients for a period of one month prior to the time of the most recent billing. At the time of the sampling, October 2007 claims were the most recent submitted; hence, the billings fell between the months of August and October 2007. Claims reviewed that

did not meet State Medi-Cal documentation requirements were coded as disallowances[1]. Billable services documented in case files for which there was not a corresponding Medi-Cal claim in the Department's billing system were noted and coded as unbilled services.

For the South Lake Tahoe Adult sample, the methodology was modified to limit the number of billings to three per client. These billings were randomly selected from Medi-Cal claims submitted between the months of March and October 2007.

Disallowances and unbilled services

As stated in Section 1 of this report regarding sampling methodology, claims that were not sufficiently documented in the case files were classified as disallowances. Though included in State Medi-Cal audits, questionable disallowances were initially identified but at the suggestion of the Department of Mental Health were excluded in the final results as they entail reviewing the substantive content of client files and making determinations about issues such as whether the amount of time billed to Medi-Cal was appropriate for the clinical services provided. For this audit, disallowances were identified only for claims that were clearly not compliant with Medi-Cal requirements and excluded documentation for claims that do not fully substantiate either the medical necessity of the service provided or individualized feedback to the specific targeted behaviors in the client plan.

Sampling Results

Table 2.2 displays the number and percentage of potentially disallowable claims by DMH client population and site.

Table 2.2
Disallowances by Sample Population and DMH

Sample Population	Disallowed Claims	Total Claims	% Disallowed Claims
Western Slope Adult	4	31	12.9%
Mallard Adult	5	41	12.2%
South Lake Tahoe Adult	8	43	18.6%
Western Slope Children	3	30	10.0%
Total	20	145.0	13.8%

Source: Harvey M. Rose Associates, LLC audit sample

The data in Table 2.2 show that approximately 13.8 percent of all sampled claims were determined to be disallowable. The South Lake Tahoe Adult sample contained the highest percentage of disallowances: 18.6 percent. The Western Slope Adult sample contained the second highest percentage at 12.9 percent.

[1] The state uses the term "recoupment" to refer to claims that cannot be substantiated and thus are "recouped" by the state. The decision was made to refer to this as "disallowment" for greater clarity, as "recoupment" would signify a loss, rather than a gain, for the County.

An interesting trend to point out is the ratio of claims to clients at the different sites as shown above in Table 2.1. Western Slope Children, for example, had a much smaller client sample size than Western Slope Adults, but a similar amount of claims. This reflects a client population that is provided services on a more frequent basis; hence, risk for Western Slope Children is greatest for client file requirements, such as an annually updated Client Plan, that have the potential to necessitate disallowment of all claims for that client. The same is true for the Mallard Adult population, which also has a slightly higher than average number of claims per client.

Table 2.3 presents a summary of disallowance reasons. The most frequently cited reason for disallowance was Incomplete Client Plans/Assessments/Progress Notes; thirteen claims were classified as such. The most common problems with these claims was missing clinician signatures or information on the documents, as required by Medi-Cal regulations. Missing Progress Notes was the next most common reason for disallowance. Due to the Department's separate systems for billing and documentation, and lapses in management of client files, it is possible to enter a claim for Medi-Cal reimbursement without a link to a documentation source. The results of the sample analysis by Department site and client population, with more details on the reasons for disallowances, are presented below, following the discussion of the fiscal impact of these audit findings.

Table 2.3
Qualitative Summary of Disallowance Reasons
for Sample Files Reviewed

Disallowance Reason	Disallowed Claims
Incomplete client plan/assessment/notes	13
Missing progress notes	4
Incomplete progress notes	1
No service provided	2
Total	**20**

Source: Harvey M. Rose Associates, LLC audit sample

Fiscal Impact of Disallowances

The value of the disallowances were calculated by multiplying the Medi-Cal rate for the appropriate service code by the number of minutes that service was provided according to case records. Rates differ for different service codes—for example, the rate for medication is more than double the rate for case management services. Audited claims that cannot be substantiated from documentation are refunded or "recouped" to the State in full. Table 2.4 provides details on the fiscal impact of all disallowances, or "recoupment" for the sample.

Table 2.4
Fiscal Impact of Disallowances in Sample Files Reviewed

Sample Population	$ Disallowed	Total Claimed	% Disallowed
Western Slope Adult	$609	$4,252	14.3%
Mallard Adult	$581	$2,992	19.4%
South Lake Tahoe Adult	$849	$6,297	13.5%
Western Slope Children	$377	$2,905	13.0%
Total Disallowed	$2,416	$16,447	14.7%
Adult Outpatient Only	$2,040	$13,542	15.1%

Source: Claim documents, Harvey M. Rose Associates, LLC audit sample case records. Rates by service code provided by Department of Mental Health. Minutes of service in case file records.

The fiscal impact of the disallowances is just as critical, if not more so, as the count and types of disallowances, to gain an understanding of program risks. For all sample populations and DMH sites, the fiscal impact of disallowances averaged 14.7 percent of total claims and ranged from 13.5 percent at the South Lake Tahoe Adult site to 19.4 percent of total claims the Mallard site. The narrow range of percentages of claims disallowed for Adult Outpatient services suggests that systemic documentation deficiencies for adult outpatient services. The rate for Adult Outpatient sites only was 15.1 percent.

The South Lake Tahoe Adult population had the highest fiscal impact as it had the greatest number of clients and claims with disallowances. The impact at the two other Adult Outpatient sites – Western Slope and Mallard – were lower than South Lake Tahoe. As a percentage of total claims, however, the Mallard Adult site's impact was higher, reflecting the effect of the relatively higher claims-to-client ratio at Mallard discussed above.

Simultaneous with this audit, the Department of Mental Health conducted its own internal review of Medi-Cal claims documentation for a larger set of records than reviewed for this audit. Their findings were that 18.8 percent of the records reviewed were potentially disallowable, a comparable, though slightly higher rate than the 14.8 percent rate from the sample files reviewed.

Adjusted Department-wide fiscal impact

To determine the potential Department-wide impact of inadequate chart documentation on Department of Mental Health revenues, an adjustment was made to the audit results to mirror the audit process utilized by the State and the Department itself in its own Utilization Management/Quality Improvement audits. The State notifies the Department of its intended sample of charts to be reviewed and the Department has an opportunity to review its charts in advance and, if possible, correct any deficiencies found. For example, if progress notes are missing in the client file, but were prepared at the time the billed service was provided and subsequently misfiled, the Department can retrieve them and add them to the case file before the State audit is conducted. The same procedure takes

place for internal audits conducted by the Department's Utilization Management/Quality Improvement division. This process generally results in a lowering of the number of potentially disallowable claims.

To determine the potential fiscal impact of the disallowances identified in the audit sample files, an adjustment was made to allow for corrections to potential disallowances such as those described above. This adjusted rate was then applied to the Department's total Medi-Cal revenues for claims from the Western Slope Adult, South Lake Tahoe Adult and Mallard Adult Outpatient sample files. The disallowance rate for Western Slope Children was excluded from the determination of Department wide fiscal impact since the number of potentially disallowable claims in the sample was mostly from one client's records and it was concluded that this could be due to a unique set of circumstances with that one client.

Table 2.5 presents the basis of the estimate of potential risk, or fiscal impact, of the disallowed Medi-Cal claims on the Department of Mental Health for Fiscal Year 2006-2007. As shown, the initial impact of the potential disallowances identified through the audit process would be $283,509. Since the results of this audit and the Department's own internal review of a larger sample of records showed similar results, the adjustments that would occur before disallowances were finalized were assumed to also be similar. On that basis, the final, adjusted disallowance rate was assumed to be 8.8 percent of claims filed. Using this rate, the impact on the Department's Medi-Cal revenues that would be recouped is $165,643 for FY 2006-2007.

Table 2.5
Potential Fiscal Impact of Fiscal Year 2006-2007
Disallowances based on Sample
of DMH Adult Outpatient
Medi-Cal Reimbursements

Program	Sample Disallowed $	Total $ Claims	% Total Claims
WSA	$609	$4,252	14.3%
Mallard	$581	$2,992	19.4%
SLT Adult	$849	$6,297	13.5%
Total	$2,040	$13,542	15.1%
Total FY 2006-07 Adult Medi-Cal Claims			$1,882,306
Impact of Initial Disallowance Rate			$283,509
Adjusted Impact Rate			8.8%*
Impact using Adjusted Rate			$165,643

Source: Fiscal Year 2006-2007 Medi-Cal billings provided by Department of Mental Health, "06/07 Billings & Revenue by Source & Index Code"

* This percentage was derived by the Department of Mental Health, after accounting for corrections that were made to potentially disallowable case files found in its own review of a larger sample of claims documentation conducted simultaneous with this audit.

The potential Medi-Cal disallowance rate and amount represents a decrease in potential State recoupment rates found in previous Department audits of its own charts and appears to indicate Department improvement in its Medi-Cal documentation. The Department's Utilization Management/Quality Improvement division conducts regular audits of its client charts and determines if they are properly documented to meet Medi-Cal standards. Its audits of charts from as recently as 2006 showed potential fiscal impact ranging from 23 to 66 percent of amounts claimed for Adult Outpatient services. The impact of those audits and resultant staff training by the Division appears to be paying off as represented by the reduction in records potentially disallowable relative to Medi-Cal standards.

It should be noted that for estimates of fiscal impact of disallowances, the County's provisional rates for Fiscal Year 2006-2007 were used. During the course of this audit, the County set a published rate for Fiscal Year 2006-2007 in its draft cost report, which has not been finalized. Those published rates are approximately six percent lower than provisional rates and would apply retroactively if they are finally approved. As the six percent decrease would apply to all claims, it would not affect the percentage fiscal impact; but it would affect the dollar amount of fiscal impacts, which would be universally decreased by six percent.

Fiscal Impact of Unbilled Services

Table 2.6 provides a summary of the fiscal impact of all unbilled services for the sample files reviewed. They were calculated by applying the appropriate Medi-Cal rate to the billable service code indicated and multiplying that rate by the number of minutes recorded on the progress note. As these figures represent documented, billable services provided to Medi-Cal eligible beneficiaries that were not billed to Medi-Cal, they represent unrealized revenue. Unbilled services totaled $2,488.23, or 15.1 percent of reviewed Medi-Cal claims.

Table 2.6
Fiscal Impact of Unbilled Services in Sample Files Reviewed

Sample Population	$ Unbilled	Total Claimed	% Unbilled
Western Slope Adult	$361.75	$4,252.38	8.5%
Mallard Adult	$1,137.32	$2,992.11	38.0%
South Lake Tahoe Adult	$916.26	$6,297.15	14.6%
Western Slope Children	$72.90	$2,904.91	2.5%
Total	$2,488.23	$16,446.55	15.1%
Adult Outpatient Only	$1,278.01	$10,549.53	12.1%

Source: Claim documents, Harvey M. Rose Associates, LLC audit sample case records. Rates by service code provided by Department of Mental Health. Minutes of service in case file records.

The highest absolute fiscal impact for unbilled services was from the Mallard site, at $1,137.32. At 38 percent, its potentially disallowed claims were also the highest as a percentage of totals claimed.

DMH's Utilization Review/Quality Improvement division has not instituted a formal process to report, address, and monitor these unbilled services. While the auditor observed that unbilled services were recorded informally and claimed to have been relayed to the appropriate managers, data on such informal process and results were not available. The Department reports that it has implemented a process where more extensive reviews of services provided are being performed by Fiscal Administrative staff to reduce or eliminate unbilled services. The Department further reports that since the audit field work was conducted, claims have been filed for the majority of these unbilled for services.

Department-wide impact

Assuming that the rate of unbilled services found in the Western Slope Adult and South Lake Tahoe Adult sample files is consistent for all comparable adult cases, the Department could be losing Medi-Cal revenues for adult outpatient services amounting to $228,030 per year based on the Fiscal Year 2006-2007 experience. Table 2.7 presents the basis for this estimate. As shown, Western Slope Children's Outpatient and Mallard Adult Outpatient billings were excluded from this estimate since they represented very low and very high rates of unbilled services, respectively. The rate of unbilled services for just the Western Slope Adult and South Lake Tahoe Adult samples, at 8.5 and 14.6 percent, respectively, were applied to total adult outpatient Fiscal Year 2006-07 claims for an estimate of the potential department-wide impact of unbilled for services.

Table 2.7
Potential Department-wide FY 2006-07 Fiscal Impact
of Unbilled Medi-Cal Services for DMH
Adult Outpatient Clients
based on Sample Results

Program	Billings	Total Claimed	% Unbilled
Western Slope Adult	$361.75	$4,252	8.5%
South Lake Tahoe Adult	$916.26	$6,297	14.6%
Total	$1,278.01	$10,549.53	12.1%
Total Adult Medi-Cal Revenues			$1,882,306
Impact: Apply Rate to Total Adult Outpatient Medi-Cal Revenues			$228,030

Source: Fiscal Year 2006-2007 Medi-Cal billings provided by Department of Mental Health, "06/07 Billings & Revenue by Source & Index Code"

The results of the audit analysis of Department Medi-Cal records for a sample of clients is now presented by client population and Department site.

Western Slope

Table 2.8 presents detailed information on disallowances for the review of a sample of Western Slope Adult and Children case records and Medi-Cal claims. Between the two Western Slope populations, the most common reasons for disallowance was incomplete client plan/assessment/progress notes or missing progress notes though the number of non-compliant records found for Children's Services was very low, representing documentation for only one client. The incomplete documents were most often due to missing signatures, as required by Medi-Cal regulations. Unbilled services for the two Western Slope sites were $361.75 for Adult Outpatient and $72.90 for Children Outpatient.

Table 2.8
Qualitative Summary of Disallowance Reasons
Western Slope Adults and Children

Western Slope Adult		Western Slope Children	
Disallowance Reason	**Disallowed Claims**	**Disallowance Reason**	**Disallowed Claims**
Incomplete client plan/assessment/notes	2	Incomplete client plan/assessment/notes	3
Missing progress notes	1	Missing progress notes	0
Inaccurate progress notes	0	Inaccurate progress notes	0
No service provided	1	No service provided	0
Total	**4**	**Total**	**3**

Source: Harvey M. Rose Associates, LLC audit sample

Fiscal Impact

The total fiscal impact of these adult outpatient disallowances for Western Slope Adult services was $609, or 14.3 percent of the $4,252 in total claims for the sample population. This rate was close to the rate for the total sample, which was 14.7 percent. The total fiscal impact of unbilled services for Western Slope Children was $377, or 13 percent of total Western Slope Children claims, slightly below the average for the entire Department sample.

Mallard

Table 2.9 presents detailed information on disallowances for the Mallard Adult sample. As with the Western Slope results above, the most frequent reason for disallowance was incomplete documents and missing progress notes.

Generally, Mallard clients receive more services than those at the Western Slope Adult site. Mallard has recently transitioned from an adult day care rehabilitation site to one offering group and individual services. Hence, instead of offering services at a single day rate, it offers services discretely, at the Medi-Cal billing rates for minutes of service. The change is primarily administrative; the beneficiaries receive the same day services while being billed to the State at a minute rate for those services. A high number of unbilled for services were also found at the Mallard site: $1,137.22, or 38 percent of the $2,992.11 in total claims in the sample.

Table 2.9
Qualitative Summary of Disallowance Reasons:
Mallard Adult Sample

Disallowance Reason	Disallowed Claims
Incomplete client plan/assessment/notes	4
No progress notes	1
Inaccurate progress notes	0
No service provided	0
Total	**5**

Source: Harvey M. Rose Associates, LLC audit sample

Fiscal Impact

The total fiscal impact of these disallowances was $581 or 19.4 percent of the $2,992 in total claims for the sample population the highest disallowance rate by far of the sample. The Mallard rate was higher than the 14.8 percent average for the total sample population.

South Lake Tahoe

Table 2.10 presents detailed information on disallowances for the South Lake Tahoe Adult sample. This population had the highest prevalence of disallowances in the sample in absolute dollars. As with the samples from the other Department sites reported above, incomplete documentation and missing or incomplete client plans, assessments and progress notes accounted for most of the potential disallowances.

Table 2.10
Qualitative Summary of Disallowance Reasons:
South Lake Tahoe Adult Sample

Disallowance Reason	Disallowed Claims
Incomplete client plan/assessment/notes	4
No progress notes	2
Inaccurate progress notes	1
No service provided	1
Total	**8**

Source: Harvey M. Rose Associates, LLC audit sample

Fiscal Impact

The total fiscal impact of these disallowances was $849, or 13.5 percent of the $6,297 in total Medi-Cal claims for the sample population. The South Lake Tahoe Adult sample also had a large amount of unbilled services: $916.26, or 14.6 percent of the $6,297 total claims from the sample. This included a mix of individual therapy, case management, assessment and one crisis intervention. The crisis intervention, like "medication" services, is particularly high in opportunity cost because of its higher Medi-Cal rate.

Conclusion

Sampling results indicate that failures to uphold Medi-Cal documentation standards for claims are consistent across all populations, although they were noticeably more prevalent in the Mallard site adult outpatient sample. Results also indicate that a significant portion of billable, documented services were not being claimed at the time the audit field work was conducted.

Recommendations

The Director of the Department of Mental Health should:

2.1 Direct the Department's Utilization Management/Quality Improvement Coordinator to continue to focus Department manager training efforts on ensuring that complete progress notes, complete assessments, and complete client plans are in every case file to minimize the risk of Medi-Cal disallowances for the Department and that all eligible services provided are included in Medi-Cal claims.

2.2 Direct the Utilization Review Coordinator to include reviews for unbilled services as part of the Department's routine Quality Improvement audits and to report the results of these audits quarterly to the Director.

2.3 Set goals for each Program Manager that make them accountable for eliminating the number of potential Medi-Cal disallowances and unbilled services in their

program areas, measurement and achievement of which should be captured through the Department's regularly performed Quality Improvement audits.

The Board of Supervisors should:

2.4 Direct the Director of Mental Health to annually report to the Board and Chief Administrative Officer the results of the Department's Quality Improvement audits and success in reducing potential Medi-Cal disallowances and unbilled services.

Costs and Benefits

For those Medi-Cal claims lacking adequate documentation to substantiate claims, the potential fiscal impact of disallowances for the sample is estimated to be 15.1 percent of that value of sampled claims in an adult outpatient sample population. Extrapolating this to the Medi-Cal claims for all adult outpatient claims for fiscal year 2006-2007 and adjusting the rate to 8.8 percent to allow for corrections to Department documentation as allowed by the State, the estimated fiscal impact of disallowances is $165,643.

For those Medi-Cal documented, unbilled services, the fiscal impact is estimated to be 12.1 percent of total adult outpatient claims. Extrapolating this to the Medi-Cal claims for all adult outpatient claims for fiscal year 2006-2007, the estimated fiscal impact of unbilled services is $228,030. Department reports of recently submitted billings for these claims should lower that amount. The recently submitted claims were not reviewed by the auditors.

3. Selection of Department of Human Services Program for Detailed Review

The Department of Human Services receives Medi-Cal revenues for three of its programs: 1) the Multipurpose Senior Services Program; 2) Targeted Case Management; and, 3) Medi-Cal Administrative Activities. Table 3.1 presents the distribution of Medi-Cal revenues and other characteristics of the three programs that were considered in determining which would be of greatest benefit for a more detailed audit.

Table 3.1
Department of Human Services
Programs that Receive Medi-Cal Revenue

Program	No. of Clients	Invoices Billed FY 2006-2007	Prior Audits FY 2006-2007
Multipurpose Senior Services Program	72	$340,224	1
TCM: Linkages	60	$ 64,866	None
TCM: Public Guardian	153	$168,404	None
Medi-Cal Administrative Activities (MAA)	n/a	$185,998	n/a

Sources: MSSP, TCM Linkages, and TCM Public Guardian client lists, as of Feburary 2008; Claims financial data of MSSP, TCM Linkages, and TCM Public Guardian invoices billed as of March 2008.

A brief description of each program is provided followed by a discussion of the selection of one program, Targeted Case Management, for more detailed audit review.

Multipurpose Senior Services Program

The primary objective of the Multipurpose Senior Services Program (MSSP) is "to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. MSSP provides services [that] enable clients to remain in or return to their homes".[1] To accomplish this, the Program staff provide case management services, defined as services rendered to assist clients in gaining access to needed services, monitoring the provision of those services, overseeing the process of assessment and reassessment of client level of care and the review of care plans. Outreach services are also provided through the program as are "waived" services, which refers to services approved for purchase under the auspices of the program. Such services and items must be authorized by case managers as appropriate and necessary for the clients and include adult day support services, housing assistance (which may include

[1] California Department of Aging, Multipurpose Senior Services Program Site Manual, 1-1, April 2004.

provision of physical adaptations and assistive devices, or emergency assistance for relocation), minor home repairs, personal care, and other services and items.

As shown in Table 3.1, MSSP had 72 clients and Fiscal Year 2006-2007 Medi-Cal revenues of $340,224. The program has been audited by the State as recently as Fiscal Year 2006-2007.

Targeted Case Management (Provided through the Public Guardian's Office and the Linkages Program)

Targeted Case Management (TCM) consists of case management services that assist Medi-Cal beneficiaries gain access to needed medical, social, educational, and other services. The objective of the program is to ensure that the changing needs of Medi-Cal eligible individuals are addressed on an ongoing basis and choices are made from the widest array of options for meeting those needs.[2]

TCM is provided through two Department of Human Services programs: the Public Guardian and the Linkages program. The Public Guardian provides services that are contingent upon the Office's appointment as conservator for an individual by the Superior Court or through its Representative Payee program for individuals who receive income through public entitlements, public benefits programs or other benefits programs and voluntarily seek financial management services. The Office's services are for individuals that are not capable of providing for their own needs, managing their own financial resources, or are subject to fraud or undue influence.[3] Services include a needs assessment, placement planning and treatment, medical decisions consultation with professional staff and family, and financial management on behalf of the conservatee or client. Public Guardian services are provided to individuals regardless of whether they are eligible for Medi-Cal. However, Medi-Cal reimbursement for TCM services is limited to Public Guardian clients who are also Medi-Cal beneficiaries.

The Linkages program offers case management services and referral to: in-home support services; respite care; personal care; chore services; home safety modifications; transportation; emergency response services; housing; nutritional services; government benefit programs; and other services as needed. Individuals qualify as eligible for the program is they are a resident of the County, 18 years of age or older, require assistance due to illness, injury, or disability in order to live independently, and need support in managing care and obtaining services that are not available through other resources.[4]

The Linkages program and services are available to eligible clients regardless of their Medi-Cal eligibility, but Medi-Cal reimbursement for TCM Linkages requires individuals

[2] State Department of Health Care Services, "Targeted Case Management: Fact Sheet." Available for download at http://www.dhcs.ca.gov

[3] The Public Guardian program description is posted on the Department's website http://www.co.el-dorado.ca.us/humanservices/PG.html

[4] The Linkages program description is posted on the Department's website at http://www.co.el-dorado.ca.us/humanservices/Linkages.html

to be Medi-Cal eligible. In other words, the Linkages costs that are reimbursable only apply to those individuals that are Medi-Cal eligible.

Medi-Cal Administrative Activities

Medi-Cal Administrative Activities are intended to improve the availability and accessibility of Medi-Cal Services to Medi-Cal eligible and potentially eligible individuals and their families. Reimbursable activities include: outreach, facilitating Medi-Cal application, Medi-Cal non-emergency transportation, contracting for Medi-Cal services, program planning and policy development, Medi-Cal Administrative Coordination and Claims Administration and Training.[5] The services can be provided by County agencies and/or contractors. In El Dorado County, the services are provided by a combination of County agencies and contractors, as allowed by Medi-Cal regulations.

Selection of Targeted Case Management program for more extensive audit review

To select a Department of Human Services Medi-Cal reimbursed program for more detailed investigation of record keeping and billing practices, a risk assessment of the three programs was performed, considering the number of clients receiving services, total amount invoiced to Medi-Cal and when the program was most recently audited. The Targeted Case Management (TCM) program was recommended for more detailed review by the auditors and approved by the Grand Jury based on this risk criteria.

Though the Multipurpose Senior Services Program generates more Medi-Cal revenue than TCM, TCM serves more clients through DHS' Public Guardian Office and Linkages program. And unlike the Multipurpose Senior Services Program, TCM has never been audited. The Multipurpose Senior Services Program was audited by the State as recently as Fiscal Year 2006-2007. These considerations led to the conclusion, with which the Grand Jury agreed, that more detailed audit review of TCM records should be performed.

The Program Manager who oversees the TCM and MAA program reimbursement claiming processes reviews encounter progress notes before invoicing the State for reimbursement, but does not review client files for overall compliance with program requirements. For example, although the progress notes for encounters may be reviewed discretely, the entire client file may not reviewed as a whole, and items that are required of the client file, such as annual Assessments may not be checked for compliance.

[5] Contract between El Dorado and the State [California Department of Health Services], effective July 1, 2004 through June 30, 2009.

4. Department of Human Services Targeted Case Management Medi-Cal Billing

- **Client billing records for a sample of Department of Human Services Targeted Case Management clients were reviewed to determine compliance with program requirements necessary for Medi-Cal reimbursement. The Targeted Case Management program is operated through the Department of Human Services' Public Guardian and Linkages programs.**

- **Most of the Targeted Case Management records reviewed for Public Guardian clients were found non-compliant with one or more aspects of Program regulations. If this pattern holds true for all Public Guardian clients, a good portion of the Department's Medi-Cal revenues for this program are at risk of being disallowed for non-compliance with Targeted Case Management regulations. On the other hand, records reviewed for Linkages program clients were found to be substantially compliant. These records were more thorough and structured consistent with Targeted Case Management requirements. Some areas of the Linkages program billing records, however, were found to be non-compliant with program requirements or determinations of compliance could not be made because of the form in which case file records were provided by DHS.**

- **This audit of Targeted Case Management program Medi-Cal billing records was impaired by the documentation provided by the Department of Human Services in that: 1) the case file documents provided could not be positively identified as those of the clients randomly selected for review because client identification numbers from the Department's client master lists were blacked out by the Department on case file documents and replaced with handwritten numbers; 2) documentation provided did not allow for verification of whether or not claims were submitted for Medi-Cal reimbursement for the cases reviewed; 3) case file documents were so extensively redacted in some cases that it was not possible to verify compliance with some program regulations; and, (4) Assessment and Individual Client Service Plan documents provided by the Department for a number of clients were prepared after the Periodic Reviews provided so it was not possible to determine if service plans and objectives in effect at the time of the Periodic Reviews had been assessed by the case managers.**

- **Given the rate of non-compliance found with the sample Targeted Case Management records reviewed, the Department of Human Services is at risk of Medi-Cal disallowances of up to $147,747 for Fiscal Year 2006-2007 if the sample results apply to all Medi-Cal beneficiary program clients. To the extent that deficiencies found can be corrected to the State's satisfaction, this amount would be reduced.**

The Department of Human Services received approximately $233,271 in Medi-Cal revenues in FY 2007-08 for its Targeted Case Management (TCM) program: $168,405 for the Public Guardian and $64,866 for the Linkages program. Authorized by State law, TCM is comprised of specialized case management services for targeted Medi-Cal-eligible individuals. The purpose of the TCM program is to ensure that those individuals can gain access to needed medical, social, educational, and other services. Case management services eligible for Medi-Cal reimbursement include needs assessment, setting needs objectives, individual service planning, service scheduling, crisis assistance planning and periodic evaluation of service effectiveness.

The State of California has received approval from the federal Centers for Medicaid and Medicare Services to provide Medi-Cal reimbursement for TCM services provided by Local Government Agencies or their contractors for the following types of Medi-Cal beneficiaries. As can be seen in Exhibit 4.1, the first four allowable provider groups correspond to county functions while the fifth and sixth allowable providers represent services that could be provided by a combination of county agencies and/or contractors.

Exhibit 4.1
Groups Eligible for TCM Services

	TCM providers allowed by State law	Medi-Cal beneficiary group profile
1.	Public Guardian	Persons 18 years or older who are under conservatorship of person and/or estate or who have otherwise demonstrated an inability to handle their personal, medical or other affairs.
2.	Aging and Adult Services/Linkages	Persons 18 years or older, in frail health and in need of assistance to access services in order to keep them from becoming institutionalized
3.	Public Health	High risk persons with a need for public health case management services such as women, infants and children up to age 21
4.	Adult Probation	Persons 18 years or older on probation who have a medical and/or mental condition.
5.	Outpatient medical service clinics	Persons unable to access or appropriately use services such as persons unable to understand medical directions because of language or comprehension barriers
6.	Community	Adults and children at risk of abuse and unfavorable developmental, behavioral, psychological or social outcomes such as persons who abuse alcohol or drugs.

TCM services are not mandated by the federal or State governments but when a Local Government Agency such as a county department elects to provide TCM services, they must enter in to an agreement with the State specifying the terms and conditions of the services to be provided and the mechanism for claiming Medi-Cal reimbursement. El Dorado County has opted to participate in the TCM program and receive Medi-Cal revenues for allowable services provided by the Public Guardian and the Linkages program.

The Public Guardian program within the Department of Human Services is provided to: 1) individuals who are conserved by the Superior Court after determination that they are not capable of providing for their own needs, managing their own financial resources, or are subject to fraud or undue influence[1]; 2) individuals who receive benefits from a program such as Social Security and voluntarily receive financial management services through the Office's Representative Payee program. Services provided by the Department include needs assessment, placement planning and treatment, medical decision consultation with professional staff and family, and financial management on behalf of the conservatee or client. The Public Guardian provides services to both Medi-Cal beneficiaries and others. As of January 2008, the Public Guardian was serving 327 clients, of which 153 were Medi-Cal beneficiaries.

The DHS Linkages program is offered to County residents 18 years of age or older who require assistance due to illness, injury, or disability in order to live independently, and need support in managing care and obtaining services that are not available through other resources. Linkages case managers coordinate and manage: the provision of in-home support services; respite care; personal care; chore services; home safety modifications; transportation; emergency response services; housing; nutritional services; government benefit programs; and other services as needed.

The Linkages program is offered to individuals regardless of whether they are eligible for Medi-Cal though only the services provided to Medi-Cal beneficiary program participants are reimbursed from Medi-Cal. As of January 2008, the Linkages program had 101 participants, of which 60 were Medi-Cal beneficiaries.

As required by State law and in DHS' agreement with the State, DHS is required to conduct a time survey for one month each year to determine the percentage of staff time spent on TCM services. These time percentages are applied to the Department's estimated annual costs for the most recent complete fiscal year and divided by the projected number of client encounters for the current fiscal year to determine the rate claimed for Medi-Cal reimbursement for TCM services in the current fiscal year.

Claims are made for each qualified client encounter with Medi-Cal beneficiaries who are under the jurisdiction of the Public Guardian or who are in the Department's Linkages programs. For the Public Guardian, an encounter is defined as, "a face-to-face contact or

[1] The Public Guardian program description is posted on the Department's website http://www.co.el-dorado.ca.us/humanservices/PG.html

a significant telephone contact with or on behalf of the Medicaid-eligible person for the purpose of rendering one or more TCM service components by a case manager".

The definition of an encounter is the same for the Linkages program except telephone contacts are only allowed "in lieu of a face-to-face encounter when environmental considerations preclude a face-to-face encounter". The allowable rates per encounter for FY 2007-8 are $472.57 for the Linkages program and $1,305.26 for the Public Guardian. These rates were determined through the required time study and cost reporting process governed by State regulations. The cost reports supporting the rates charged by DHS were obtained and reviewed but the supporting documents and bases of the rates charged were not analyzed as part of this audit.

Allowable TCM services to be provided and documented for Medi-Cal reimbursement include the following. Any of these services can qualify as billable encounters if they are provided in face to face meetings with the client.

1. *Needs Assessment*. The Assessment documents the conditions of the client and supports the selection of services for the individual. The Assessment should contain at least the following elements: 1) medical/mental health; 2) training; 3) vocational needs; 4) social/emotional issues; 5) housing/physical needs; 6) family/social matters; and, 7) finances.

2. *Individual Client Service Plan*. The case manager is required to develop a comprehensive written individualized service plan based on the Assessment. The Plan should identify the services to be provided to address the concerns identified in the Assessment. It must identify specific actions to be taken and include the duration and frequency of such actions. These Plans must be signed by the case manager's supervisor.

3. *Periodic review*. This is an evaluation of the beneficiary's progress toward achieving goals in Individual Client Service Plans must be assessed at least every six months. The Linkages program requires periodic review at least every 3 months.

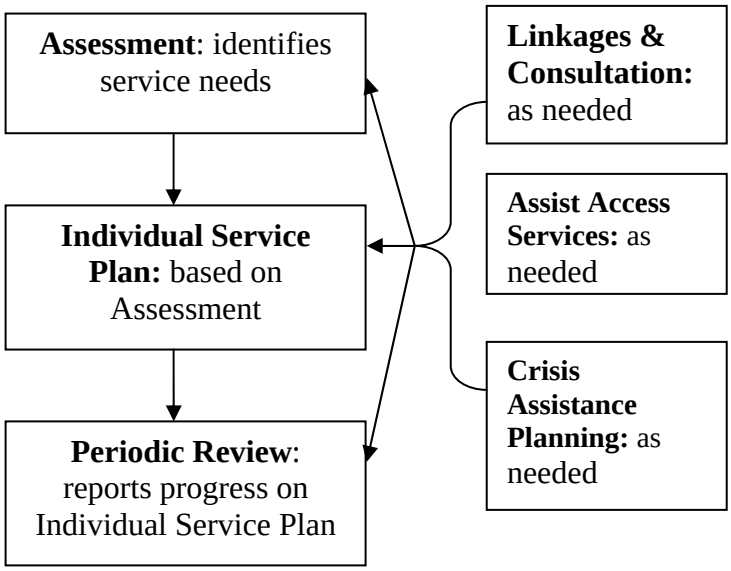
4. *Linkage and consultation*. Case managers may provide beneficiaries with linkage and consultation and referral to service providers as needed. If such referrals are provided, case managers are required to follow up within 30 days of the referral service date to determine the outcome.

5. *Assistance accessing services*. This includes arranging appointments and/or transportation to medical, social, educational, and other services; or arranging translation services to facilitate services.

6. *Crisis assistance planning*. Crisis planning evaluates, coordinates, and arranges immediate service or treatment in a crisis situation.

Exhibit 4.2 presents a graphic depiction of the relationship between these elements.

Exhibit 4.2
Required TCM Program Element Relationships



Audit Tests

A random sample of Medi-Cal client billing records from the Linkages and Public Guardian programs were reviewed for this audit to determine if services are being provided and documented consistent with TCM regulations and that adequate documentation is in place to support Medi-Cal claims. To make this determination, documentation was requested for the most recent invoiced encounter for each selected client in August 2007 or before and for all other encounters or contacts for the thirteen months prior to that most recent encounter. August 2007 was selected as the latest point for an invoiced encounter because the Department had not billed the State for TCM services beyond that month at the time the case billing records were requested.

In addition to the most recent invoiced encounter, documentation was requested for each client's Assessment in effect during the review period, Individual Service Plan(s) in effect during the review period for the client, Periodic Reviews and any Linkage and Consultation, Service Access Assistance and Crisis Assistance Planning services provided for the thirteen months preceding the most recent invoiced encounter. Thirteen months' worth of records were requested to ensure that a determination could be made regarding compliance with Periodic Review interval requirements since TCM requirements are for Periodic Reviews at least every six months for the Public Guardian and every three months for the Linkages program. It also allowed for a comparison of

Assessments, Individual Service Plans and Periodic Reviews to analyze whether the same objectives and services were identified and monitored in all three documents, consistent with TCM requirements.

There were a number of impairments to the review of the random sample of TCM billing records. To avoid providing documents with client names, the Department of Human Services provided clients lists for sample selection with client identification numbers only. Consistent with the terms of the February 20, 2008 court order issued requiring the Department to provide the records reviewed, a request was made by the auditors that the identification numbers on the Department's client master list be visible in the case file documents to verify that the client billing records provided by the Department were in fact those of the randomly selected clients. This intended method of validating that the selected records were the actual records provided was not possible as the Department blacked out the client identification numbers in the case file documents and handwrote the identification numbers on each document. As a result, it cannot be confirmed that the selected records were the ones provided by the Department.

Another impairment to the audit process was that it was not possible to validate that the selected records contained client encounters for which the Department billed Medi-Cal. A request was made for documentation showing a cross-reference such as the client identification number of the reviewed records on the invoice but this was not provided by the Department. As a result, it was not possible to verify which encounters reviewed were billed to Medi-Cal.

Two other impairments affected this TCM case file review. First was the extensive redacting of the case file documents by DHS to the extent that compliance with some TCM program regulations could not be determined. Details of this matter are discussed further in the subsequent discussion of the case file review. The second other impairment was that the Assessment and Individual Client Service Plan documents provided for some of the case records were prepared after the Periodic Review documents provided though the request was made for Assessments and Client Service Plans in effect during the review period for each client. As a result, it was not possible to assess compliance with TCM program regulations for those Periodic Reviews since they are supposed to assess the extent to which the client has achieved the service goals and objectives detailed in preceding Assessments and Individual Client Service Plans. More details on these impairments are provided in the following analysis of the case records reviewed.

According to DHS, these impairments would not occur if the State were to audit TCM program records since they would be entitled to review all aspects of case records and records. However, a system should be established so that other parties with an interest in County Medi-Cal revenues, such as the Chief Administrator's Office, the Auditor-Controller or future Grand Juries, can audit these records without these impairments and still protect the confidentiality of the clients. Other agencies subject to audit of client records have made arrangements where names and key identifiers are struck out of records but the substance remains largely in tact.

Public Guardian Client Records Reviewed

Twenty Medi-Cal eligible clients were randomly selected for review from the Public Guardian's client list. DHS did not submit documentation for eight of the 20 requested sets of records for the following stated reasons: three had billings after the August 2007 cutoff date, two were erroneously attributed to the program sample and three had not received services. Consequently, twelve of the twenty requested Public Guardian Medi-Cal beneficiary client case records were reviewed.

A minority of the twelve randomly selected sets of Public Guardian client records reviewed were found to be fully compliant with TCM program regulations and are thus at risk for Medi-Cal disallowance. Some measures of compliance were difficult to determine since so much of the content of the records provided was redacted by the Department of Human Services. For example, Periodic Reviews are supposed to assess accomplishment of the objectives set forth in Individual Client Service Plans. Unfortunately, much of the text in the Periodic Reviews and Individual Client Service Plan documents was blacked out by DHS to the point that it could not be determined in all cases what services or service objectives were being discussed. In spite of that, it was still possible to determine in the majority of cases whether or not the Periodic Reviews were compliant with most TCM requirements.

DHS compliance with TCM program and documentation requirements was assessed in spite of the limitations posed by the impairments described above. The results are presented below for each TCM service component. In cases where compliance could not be determined due to the state of records provided, no conclusion was drawn.

Assessments

The purpose of the required TCM Assessment is to document the client's needs in the following areas: 1) Medical/Mental Health; 2) Training needs for community living; 3) Vocational/Education needs; 4) Physical needs, such as food and clothing; 5) Social/Emotional status; 5) Housing/Physical environment; and, 6) Family/Social Support systems. TCM Assessments are to serve as the basis for the activities and services suggested and selected for the client.

The Assessment documentation provided by DHS for all but one of the twelve Public Guardian clients reviewed were Re-assessments rather than the requested clients Assessments in effect for the period being reviewed. These Re-assessments unfortunately did not contain all service elements required by TCM regulations nor are they required to do so. However, the Public Guardian's Initial Assessments that take place when clients are first conserved does include all the required TCM elements. However, since the initial Assessments were not provided in the case records and the Re-assessment documents are more abbreviated, it was not possible to determine from the documents provided by the Department if issues identified in the initial Assessments were being addressed in Individual Client Service Plans, as required by TCM regulations.

The Public Guardian's Re-assessment form contains only four categories: 1) Medical/Mental; 2) Social/Environmental; 3) Financial; and 4) Closing (for comments and summary statements). While some of the other elements required for TCM Assessments are embedded in the four Re-assessment categories (e.g., Family/Social Support Systems is a subsection of the Social/Environmental category) or may be addressed in summary written comments, some of the TCM required elements such as Training or Vocational/Education needs are simply not included and could potentially go unaddressed in Re-assessments. The Public Guardian could ensure greater compliance with TCM Assessment requirements and greater continuity in client services by revising its Re-assessment standardized forms to include all required Assessment elements.

Individual Client Service Plans

According to TCM regulations, Individual Client Service Plans are supposed to be based on each client's Assessment (or Re-assessment) document. The Plans should specify actions to be taken to meet the clients' service needs and are supposed to identify the nature, frequency and duration of activities and specific strategies to achieve service outcomes in the areas addressed in the Assessment (e.g., medical/dental, training, vocational/educational, etc.). The Plans are supposed to be comprehensive written documents.

None of the Public Guardian Individual Client Service Plans reviewed appear to fully comply with TCM regulations. First, so much of the content of the Assessments and Individual Client Service Plans had been redacted in the records provided by DHS that it made auditing these records very difficult as it was not always possible to tell what client issues, if any, were addressed in the Individual Client Service Plans or if those issues related to the Assessments. In cases where a reasonable amount of Assessment content could be discerned, there was no apparent reference to it in the associated Individual Client Service Plans.

Another problem with the Individual Client Service Plans reviewed is that DHS provided only the Assessments or Re-assessments prepared simultaneous with the Plans rather than those in effect for the full year reviewed for each client, as requested. As a result, it was not possible to determine if the Plans provided were addressing issues identified in previous Assessments or only in the Re-assessments.

The Individual Client Service Plan documents in the sample client records could be characterized more as checklists rather than "written, comprehensive individual service plans"[2], as required by TCM regulations. Instead of writing, many Plans simply contained checked off boxes for "Problems or Service Areas" such as "Financial" with no written commentary or specific objectives or actions to be taken. Many of the Plans reviewed did not identify services the client would be referred to, as required by TCM regulations, or were simply comprised of notes regarding previous actions taken by the case manager such as, "Deputy Public Guardian got a temporary card for file."

[2] Targeted Case Management Overview, page T-2-1-1, California Department of Health Care Services.

Though a TCM program requirement, none of the Plans in the twelve sets of case records reviewed identified the frequency or duration of the proposed actions to be taken. Combined with the weak nexuses between Individual Client Service Plans and the Assessments reviewed, a low percentage of the Individual Client Service Plans were determined to be compliant with TCM Medi-Cal requirements, as documented in Exhibit 4.3.

Exhibit 4.3
Summary of Results
Review of 24 Individual Client Service Plans
Public Guardian

	TCM compliant	Not TCM compliant	Could not be determined due to state of records	Total	% TCM compliant
Plans based on Assessments	6	4	14	24	25%
Plans listing specific activities	9	13	2	24	37.5%
Plans with activity frequency & duration	0	24	0	24	0%

Periodic Reviews

According to TCM regulations, follow up on the extent to which the objectives of the Individual Client Service Plans are being accomplished is supposed to occur and be documented through face-to-face Periodic Reviews conducted at least every six months. The twelve sets of Public Guardian case records in the sample should have contained 27 Periodic Reviews[3] but as shown in Exhibit 4.4, only ten Periodic Review documents were found to be compliant with the six month regulation. This amounts to 37 percent of the total 27 Periodic Reviews in the sample.

Of the Periodic Reviews evaluated, only one included a link to Individual Client Service Plan objectives in the write-up as required by TCM regulations. Another case file was assumed to be compliant even though it didn't contain a Periodic Review because the client had not been under the jurisdiction of the Public Guardian for six months as of August 2007, the cutoff date for requested records since no encounters after that date had

[3] 13 months of records for reviewed for each client picked. Since 12 sets of case records were provided by DHS and Periodic Reviews are supposed to occur at least every six months, this should have produced at least 24 Periodic Reviews. However, some of the case records reviewed were for new clients who had not been Public Guardian clients long enough to generate two Periodic Reviews. A few had more than two Periodic Reviews in their case records which increased the number of Periodic Reviews that should have been 26 Periodic Reviews in the case records to be compliant with TCM regulations.

been invoiced by the County at the time records were requested from the Department for this audit. The remaining twenty-five Periodic Reviews were considered non-compliant because seventeen did not include assessments of Individual Client Service Plan objectives and seven that should have been conducted and in the case records reviewed were missing entirely.

The median number of days between Periodic Reviews was 89 days for compliant cases but 322, or 142 days in excess of the TCM 180 day requirement, for non-compliant cases. The median number of days between Periodic Reviews for all cases records reviewed that contained Periodic Reviews was 199 days.

Exhibit 4.4
Summary of Results
Review of Periodic Reviews
Public Guardian

	TCM compliant	Not TCM compliant	Total	% TCM compliant
Encounters completed every six months	10	17	27	37.0%
Median # days between Periodic Reviews	89	322	199	n.a.
Periodic Reviews assessing Service Plan objectives accomplished	2	25	27	7.4%

Linkage & Consultation

As mentioned above, TCM services can include providing clients with referrals to service providers and placement activities. When such services, called Linkage and Consultation, are provided, TCM regulations require that the initial referral or consultation be documented and that a documented follow-up occurs within a maximum of 30 days to determine whether the services were provided and whether they met the client's needs. Linkage and Consultation services are not required but when they are provided, they must follow the protocols described.

Linkage and Consultation services were provided eleven times in the twelve sets of Public Guardian client records reviewed. None of the recorded Linkage and Consultation services reviewed were fully compliant with TCM requirements. In all cases, there were either no service referrals or, if there were, the nature of the services could not be confirmed because so much of the text in the report was blacked out by DHS. Documentation of required 30 day follow-ups to the Linkage and Consultation services were not found in any of the eleven reported incidents.

Exhibit 4.5
Summary of Results
Review of Linkage and Consultation Services
Public Guardian

	TCM compliant	Not TCM compliant	Could not be determined due to state of records	Total	% TCM compliant
Referrals for Services documented	1	5	5	11	9.1%
Follow up within 30 days	0	11	0	11	0%

Assistance Accessing Services

This TCM allowable service can include arranging appointments, transportation to appointments, and other services identified in Individual Client Service Plans. Three of the twelve case records reviewed included documentation of providing this service. Due to the extensive amount of text blacked out on the report documents provided, it was not possible to tell what services were being in two of the three records reviewed. In one case, it was possible to tell that transportation was being arranged. In this case, the arranged service had also been cited as a need in the client's Individual Client Service Plan.

Crisis Assistance Planning

None of the case records reviewed included reports of this service having been provided.

Linkages Program Client Records Reviewed

Fifteen Medi-Cal eligible clients were selected for sampling from the DHS Linkages program. Documentation for five of the 15 clients was not provided by DHS because the Department reported there had been no encounters billed for those clients during the review period since they became clients after August 2007. Since the most recent Medi-Cal invoices submitted at the time of this audit was in August 2007, encounters after that time were not reviewed for this audit. As a result of the five clients having no billed encounters, only ten sets of Linkages client records from the original random sample selection were reviewed.

The TCM service components and requirements for the Linkages program is the same as for the Public Guardian with the exception that Periodic Reviews must take place at least every three months instead of the Public Guardian requirement of every six months. Otherwise, the approach to the review of these program case records was similar to the review of Public Guardian case records.

Overall, compliance with TCM program requirements was much higher for the Linkages program than for the Public Guardian program. Progress report documentation was much better and the program's standardized progress notes and forms are thorough and appear to be designed to integrate Assessments, Individual Client Service Plans and Periodic Reviews.

However, some areas of documentation were found non-compliant with TCM regulations, as reported below, and are therefore at risk of having their Medi-Cal reimbursement disallowed.

Assessments

As with the Public Guardian records, the Linkages records reviewed contained more Re-assessments than initial Assessments; of the ten sets of client records reviewed, four contained initial Assessments and the other six contained annual Re-assessments. However, unlike the Public Guardian, the standardized forms used for Linkages Assessments and Re-assessments are the same and contain all of the service elements required for TCM programs except for Vocational/Educational needs, which are not called out on the standardized Linkages Assessment form. In some cases, these needs may be addressed in the Comments section but, if there are no such comments, there is no assurance from the documentation that the clients' needs in this area were assessed, as required by TCM.

Individual Client Service Plans

All ten sets of case records reviewed contained Individual Client Service Plans, generally prepared at the same time as Re-assessments. Unlike the Public Guardian's Plan documents, Linkages program staff uses a standardized Service Plan form that requires the case manager to propose specific actions to be taken in various service categories

such as Case Management, Transportation, Respite/Homemaker, etc. For example, in a Service Plan reviewed in one of the audit sample sets of records, under the Service category, "Housing Assistance/Chore/Homemaker", the following specific actions were proposed:

> "Monitor the client's ability to maintain her home. Refer to volunteer and handyman services for home repairs/maintenance. Assist with providing a one-time heavy duty housecleaning service if necessary."

A space is also included on the Service Plan form for the case manager to describe the status of each action in Plan Addendums. In most cases reviewed, dates and descriptions of specific actions taken on at least some of the items were recorded by the case manager.

Linkages program Service Plan documents are superior to those used by the Public Guardian's Office in that they require the case manager to identify specific actions to be taken. Though much of the text in the documents provided by DHS was struck out and could not be read, in all of the Service Plan documents reviewed, at least one issue identified could also be found in the discussion in the Assessment or Re-assessment documents. Only one Plan had so little text left after the Department's redactions that it was not possible to find corresponding issues in the Assessment document.

Exhibit 4.6 shows the results of the selected TCM requirements pertaining to Individual Client Service Plans in the ten Linkages case records reviewed.

Exhibit 4.6
Review of
10 Individual Client Service Plans
Linkages Program

	TCM compliant	Not TCM compliant	Could not be determined due to state of records	Total	% TCM compliant
Plans based on Assessments	9	0	1	10	90%
Plans listing specific activities	10	0	0	10	100%
Plans with activity frequency, duration	0	10	0	10	0%

As shown in Exhibit 4.6, Linkages Service Plans were found to contain specific services and actions to be taken and were thus determined to be compliant with TCM regulations in this regard. The consistency of approach found in the case records reviewed makes it appear that Linkages program management has directed its staff to include actions to be

taken in Plan documents, an approach that does not appear to be in place in the Public Guardian's Office. Actions specified in Linkages Plans include referring the clients to individuals, organizations and/or agencies that will meet their service objectives. Unfortunately, the nature of these referrals could not be verified due to the heavily redacted documents provided by the Department. However, the Linkages Re-assessment documents reviewed did include information on the specific services and agencies to which the clients have been referred since their last Assessment.

While the Linkages Individual Client Services Plans represent an improvement over the Public Guardian Plans reviewed, they were found not fully compliant with TCM regulations in that none of the Service Plans reviewed described the frequency or nature of the activities and specific services to be performed, as required by TCM regulations.

Periodic Reviews

Though TCM regulations require Periodic Reviews of program clients at least every six months, the Linkages program has a more restrictive requirement that Periodic Reviews take place at least every three months. The purpose of the reviews is to determine if the client is achieving the objectives identified in their Individual Client Service Plans and to determine if current services should be continued, modified or discontinued.

As shown in Exhibit 4.7, the majority of Linkages Program Period Reviews were conducted within the required three month interval requirement. The median number of days between Periodic Reviews for the compliant cases in the case records reviewed was 46.5 days. For the three non-compliant cases, the median number of days between Periodic Reviews was 53.5 days. Most Periodic Reviews in all records reviewed were within the required 90 day maximum but there was one Periodic Review in each of the three non-compliant sets of case records that exceeded the allowable interval time. However, Periodic Reviews in the sample case records were generally very specific and addressed issues such as Housing, Medical Services, Transportation and others.

A determination of whether the Linkages program is complying with the TCM requirement that Periodic Reviews evaluate the client's progress toward achieving their Service Plan objectives could only be definitively made for four of the ten case sets of case records reviewed. A determination could not be made for the remaining six case sets of case records either because the Service Plans provided were for time periods after the periods covered by the Periodic Reviews provided and thus could not be compared, or, because so much text has been redacted that it was not possible to tell what services were being assessed in the Periodic Reviews. Some of the Service Plans provided by DHS were those prepared after the 13 month review period for the case records.

Exhibit 4.7 presents the results of the assessment of Periodic Reviews conducted for this audit.

Exhibit 4.7
Periodic Reviews in 10 Sets of Case Records
Linkages Program

	TCM compliant	Not TCM compliant	Could not be determined due to state of records	Total	% TCM compliant
Encounters completed every three months	62	3	0	65	95.2%
Median # days between Periodic Reviews	46.5	53.5	n.a.	53.5	n.a.
# assessing Service Plan objectives accomplished?	4	0	6	10	40%

Linkage & Consultation

Linkage and Consultation services are when case managers provide clients with referrals to services and placement activities consistent with the clients' service needs and objectives. TCM regulations require that referral to such services be followed up within 30 days to determine if the services were received and whether they met the client's needs. Though progress notes in the case records reviewed showed that Linkage program case managers do provide Linkage and Consultation services, the Program's encounter documentation does not classify such services by this name. None of the case records in which such services are recorded contained 30 day follow-up documentation either. Linkage and Consultation encounters in these case records were embedded in progress notes classified as either Assessments, Re-assessments, Quarterly Visits or Home Visits.

While the case records reviewed showed that most Linkages clients do receive visits from the case managers more frequently than the minimum required four times a year, the fact that certain Linkage and Consultation services are not documented as such has resulted in an absence of TCM required 30 day follow-ups to such services. The intent of this TCM requirement appears to be to enhance the effectiveness of case manager services by not only making referrals, but determining if the clients used the service and if the service met their needs.

Assistance Accessing Services

TCM allows case managers to provide Assistance Accessing Services to their clients. As the name implies, this can include arranging appointments and/or transportation for medical, social, educational or other services, or arranging translation services to facilitate communications between clients and case managers or others. Linkages progress notes reviewed for the ten sample case records showed that such services are frequently provided by Linkages staff but they are not classified as such. Instead, all client encounters are classified only as Assessments, Re-assessments, Quarterly Visits and Home Visits. Classifying progress notes with the title Assistance Accessing Services would make the records more clear which TCM allowed services are being provided.

Crisis Assistance Planning

This final service allowed for the TCM program is for arranging or coordinating immediate services or treatment when the client is in an emergency situation. There were no records of such services in the ten sets of case records reviewed.

Fiscal impact of non-compliance with TCM requirements

Medi-Cal disallowances for TCM services can be determined in different ways. Billings are submitted for "encounters" which, as discussed above, must be face-to-face interactions between a TCM case manager and a client. Billing for driving a client to an appointment or billing for an encounter that is not documented would both not be acceptable and the amount billed for such an encounter would presumably be disallowed through a State audit. Inaccurate time study or cost report details could also lead to a disallowance if the data in these documents were inaccurate or not properly used for billing purposes.

Another way of determining the appropriateness of Medi-Cal billings for TCM services is through a review of case records to assess adherence to TCM program requirements. Medi-Cal reimbursement for TCM services is based on the premise that all program requirements are being met. This was the approach used for this audit and the results are discussed above.

Based on the findings discussed above regarding TCM program requirement compliance in the Public Guardian's Office and the Linkages program, an estimate of fiscal impact has been made. The basis of this estimate is the number of billable encounters determined to be substantially out of compliance with TCM program requirements. Since the TCM program has many requirements, some more significant than others, some judgment was necessary to define substantial compliance. For example, none of the case records reviewed for either the Public Guardian or the Linkages program contained the frequency or duration of activities recommended for clients in the Individual Client Service Plans, as required by TCM regulations. Using this measure, all encounters billed for during preparation of Client Services Plans are out of compliance with TCM regulations and are therefore subject to Medi-Cal disallowance.

A different standard was used though since the absence of frequency and duration of Service Plan activities was not considered as serious a breach of compliance as, for example, lack of compliance with the TCM requirement that a face-to-face Periodic Review of progress be conducted with the client at least every six months. If a case file was found compliant with all TCM requirements except including the frequency and duration of activities in the Individual Client Service Plan, the file was considered compliant. If a case file was non-compliant in a variety of areas such as: not specifying activities for the client in the Individual Client Service Plan; not cross-referencing service needs from the client's Assessment in the Individual Client Service Plan; and, not specifying the frequency and duration of activities in the Individual Client Service Plan, the case file was considered non-compliant and subject to Medi-Cal disallowance.

Using this approach, 36 of the 42 Public Guardian encounter records reviewed and three of the 67 Linkages program encounter records reviewed were considered non-compliant with TCM requirements and subject to Medi-Cal disallowances. Applying these ratios of non-compliant encounters to total Fiscal Year 2006-2007 Medi-Cal revenues for the two TCM programs in the Department of Human Services produces the following fiscal impacts.

Table 4.8
Estimated Impact of
Non-Compliance with TCM Regulations
on DHS Medi-Cal Revenue

	Public Guardian	Linkages
# Encounters Reviewed	42	67
# non-Compliant	36	3
% non-compliant	85.7%	4.5%
Total FY 2006-07 Medi-Cal Revenue	$168,405	$64,866
Potential Medi-Cal Disallowance	$144,828	$2,919

As shown in Table 4.8. the fiscal impact on the Department would be $140,338 for the Public Guardian's Medi-Cal revenues and $19,460 for the Linkages program. To the extent that deficiencies found can be corrected to the State's satisfaction, this amount would be reduced.

Conclusion

Many of the Department of Human Services Public Guardian program case records appear to be out of compliance with TCM program requirements, based on a review of a sample of client case records and documentation supporting Medi-Cal claims for reimbursement. Few of the case records reviewed make the required link between client Assessments, Individual Client Service Plans and Periodic Reviews to ensure that client

needs have been identified and addressed with specific activities and service strategies. Though a TCM requirement, follow-up checks on services to which clients are referred are routinely not taking place. Most cases are not meeting the six month Periodic Review requirement.

The Department's Linkages program, on the other hand, was found substantially in compliance with TCM program requirements in the ten sample sets of case records reviewed. Linkages program management appears to have designed their case file documentation and established policies and procedures with TCM program requirements, or intent, in mind. Periodic review documents are structured to ensure that service objectives and client needs identified in previous assessments and reviews continue to be addressed.

Recommendations

The Director of Human Services should:

4.1 Direct Public Guardian Office management to establish written policies and procedures and documentation requirements that are consistent with Targeted Case Management program requirements and regulations, to include: inclusion in Individual Client Services Plans of client issues identified in Assessments; inclusion of specific actions and services in Individual Client Services Plans; and, specific discussion in Periodic Reviews of client progress in meeting service objectives and needs identified in previous Assessments and Service Plans.

4.2 Direct Linkages program management to direct staff to include frequency and duration of activities and services in their Individual Client Services Plans.

4.3 Direct the Department's TCM Coordinator to conduct periodic spot audits of Public Guardian and Linkages program Medi-Cal beneficiary client case records to ensure that they are compliant with TCM requirements and report the results in writing to the Director every six months.

4.4 Establish protocols for periodic reviews and audits of TCM and other Medi-Cal program case records by oversight agents such as the County Auditor-Controller, the Chief Administrative Officer and future Grand Juries that will allow for unimpaired audits of Medi-Cal programs by providing all documents needed to assess program compliance while still protecting client privacy.

Costs and Benefits

The costs of implementing the above recommendations will mostly be in the form of Department of Human Services staff time. The benefits of implementing the recommendations will include better managed services for TCM clients and reduced risk of Medi-Cal disallowances for both programs. Based on the review of TCM client case records from the Public Guardian Office and the Linkages program, the Department is at risk of an estimated Medi-Cal disallowance for Fiscal Year 2006-2007 of $144,828 for

the Public Guardian and $2,919 for the Linkages program, for a total disallowance of $147,747. To the extent that deficiencies found can be corrected to the State's satisfaction, this amount would be reduced.