



Implementation of State Auditor's Recommendations

Audits Released in January 2007 Through December 2008

Special Report to
*Assembly and Senate
Standing/Policy Committees*

February 2009 Report 2009-406



CALIFORNIA
STATE AUDITOR

The first five copies of each California State Auditor report are free. Additional copies are \$3 each, payable by check or money order. You can obtain reports by contacting the Bureau of State Audits at the following address:

California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814
916.445.0255 or TTY 916.445.0033

OR

This report is also available on the World Wide Web <http://www.bsa.ca.gov>

The California State Auditor is pleased to announce the availability of an on-line subscription service. For information on how to subscribe, please contact the Information Technology Unit at 916.445.0255, ext. 456, or visit our Web site at www.bsa.ca.gov.

Alternate format reports available upon request.

Permission is granted to reproduce reports.

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Elaine M. Howle
State Auditor
Doug Cordiner
Chief Deputy

CALIFORNIA STATE AUDITOR

Bureau of State Audits

555 Capitol Mall, Suite 300

Sacramento, CA 95814

916.445.0255

916.327.0019 fax

www.bsa.ca.gov

February 24, 2009

2009-406

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

Dear Governor and Legislative Leaders:

The California State Auditor's Office presents its special report for the legislative standing/policy committees, which summarizes audits and investigations we issued during the previous two years. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations. To facilitate use of the report we have included a table that summarizes the status of each agency's implementation efforts based on its most recent response. This special report also includes an appendix that summarizes monetary benefits auditees could realize if they implement our recommendations or take appropriate corrective action.

This information will also be available in 10 special reports specifically tailored for each Assembly and Senate budget subcommittee on our Web site at www.bsa.ca.gov. Finally, we notify auditees of the release of these special reports.

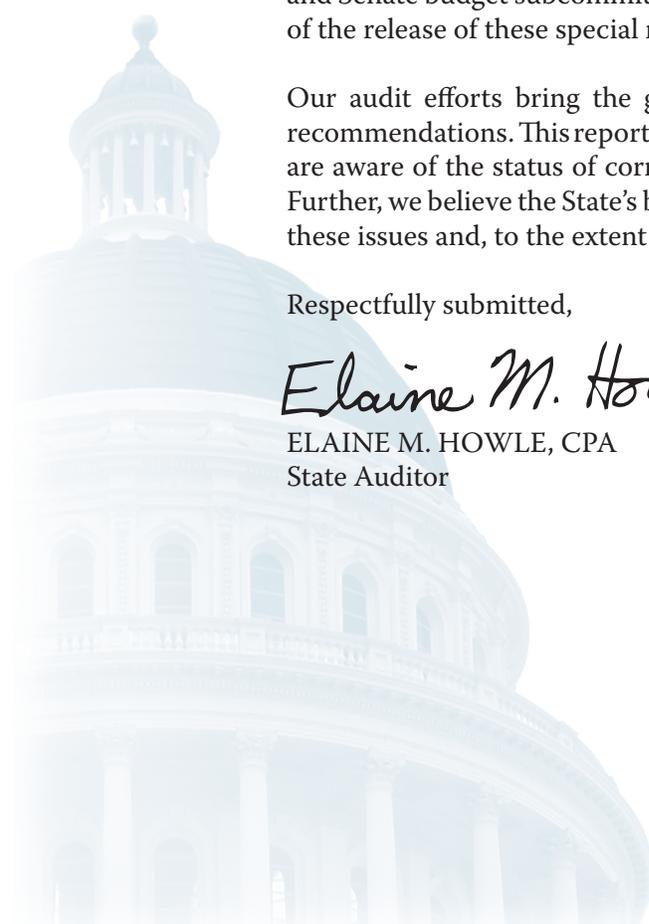
Our audit efforts bring the greatest returns when the auditee acts upon our findings and recommendations. This report is one vehicle to ensure that the State's policy makers and managers are aware of the status of corrective action agencies and departments report they have taken. Further, we believe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

Respectfully submitted,



Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor



Contents

Introduction and Summary Table	1
Aging and Long-Term Care	
Report Number 2006-035, Department of Health Services: <i>It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities</i>	9
Report Number 2006-106, Department of Health Services: <i>Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities</i>	15
Agriculture and Water Resources	
Report Number 2007-108, Department of Water Resources: <i>Its Administration of Grants Under the Flood Protection Corridor Program Needs Improvement</i>	23
Appropriations	
Report Number 2005-123, Department of Corporations: <i>It Needs Stronger Oversight of Its Operations and More Efficient Processing of License Applications and Complaints</i>	29
Report Number 2006-501, California Department of Corrections and Rehabilitation: <i>It Needs to Improve Its Processes for Contracting and Paying Medical Service Providers as Well as for Complying With the Political Reform Act and Verifying the Credentials of Contract Medical Service Providers</i>	37
Report Number 2006-036, Indian Gaming Special Distribution Fund: <i>Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments</i>	51
Report Number 2007-124, Safely Surrendered Baby Law: <i>Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact</i>	59
Report Number 2007-040, Department of Public Health: <i>Laboratory Field Services' Lack of Clinical Laboratory Oversight Places the Public at Risk</i>	67

Arts, Entertainment, Sports, Tourism, and Internet Media

Report Number 2006-036, Indian Gaming Special Distribution Fund: *Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments (see summary on page 51)*

Banking, Finance, and Insurance

Report Number 2005-123, Department of Corporations: *It Needs Stronger Oversight of Its Operations and More Efficient Processing of License Applications and Complaints (see summary on page 29)*

Business, Professions, and Economic Development

Report Number 2007-038, Medical Board of California: *It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund* 75

Report Number 2007-111, California Highway Patrol: *It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently* 77

Report Number 2007-117, State Board of Chiropractic Examiners: *Board Members Violated State Laws and Procedural Requirements, and Its Enforcement, Licensing, and Continuing Education Programs Need Improvement* 85

Report Number 2008-112, Electronic Waste: *Some State Agencies Have Discarded Their Electronic Waste Improperly, While State and Local Oversight Is Limited* 103

Report Number 2005-123, Department of Corporations: *It Needs Stronger Oversight of Its Operations and More Efficient Processing of License Applications and Complaints (see summary on page 29)*

Report Number I2008-2, Investigations of Improper Activities by State Employees: *January 2008 Through June 2008 [I2007-1046] Contractors State License Board* 109

Education

Report Number 2006-032, California's Postsecondary Educational Institutions: *Stricter Controls and Greater Oversight Would Increase the Accuracy of Crime Statistics Reporting* 111

Report Number 2006-109, Home-to-School Transportation Program: *The Funding Formula Should Be Modified to Be More Equitable* 119

Report Number I2007-2, Investigations of Improper Activities by State Employees: *February 2007 Through June 2007 [I2007-0671]*
California State Polytechnic University, Pomona 121

Report Number 2007-102.1, California State University:
It Needs to Strengthen Its Oversight and Establish Stricter Policies for Compensating Current and Former Employees 123

Report Number 2007-102.2, California State University:
It is Inconsistent in Considering Diversity When Hiring Professors, Management Personnel, Presidents, and System Executives 129

Report Number 2007-116, Affordability of College Textbooks:
Textbook Prices Have Risen Significantly in the Last Four Years, but Some Strategies May Help to Control These Costs for Students 137

Report Number 2008-109, California Department of Education:
Although It Generally Provides Appropriate Oversight of the Special Education Hearings and Mediations Process, a Few Areas Could Be Improved 145

Report Number 2007-124, Safely Surrendered Baby Law:
Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact (see summary on page 59)

Elections, Reapportionment, and Constitutional Amendments

Report Number 2008-106, County Poll Workers: *The Office of the Secretary of State Has Developed Statewide Guidelines, but County Training Programs Need Some Improvement* 149

Energy, Utilities, and Communications

Report Number 2007-106, Grade Separation Program:
An Unchanged Budget and Project Allocation Levels Established More Than 30 Years Ago May Discourage Local Agencies From Taking Advantage of the Program 159

Environmental Safety and Toxic Materials

Report Number 2006-115, The Carl Moyer Memorial Air Quality Standards Attainment Program: *Improved Practices in Applicant Selection, Contracting, and Marketing Could Lead to More Cost-Effective Emission Reductions and Enhanced Operations* 161

Report Number 2008-102, Office of Spill Prevention and Response: *It Has Met Many of Its Oversight and Response Duties, but Interaction With Local Government, the Media, and Volunteers Needs Improvement* 169

Report Number 2008-112, Electronic Waste: *Some State Agencies Have Discarded Their Electronic Waste Improperly, While State and Local Oversight Is Limited (see summary on page 103)*

Report Number I2008-2, Investigations of Improper Activities by State Employees: *January 2008 Through June 2008 [I2008-0678] California Environmental Protection Agency* 175

Report Number 2007-114, Low-Level Radioactive Waste: *The State Has Limited Information That Hampers Its Ability to Assess the Need for a Disposal Facility and Must Improve Its Oversight to Better Protect the Public* 177

Governmental Organization

Report Number 2007-117, State Board of Chiropractic Examiners: *Board Members Violated State Laws and Procedural Requirements, and Its Enforcement, Licensing, and Continuing Education Programs Need Improvement (see summary on page 85)*

Report Number 2006-116R, Medical Board of California's Physician Diversion Program: *While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public* 183

Report Number 2007-038, Medical Board of California: *It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund (see summary on page 75)*

Report Number 2007-111, California Highway Patrol: *It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently (see summary on page 77)*

Report Number 2008-112, Electronic Waste: *Some State Agencies Have Discarded Their Electronic Waste Improperly, While State and Local Oversight Is Limited (see summary on page 103)*

Report Number 2006-036, Indian Gaming Special Distribution Fund: *Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments (see summary on page 51)*

Report Number I2008-2, Investigations of Improper Activities by State Employees: January 2008 Through June 2008 [I2007-1046]
Contractors State License Board (see summary on page 109)

Health and Human Services

Report Number 2006-110, Department of Health Services: It Needs to Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers 187

Report Number 2006-116R, Medical Board of California's Physician Diversion Program: While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public (see summary on page 183)

Report Number I2007-2, Investigations of Improper Activities by State Employees: February 2007 Through June 2007 [I2006-1099]
Department of Mental Health, Coalinga State Hospital 193

Report Number I2007-2, Investigations of Improper Activities by State Employees: February 2007 Through June 2007 [I2006-1012]
Department of Health Services 195

Report Number 2007-107, Nonprofit Hospitals: Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status 197

Report Number I2008-1, Investigations of Improper Activities by State Employees: July 2007 Through December 2007 [I2006-1040]
Department of Social Services 201

Report Number 2007-115, Sex Offender Placement: State Laws Are Not Always Clear, and No One Formally Assesses the Impact Sex Offender Placement Has on Local Communities 203

Report Number 2007-121, Veterans Home of California at Yountville: It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement 207

Report Number 2007-124, Safely Surrendered Baby Law: Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact (see summary on page 59)

Report Number 2007-114, Low-Level Radioactive Waste:
The State Has Limited Information That Hampers Its Ability to Assess the Need for a Disposal Facility and Must Improve Its Oversight to Better Protect the Public (see summary on page 177)

Report Number 2007-122, Department of Health Care Services:
Although Notified of Changes in Billing Requirements, Providers of Durable Medical Equipment Frequently Overcharged Medi-Cal 215

Report Number 2007-040, Department of Public Health:
Laboratory Field Services' Lack of Clinical Laboratory Oversight Places the Public at Risk (see summary on page 67)

Report Number 2008-113, Victim Compensation and Government Claims Board: *It Has Begun Improving the Victim Compensation Program, but More Remains to Be Done* 219

Report Number 2006-035, Department of Health Care Services:
It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities (see summary on page 9)

Report Number 2006-108, California Institute for Regenerative Medicine: *It Has a Strategic Plan, but It Needs to Finish Developing Grant-Related Policies and Continue Strengthening Management Controls to Ensure Policy Compliance and Cost Containment* 227

Report Number I2007-1, Investigations of Improper Activities by State Employees: *July 2006 Through January 2007 [I2006-0731] Department of Health Care Services* 237

Report Number 2007-038, Medical Board of California: *It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund (see summary on page 75)*

Higher Education

Report Number 2006-032, California's Postsecondary Educational Institutions: *Stricter Controls and Greater Oversight Would Increase the Accuracy of Crime Statistics Reporting (see summary on page 111)*

Report Number I2007-2, Investigations of Improper Activities by State Employees: *February 2007 Through June 2007 [I2007-0671] California State Polytechnic University, Pomona (see summary on page 121)*

Report Number 2007-102.1, California State University:
*It Needs to Strengthen Its Oversight and Establish Stricter Policies for
Compensating Current and Former Employees (see summary on
page 123)*

Report Number 2007-102.2, California State University:
*It is Inconsistent in Considering Diversity When Hiring Professors,
Management Personnel, Presidents, and System Executives
(see summary on page 129)*

Report Number 2007-116, Affordability of College Textbooks:
*Textbook Prices Have Risen Significantly in the Last Four Years,
but Some Strategies May Help to Control These Costs for Students
(see summary on page 137)*

Housing and Community Development

**Report Number 2007-037, Department of Housing and
Community Development:** *Awards of Housing Bond Funds Have
Been Timely and Complied With the Law, but Monitoring of the Use of
Funds Has Been Inconsistent* 239

Insurance

Report Number 2005-115.2, Department of Insurance: *Former
Executive Life Insurance Policyholders Have Incurred Significant
Economic Losses, and Distributions of Funds Have Been Inconsistently
Monitored and Reported* 243

**Report Number 2008-103, California Unemployment Insurance
Appeals Board:** *Its Weak Policies and Practices Could Undermine
Employment Opportunity and Lead to the Misuse of State Resources* 247

Judiciary

Report Number 2007-030, State Bar of California: *With Strategic
Planning Not Yet Completed, It Projects General Fund Deficits and Needs
Continued Improvement in Program Administration* 255

Report Number 2007-109, DNA Identification Fund:
*Improvements are Needed in Reporting Fund Revenues and Assessing and
Distributing DNA Penalties, but Counties and Courts We Reviewed Have
Properly Collected Penalties and Transferred Revenues to the State* 261

**Report Number I2008-1: Investigations of Improper Activities
by State Employees: July 2007 Through December 2007 [I2007-0958]**
Department of Justice 265

Labor, Employment, and Industrial Relations

Report Number I2007-1, Investigations of Improper Activities by State Employees: July 2006 Through January 2007 [I2006-0731]
Department of Health Care Services (see summary on page 237)

Report Number I2008-1, Investigations of Improper Activities by State Employees: July 2007 Through December 2007 [I2007-0728]
Department of Justice 267

Report Number I2008-2, Investigations of Improper Activities by State Employees: January 2008 Through June 2008 [I2006-0826]
Department of Corrections and Rehabilitation 269

Report Number I2007-1, Investigations of Improper Activities by State Employees: July 2006 Through January 2007 [I2006-0945]
California Exposition and State Fair 271

Report Number I2008-2, Investigations of Improper Activities by State Employees: January 2008 Through June 2008 [I2007-1046]
Contractors State License Board (see summary on page 109)

Report Number I2008-2, Investigations of Improper Activities by State Employees: January 2008 Through June 2008 [I2008-0678]
California Environmental Protection Agency (see summary on page 175)

Report Number 2008-103, California Unemployment Insurance Appeals Board: Its Weak Policies and Practices Could Undermine Employment Opportunity and Lead to the Misuse of State Resources (see summary on page 247)

Report Number 2007-102.1, California State University: It Needs to Strengthen Its Oversight and Establish Stricter Policies for Compensating Current and Former Employees (see summary on page 123)

Report Number 2007-102.2, California State University: It is Inconsistent in Considering Diversity When Hiring Professors, Management Personnel, Presidents, and System Executives (see summary on page 129)

Local Government

Report Number 2006-109, Home-to-School Transportation Program: The Funding Formula Should Be Modified to Be More Equitable (see summary on page 119)

Report Number 2006-115, The Carl Moyer Memorial Air Quality Standards Attainment Program: *Improved Practices in Applicant Selection, Contracting, and Marketing Could Lead to More Cost-Effective Emission Reductions and Enhanced Operations (see summary on page 161)*

Report Number 2007-109, DNA Identification Fund: *Improvements are Needed in Reporting Fund Revenues and Assessing and Distributing DNA Penalties, but Counties and Courts We Reviewed Have Properly Collected Penalties and Transferred Revenues to the State (see summary on page 261)*

Report Number 2007-107, Nonprofit Hospitals: *Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status (see summary on page 197)*

Report Number 2007-129, Santa Clara Valley Transportation Authority: *It Has Made Several Improvements in Recent Years, but Changes Are Still Needed* 275

Report Number 2008-106, County Poll Workers: *The Office of the Secretary of State Has Developed Statewide Guidelines, but County Training Programs Need Some Improvement (see summary on page 149)*

Report Number 2006-036, Indian Gaming Special Distribution Fund: *Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments (see summary on page 51)*

Report Number 2007-106, Grade Separation Program: *An Unchanged Budget and Project Allocation Levels Established More Than 30 Years Ago May Discourage Local Agencies From Taking Advantage of the Program (see summary on page 159)*

Report Number 2008-113, Victim Compensation and Government Claims Board: *It Has Begun Improving the Victim Compensation Program, but More Remains to Be Done (see summary on page 219)*

Report Number 2007-124, Safely Surrendered Baby Law: *Stronger Guidance From the State and Better Information for the Public Could Enhance Its Impact (see summary on page 59)*

Natural Resources, Parks, and Wildlife

Report Number I2007-1, Investigations of Improper Activities by State Employees: July 2006 Through January 2007 [I2006-0908]
Department of Conservation 281

Report Number 2007-108, Department of Water Resources: Its Administration of Grants Under the Flood Protection Corridor Program Needs Improvement (see summary on page 23)

Report Number 2008-115, Department of Fish and Game: Its Limited Success in Identifying Viable Projects and Its Weak Controls Reduce the Benefit of Revenues From Sales of the Bay-Delta Sport Fishing Enhancement Stamp 285

Report Number 2008-102, Office of Spill Prevention and Response: It Has Met Many of Its Oversight and Response Duties, but Interaction With Local Government, the Media, and Volunteers Needs Improvement (see summary on page 169)

Privacy and Public Safety

Report Number 2006-106, Department of Health Services: Its Licensing and Certification Division Is Struggling to Meet State and Federal Oversight Requirements for Skilled Nursing Facilities (see summary on page 15)

Report Number 2006-501, California Department of Corrections and Rehabilitation: It Needs to Improve Its Processes for Contracting and Paying Medical Service Providers as Well as for Complying With the Political Reform Act and Verifying the Credentials of Contract Medical Service Providers (see summary on page 37)

Report Number 2006-116R, Medical Board of California's Physician Diversion Program: While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public (see summary on page 183)

Report Number I2007-2, Investigations of Improper Activities by State Employees: February 2007 Through June 2007 [I2007-0715]
California Highway Patrol 273

Report Number I2008-1, Investigations of Improper Activities by State Employees: July 2007 Through December 2007 [I2006-0665]
Department of Corrections and Rehabilitation 289

Report Number 2008-104, Department of Corrections and Rehabilitation: *It Does Not Always Follow Its Policies When Discharging Parolees* 291

Report Number 2007-111, California Highway Patrol: *It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently (see summary on page 77)*

Report Number I2008-1, Investigations of Improper Activities by State Employees: *July 2007 Through December 2007 [I2007-0958] Department of Justice (see summary on page 265)*

Report Number 2007-115, Sex Offender Placement: *State Laws Are Not Always Clear, and No One Formally Assesses the Impact Sex Offender Placement Has on Local Communities (see summary on page 203)*

Report Number 2007-114, Low-Level Radioactive Waste: *The State Has Limited Information That Hampers Its Ability to Assess the Need for a Disposal Facility and Must Improve Its Oversight to Better Protect the Public (see summary on page 177)*

Report Number 2008-113, Victim Compensation and Government Claims Board: *It Has Begun Improving the Victim Compensation Program, but More Remains to Be Done (see summary on page 219)*

Report Number 2006-032, California's Postsecondary Educational Institutions: *Stricter Controls and Greater Oversight Would Increase the Accuracy of Crime Statistics Reporting (see summary on page 111)*

Report Number 2007-040, Department of Public Health: *Laboratory Field Services' Lack of Clinical Laboratory Oversight Places the Public at Risk (see summary on page 67)*

Report Number 2007-106, Grade Separation Program: *An Unchanged Budget and Project Allocation Levels Established More Than 30 Years Ago May Discourage Local Agencies From Taking Advantage of the Program (see summary on page 159)*

Public Employees, Retirement, and Social Security

Report Number I2007-1, Investigations of Improper Activities by State Employees: *July 2006 Through January 2007 [I2006-0945] California Exposition and State Fair (see summary on page 271)*

Report Number I2008-1, Investigations of Improper Activities by State Employees: July 2007 Through December 2007 [I2007-0728]
Department of Justice (see summary on page 267)

Report Number I2008-2, Investigations of Improper Activities by State Employees: January 2008 Through June 2008 [I2007-1046]
Contractors State License Board (see summary on page 109)

Report Number 2008-103, California Unemployment Insurance Appeals Board: Its Weak Policies and Practices Could Undermine Employment Opportunity and Lead to the Misuse of State Resources
(see summary on page 247)

Report Number 2007-102.1, California State University: It Needs to Strengthen Its Oversight and Establish Stricter Policies for Compensating Current and Former Employees
(see summary on page 123)

Report Number 2007-102.2, California State University: It is Inconsistent in Considering Diversity When Hiring Professors, Management Personnel, Presidents, and System Executives
(see summary on page 129)

Report Number 2007-111, California Highway Patrol: It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently
(see summary on page 77)

Revenue and Taxation

Report Number 2006-108, California Institute for Regenerative Medicine: It Has a Strategic Plan, but It Needs to Finish Developing Grant-Related Policies and Continue Strengthening Management Controls to Ensure Policy Compliance and Cost Containment
(see summary on page 227)

Report Number 2006-036, Indian Gaming Special Distribution Fund: Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments
(see summary on page 51)

Report Number 2007-109, DNA Identification Fund: Improvements are Needed in Reporting Fund Revenues and Assessing and Distributing DNA Penalties, but Counties and Courts We Reviewed Have Properly Collected Penalties and Transferred Revenues to the State
(see summary on page 261)

Report Number 2007-107, Nonprofit Hospitals: *Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status (see summary on page 197)*

Transportation

Report Number 2007-106, Grade Separation Program: *An Unchanged Budget and Project Allocation Levels Established More Than 30 Years Ago May Discourage Local Agencies From Taking Advantage of the Program (see summary on page 159)*

Report Number I2007-2, Investigations of Improper Activities by State Employees: *February 2007 Through June 2007 [I2007-0715] California Highway Patrol (see summary on page 273)*

Report Number 2007-129, Santa Clara Valley Transportation Authority: *It Has Made Several Improvements in Recent Years, but Changes Are Still Needed (see summary on page 275)*

Report Number 2006-109, Home-to-School Transportation Program: *The Funding Formula Should Be Modified to Be More Equitable (see summary on page 119)*

Veterans Affairs

Report Number 2007-121, Veterans Home of California at Yountville: *It Needs Stronger Planning and Oversight in Key Operational Areas, and Some Processes for Resolving Complaints Need Improvement (see summary on page 207)*

Appendix

Summary of Monetary Benefits Identified in Audit Reports Released From July 1, 2001, Through December 31, 2008 295

Index

State and Local Entities With Recommendations From Audits Included in This Special Report 305

Introduction

This report summarizes the major findings and recommendations from audit and investigative reports we issued from January 2007 through December 2008. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol  in the margin of the auditee's action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

Policy areas that generally correspond to the Assembly and Senate standing committees organize this report. Under each policy area we have included report summaries that relate to an area's jurisdiction. Because an audit or investigation may involve more than one issue or because it may cross the jurisdictions of more than one standing committee, a report summary could be included in more than one policy area. For example, for an audit of the Grade Separation Program, the audit report summary would be listed under three policy areas—Energy, Utilities, and Communications; Privacy and Public Safety; and Transportation.

We have compiled the recommendations we directed to the Legislature and have summarized them in a separate report we issued in January 2009 (report number 2008-701). Additionally, we have summarized monetary benefits such as cost recoveries, cost savings, or increased revenues that we estimated auditees could realize if they implement our recommendations or take appropriate corrective action in the Appendix of this report. We estimate that auditees could have realized roughly \$1.26 billion of monetary benefits during the period July 1, 2001, through December 31, 2008, if they implemented our recommendations. For example, in our audit of the Department of Public Health (department) we determined that Laboratory Services had raised its fees improperly one year and failed to impose two subsequent fee increases called for in the budget act. As a result, Laboratory Services did not collect more than \$1 million in fees from clinical laboratories; though it would need spending authority to be able to spend the additional revenue.

In addition to these issues of fiscal responsibility, the department has not overseen clinical laboratories as state law and regulations mandate. For example, Laboratory Services is not inspecting laboratories every two years as state law requires and has no plans to do so unless it receives additional resources. State law requires that Laboratory Services investigate consumer complaints, however, in late 2007 Laboratory Services had a backlog of complaints it had received, and it closed many cases without taking action. Particularly troubling was one complaint regarding a laboratory that was believed to have cross-contaminated blood samples, leading a medical professional to reportedly misdiagnose tuberculosis in a patient who consequently was hospitalized twice for complications from the prescribed tuberculosis treatments she received. One reason Laboratory Services cited for not pursuing the case was sparse resources. However, if Laboratory Services had correctly collected fees it was due, it could potentially use those funds to obtain the resources necessary to comply with the state laws and regulations that it reports it cannot comply with at current resource levels.

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

We report all instances of substantiated improper governmental activities resulting from our investigative activities to the cognizant state department for corrective action. These departments are required to report the status of their corrective actions every 30 days until all such actions are complete. During 2007 and 2008 our investigations have identified over \$1 million in state governmental improper acts and spending including improper overtime payments, failure to accurately report absences, and mismanagement of state resources and funds. These investigations are typically initiated via tips to the office's Whistleblower hotline, 1.800.952.5665.

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Department of Corporations					2	4	1	0	
License Applications and Complaints Report 2005-123				●					29
Department of Consumer Affairs, Contractors State License Board					0	1	0	0	
Investigations Report I2008-2 [I2007-1046]	●								109
Education									
Universities and Community College California Postsecondary Education Commission					24	5	1	0	
Crime Statistics Report 2006-032				●	1				111
Department of Education					0	0	0	1	
Home-to-School Transportation Report 2006-109				●					119
California State Polytechnic University, Pomona					0	1	0	0	
Investigations Report I2007-2 [I2007-0671]				●					121
California State University									
CSU Compensation Report 2007-102.1				●	0	5	1	0	123
CSU Hiring Practices Report 2007-102.2				●	0	4	1	0	129
University of California California State University Community Colleges					0	0	2	3	
College Textbooks Affordability Report 2007-116					1	0	5	0	
College Textbooks Affordability Report 2007-116		●			0	1	4	0	137
Department of Education					0	1	2	0	
Special Education Hearings Report 2008-109	●								145
Department of Social Services					0	1	5	0	
Safely Surrendered Baby Report 2007-124			●						59
Elections, Reapportionment, and Constitutional Amendments									
Office of the Secretary of State County Registrars					0	1	0	0	
Poll Workers Training Report 2008-106		●			14	1	17	0	149
Energy, Utilities, and Communications									
Department of Transportation					0	1	0	0	
Grade Separation Program Report 2007-106				●					159
Environmental Safety and Toxic Materials									
Air Resources Board Local Air Quality Districts					3	1	0	0	
Carl Moyer Program Report 2006-115				●	1	5	0	3	161
Office of Spill Prevention and Response					0	2	4	0	
Cosco Busan Report 2008-102		●							169
California Highway Patrol Department of Motor Vehicles Department of Transportation Employment Development Department Department of Justice Department of General Services Department of Toxic Substance Control Waste Management Board					0	0	1	0	
E-Waste Report 2008-112	●				0	0	3	0	
					0	0	2	0	
					0	0	2	0	
					0	0	1	0	
					0	0	1	0	
					0	0	1	0	
					0	0	1	0	
E-Waste Report 2008-112	●				0	0	1	0	103
California Environmental Protection Agency					0	2	0	0	
Investigations Report I2008-2 [I2008-0678]	●								175
Department of Public Health					0	5	1	0	
Low-Level Radioactive Waste Report 2007-114			●						177
Governmental Organization									
State Board of Chiropractic Examiners					11	11	0	0	
Chiropractic Board Report 2007-117			●						85

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Medical Board of California									
Physician Diversion Program Report 2006-116R			●		Program discontinued				183
Assessment of Fees Report 2007-038				●	1	0	1	0	75
California Highway Patrol					2	2	0	0	
Department of General Services					3	1	0	0	
CHP Contracting Report 2007-111			●						77
California Highway Patrol					0	0	1	0	
Department of Motor Vehicles					0	0	3	0	
Department of Transportation					0	0	2	0	
Employment Development Department					0	0	2	0	
Department of Justice					0	0	1	0	
Department of General Services					0	0	1	0	
Department of Toxic Substance Control					0	0	1	0	
Waste Management Board					0	0	1	0	
E-Waste Report 2008-112	●								103
Indian Gaming Benefit Committees					17	0	2	4	
Gambling Commission					0	0	0	1	
Indian Gaming Report 2006-036				●					51
Department of Consumer Affairs, Contractors State License Board					0	1	0	0	
Investigations Report I2008-2 [I2007-1046]	●								109
Health and Human Services									
Department of Health Care Services					4	1	0	0	
Medi-Cal Providers Report 2006-110				●					187
Medical Board of California					Program discontinued				
Physician Diversion Program Report 2006-116R			●						183
Department of Mental Health-Coalinga					1	0	0	0	
Investigations Report I2007-2 [I2006-1099]				●					193
Department of Health Care Services					2	0	0	0	
Investigations Report I2007-2 [I2006-1012]				●					195
Board of Equalization					1	0	0	0	
Franchise Tax Board					1	1	0	0	
Nonprofit Hospitals Report 2007-107				●					197
Department of Corrections and Rehabilitation					1	1	1	0	
Department of Social Services					1	0	0	0	
Department of Justice					1	0	0	0	
Sex Offender Placement Report 2007-115				●					203
Department of Public Health					1	0	0	0	
Department of Veterans Affairs					4	2	0	0	
Veterans Board					1	0	0	0	
Yountville Veterans Home Report 2007-121				●					207
Department of Social Services					0	1	5	0	
Safely Surrendered Baby Report 2007-124				●					59
Investigations Report I2008-1 [I2006-1040]		●			0	1	0	0	201
Department of Public Health					0	5	1	0	
Low-Level Radioactive Waste Report 2007-114				●					177
Department of Health Care Services					1	1	0	1	
Durable Medical Equipment 2007-122				●					215
Department of Public Health					0	9	0	0	
Clinical Laboratories Report 2007-040		●							67

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Victim Compensation and Government Claims Board					0	0	10	0	
Victim Compensation Program 2008-113	●								219
Department of Health Care Services					0	5	0	1	
Skilled Nursing Facilities Report 2006-035				●					9
California Institute for Regenerative Medicine					7	4	0	1	
Stem Cell Report 2006-108				●					227
Department of Health Care Services					0	1	0	0	
Investigations Report I2007-1 [I2006-0731]			●						237
Medical Board of California					1	0	1	0	
Assessment Fees Report 2007-038				●					75
Higher Education									
Universities and Community College					24	5	1	0	
California Postsecondary Education Commission					1	0	0	0	
Crime Statistics Report 2006-032				●					111
California State Polytechnic University, Pomona					0	1	0	0	
Investigations Report I2007-2 [I2007-0671]				●					121
California State University									
CSU Compensation Report 2007-102.1				●	0	5	1	0	123
CSU Hiring Practices Report 2007-102.2				●	0	4	1	0	129
University of California					0	0	2	3	
California State University					1	0	5	0	
Community Colleges					0	1	4	0	
College Textbooks Affordability Report 2007-116		●							137
Housing and Community Development									
Department of Housing and Community Development					2	1	0	0	
Housing Bonds Report 2007-037				●					239
Insurance									
Department of Insurance					3	1	0	0	
Executive Life Insurance Report 2005-115.2			●						243
Unemployment Insurance Appeals Board					0	3	3	0	
Unemployment Insurance Report 2008-103	●								247
Judiciary									
State Bar of California					0	3	0	0	
State Bar Report 2007-030				●					255
Department of Justice					1	0	0	0	
Administrative Office of the Courts					1	0	0	0	
State Controller					1	0	0	0	
County Superior Courts					3	0	0	0	
DNA Identification Fund Report 2007-109				●					261
Department of Justice					2	0	0	0	
Investigations Report I2008-1 [I2007-0958]			●						265
Labor, Employment, and Industrial Relations									
California Exposition and State Fair					1	0	0	0	
Investigations Report I2007-1 [I2006-0945]				●					271
Department of Health Care Services					0	1	0	0	
Investigations Report I2007-1 [I2006-0731]			●						237
Department of Justice					1	0	0	0	
Investigations Report I2008-1 [I2007-0728]			●						267
Department of Corrections and Rehabilitation					0	0	1	0	
Investigations Report I2008-2 [I2006-0826]	●								269

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Department of Consumer Affairs, State Contractors License Board					0	1	0	0	
Investigations Report I2008-2 [I2007-1046]	●								109
California Environmental Protection Agency					0	2	0	0	
Investigations Report I2008-2 [I2008-0678]	●								175
Unemployment Insurance Appeals Board					0	3	3	0	
Unemployment Insurance Report 2008-103	●								247
California State University									
CSU Compensation Report 2007-102.1				●	0	5	1	0	123
CSU Hiring Report 2007-102.2				●	0	4	1	0	129
Local Government									
Department of Education					0	0	0	1	
Home-to-School Transportation Report 2006-109				●					119
Air Resources Board					3	1	0	0	
Local Air Quality Districts					1	5	0	3	
Carl Moyer Program Report 2006-115				●					161
Department of Justice					1	0	0	0	
Administrative Office of the Courts					1	0	0	0	
State Controller					1	0	0	0	
County Superior Courts					3	0	0	0	
DNA Identification Fund Report 2007-109				●					261
Board of Equalization					1	0	0	0	
Franchise Tax Board					1	1	0	0	
Nonprofit Hospitals Report 2007-107				●					197
Santa Clara Valley Transportation Authority					1	4	1	0	
Santa Clara Valley Transportation Report 2007-129			●						275
Office of the Secretary of State					0	1	0	0	
County Registrars					14	1	17	0	
Poll Workers Training Report 2008-106		●							149
Indian Gaming Benefit Committees					17	0	2	4	
Gambling Commission					0	0	0	1	
Indian Gaming Report 2006-036				●					51
Department of Transportation					0	1	0	0	
Grade Separation Program Report 2007-106				●					159
Victim Compensation and Government Claims Board					0	0	10	0	
Victim Compensation Program Report 2008-113	●								219
Department of Social Services					0	1	5	0	
Safely Surrendered Baby Report 2007-124			●						59
Natural Resources, Parks, and Wildlife									
Department of Conservation					1	1	0	0	
Investigations Report I2007-1 [I2006-0908]				●					281
Department of Water Resources					3	0	2	0	
Flood Protection Corridor Report 2007-108				●					23
Department of Fish and Game					0	3	0	0	
Bay-Delta Stamp Report 2008-115		●							285
Office of Spill Prevention and Response					0	2	4	0	
Cosco Busan Report 2008-102		●							169
Privacy and Public Safety									
Department of Corrections and Rehabilitation					1	0	0	0	
Investigations Report I2008-1 [I2006-0665]			●						289
Department of Corrections and Rehabilitation					0	1	2	0	
Parole Discharge Report 2008-104		●							291

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Department of Public Health Licensing and Certifications Report 2006-106				●	4	2	3	0	15
California Prison Health Care Services Medical Service Contracting Report 2006-501				●	3	9	0	2	37
Medical Board of California Physician Diversion Program Report 2006-116R				●	Program discontinued				183
California Highway Patrol Investigations Report I2007-2 [2007-0715]		●			1	0	0	0	273
California Highway Patrol Department of General Services CHP Contracting Report 2007-111			●		1	2	0	0	
Department of Justice Investigations Report I2008-1 [I2007-0958]			●		3	1	0	0	77
Department of Corrections and Rehabilitation Department of Social Services Department of Justice Sex Offender Placement Report 2007-115			●		2	0	0	0	265
Department of Public Health Low-Level Radioactive Waste Report 2007-114			●		1	1	1	0	
Victim Compensation and Government Claims Board Victim Compensation Program Report 2008-113					1	0	0	0	
Universities and Community College California Postsecondary Education Commission Crime Statistics Report 2006-032	●				1	0	0	0	203
Department of Public Health Clinical Laboratories Report 2007-040		●			0	5	1	0	177
Department of Transportation Grade Separation Program Report 2007-106				●	0	0	10	0	219
Public Employees, Retirement, and Social Security California Exposition State Fair Investigations Report I2007-1 [I2006-0945]				●	24	5	1	0	
Department of Justice Investigations Report I2008-1 [I2007-0728]			●		1	0	0	0	111
Department of Consumer Affairs, State Contractors License Board Investigations Report I2008-2 [I2007-1046]	●				0	9	0	0	67
Unemployment Insurance Appeals Board Unemployment Insurance Report 2008-103	●				0	1	0	0	159
California State University CSU Compensation Report 2007-102.1 CSU Hiring Practices Report 2007-102.2				●	0	0	0	0	
California Highway Patrol Department of General Services CHP Contracting Report 2007-111			●		1	2	0	0	123
Revenue and Taxation California Institute for Regenerative Medicine Stem Cell Report 2006-108				●	0	4	1	0	129
Indian Gaming Benefit Committees Gambling Commission Indian Gaming Report 2006-036				●	1	2	0	0	77
					7	4	0	1	227
					17	0	2	4	
					0	0	0	1	51

	INITIAL RESPONSE	FOLLOW-UP RESPONSE			STATUS OF RECOMMENDATION				PAGE NUMBERS
		60-DAY	SIX-MONTH	ONE-YEAR	FULLY IMPLEMENTED	PARTIALLY IMPLEMENTED	PENDING	NO ACTION TAKEN	
Department of Justice					1	0	0	0	
Administrative Office of the Courts					1	0	0	0	
State Controller					1	0	0	0	
County Superior Courts					3	0	0	0	
DNA Identification Fund Report 2007-109				●					261
Board of Equalization					1	0	0	0	
Franchise Tax Board					1	1	0	0	
Nonprofit Hospitals Report 2007-107				●					197
Transportation									
Department of Transportation					0	1	0	0	
Grade Separation Program Report 2007-106				●					159
California Highway Patrol					1	0	0	0	
Investigations Report I2007-2 [2007-0715]		●							273
Santa Clara Valley Transportation Authority					1	4	1	0	
Santa Clara Valley Transportation Report 2007-129			●						275
Department of Education					0	0	0	1	
Home-to-School Transportation Report 2006-109				●					119
Veterans Affairs									
Department of Public Health	●				1	0	0	0	
Department of Veterans Affairs			●		4	2	0	0	
Veterans Board			●		1	0	0	0	
Yountville Veterans Home Report 2007-121									207

To obtain copies of the complete audit and investigative reports, access the bureau's Web site at www.bsa.ca.gov or contact the bureau at 916.445.0255 or TTY 916.445.0033.

Department of Health Services

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

REPORT NUMBER 2006-035, FEBRUARY 2007

Department of Health Services' response as of February 2008

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

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

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

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

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

Audit Highlights . . .

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

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

continued on next page . . .

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

- » *Neither Health Services nor its consultants formally made changes to final reimbursement rates or to the reimbursement rate system.*
- » *Health Services' contractor responsible for receiving and authorizing payment for Medi-Cal claims, authorized over \$3.3 million in duplicate payments to some facilities for the same services.*
- » *Health Services and its contractor have begun the process of recouping the duplicate payments.*

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

Health Services' Action: None.

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

Department of Health Services

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

REPORT NUMBER 2006-106, APRIL 2007

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

Audit Highlights . . .

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

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

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

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

Health Services' Action: Pending.

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

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

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

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

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

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

Health Services' Action: Pending.

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

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

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

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

Health Services' Action: Pending.

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

Department of Water Resources

Its Administration of Grants Under the Flood Protection Corridor Program Needs Improvement

REPORT NUMBER 2007-108, NOVEMBER 2007

Department of Water Resources' response as of November 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the Department of Water Resources' (Water Resources) administration of the Flood Protection Corridor Program (flood protection program). California's voters created the flood protection program by approving the Safe Drinking Water, Clean Water, Watershed Protection and Flood Protection Bond Act (Proposition 13) in March 2000. With an initial funding of \$70 million, of which \$57 million was available for projects, the program aims to increase flood protection, agricultural land preservation, and wildlife habitat protection throughout the State by taking various actions, such as acquiring real property interests and setting back and strengthening existing levees. The audit committee asked us to review and evaluate Water Resources' processes for selecting projects under the flood protection program. We were also asked to assess Water Resources' policies and procedures for monitoring projects and its fiscal controls over payments to grantees. In addition, the audit committee asked us to assess how Water Resources holds grantees accountable to the terms of their grant agreements and to determine whether it has properly reported on project status.

In November 2006 California's voters approved two propositions—the Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Bond Act of 2006 (Proposition 84) and the Disaster Preparedness and Flood Prevention Bond Act of 2006 (Proposition 1E)—that will provide Water Resources an additional \$330 million for similar flood protection projects.

Finding #1: Water Resources selected projects using poorly defined criteria and made funding decisions based on incomplete information.

Decisions made by Water Resources to award first \$28 million and then \$29.1 million more in local grants were based on poorly defined selection criteria and incomplete information. Water Resources awarded the initial \$28 million to five projects without a scoring process to consistently compare the benefits in flood protection, agricultural land conservation, and wildlife habitat protection specified in each project proposal. Although Water Resources had developed a scoring tool for this purpose, it chose not to use the tool based on the advice of its legal counsel. As a result, it is unclear why the five projects Water Resources chose to fund were better investments of Proposition 13 funds from the flood protection program than the six projects it rejected. Most notably, the flood protection program's highest priced grant, the purchase of Staten Island at a cost of \$17.6 million, has yet to result in a tangible flood protection project.

Audit Highlights . . .

Our review of the Department of Water Resources' (Water Resources) administration of the Flood Protection Corridor Program revealed that:

- » *When Water Resources awarded \$28 million for grants in 2001, it based the decisions on a weak selection process with poorly defined selection criteria.*
- » *It is unclear whether the highest priced grant, the acquisition of Staten Island, will result in a tangible flood protection project in return for the \$17.6 million in funds awarded.*
- » *Water Resources awarded an additional \$29.1 million for grants in 2003 without the aid of key information called for in its regulations to evaluate potential projects' flood protection benefits.*
- » *Water Resources has not enforced many of the monitoring procedures it established.*
- » *Water Resources has not contacted the city of Santee since March 2004, when it disbursed the final \$3.65 million remaining on a \$4.75 million project, despite the city's failure to submit required reports.*
- » *Water Resources neither resolved its appraisal staff's concerns nor those of the Department of General Services that the appraised value of Staten Island was too high, and as a result, the State potentially paid more than fair market value for the property.*

When awarding \$29.1 million in a second round of grants, Water Resources did not require applicants to submit two key types of information mandated in the flood protection program's regulations—hydrologic studies and evidence that owners were willing to sell their properties—for Water Resources to evaluate the relative merits of potential projects. Water Resources was also inconsistent when deciding whether to approve funding requests for structural and recreational enhancements, like pedestrian bridges and bike trails.

To provide consistency in its project selection process and to better justify its future funding decisions for the additional \$330 million that it will receive from propositions 84 and 1E, we recommended that Water Resources select projects in a manner that allows it to justify its funding decisions. One way Water Resources could achieve this would be to develop and use a consistent scoring process and use the scores as a basis for making funding decisions. We also recommended that Water Resources adhere to the flood protection program regulations by requiring applicants to submit hydrologic studies and evidence that owners are willing to sell their properties. Finally, Water Resources should develop policies and procedures to consistently evaluate whether proposed structural and recreational enhancements conform to the goals of the flood protection program and are the most effective use of funds.

Water Resources' Action: Pending.

Since the audit, Water Resources' flood protection program has awarded \$24 million in competitive grants for eight projects being funded under Proposition 84. Water Resources awarded this funding in May 2008 and it is currently developing a Flood Protection Corridor Program Guidelines document that appears to address many aspects of this recommendation. While still in draft form as of late October 2008, Water Resources intends to use this document to guide how it will allocate funding for additional projects under propositions 84 and 1E. The document appears to address many aspects of our recommendation including evaluating the merits of noncompetitive grants [direct-expenditure grants] using a point-based system, requiring applicants to submit evidence that affected landowners are willing participants in any proposed real-property transactions, and evaluating the potential impact of scope changes on a project's benefits. Water Resources has also developed guidelines that should promote greater consistency when it evaluates the merits of a project's proposed structural or recreational enhancements. Specifically, Water Resources will limit project funding for these activities to no more than 30 percent of the award, unless the grant recipient obtains prior approval from the director of Water Resources.

Water Resources' draft guidelines do not change its prior practice of evaluating the merits of potential projects without complete hydrological studies. Instead, Water Resources continues to allow program applicants to submit an engineer or hydrologist's opinion of a project's flood benefits in lieu of a hydrological study, as long as the applicant completes a full analysis early in the project's schedule. However, it does not appear that Water Resources is following this policy in practice. Specifically, Water Resources disbursed more than \$4.5 million in 2008 to a grant recipient without a hydrological study. Instead, Water Resources relied on an engineer's opinion of the project's flood benefits. When we asked a manager in Water Resources why his program had not obtained the full study, he indicated that the project's flood benefits were obvious and requiring a hydrological study was unnecessary and expensive. However, as we state on page 24 of the audit report, such a practice is inconsistent with state regulations and is counter to its intent to use these studies to help reduce the risk of funding projects with uncertain flood protection benefits. Further, our recommendation on page 29 of the audit report suggested that program funds could be used to pay for the hydrologic studies upfront before Water Resources committed more funding to projects.

Finding #2: Water Resources has not adequately monitored projects.

Although Water Resources has established a monitoring approach that would be effective if enforced, it did not always follow good monitoring practices. Progress reports for nine of 12 projects we reviewed failed to discuss schedule and budget status, did not include records of project expenditures to support

costs incurred, and did not report on any key issues affecting timely project completion. This lack of critical information has compromised Water Resources' ability to effectively monitor these flood protection program projects.

Further undermining the inadequate progress reports received was Water Resources' inability to meet its goal of regularly visiting project sites to monitor progress, inconsistent documentation of communication with grantees, and inadequate tracking of project expenditures against their budgets. Additionally, Water Resources chose not to withhold a percentage of each progress payment to grantees to ensure project completion, which may have contributed to the delays that most projects have encountered. Water Resources claims that staff turnover, staff redirection, vacancies caused by the hiring freeze, and travel restrictions due to budget restrictions contribute to these monitoring weaknesses, but its lack of formal procedures to guide staff also likely contributed to its inconsistent monitoring approach.

To effectively monitor projects, we recommended that Water Resources develop policies and procedures to ensure that it receives sufficiently detailed and complete progress reports from grantees; communicates to staff its expectations for conducting and documenting site visits; develops a process to consistently record communication with grantees; and accurately track and monitor funds disbursed to grantees. To help ensure projects are completed timely and in accordance with the grant agreements, Water Resources should withhold a percentage of payments to a grantee when appropriate and release the funds only after it is satisfied that the project is reasonably complete.

Water Resources' Action: Pending.

Since the audit was published in November 2007, Water Resources has awarded \$24 million for eight projects; however, only one of the eight projects has received funding. As a result, it is too early to assess whether Water Resources is adequately monitoring its projects. Nevertheless, we noted that Water Resources' staff now use software that may help them better monitor their projects. Through the use of templates and procedures that are built in to the software, as well as the requirements described in its guidelines document, we noted the following:

- Water Resources requires grantees to submit progress reports containing actions taken since the previous report, key issues to resolve, an update on whether the project remains on budget and on schedule, and supporting documentation for expenditures.
- Water Resources has communicated its expectations that staff contact grant recipients at least once every six months, regardless of whether any progress has been made and for staff to retain this documentation in project files.
- Water Resources has communicated its expectations that staff should generally conduct site visits twice each year. In addition, it has developed standardized site visit checklists to assess a project's status, timeline, and key issues to be resolved.
- Water Resources has developed a policy of withholding up to 10 percent of certain grant payments to ensure the timely completion of projects. We saw evidence that Water Resources withheld more than \$50,000 for one project when the payment was not going into escrow for land acquisition.

Further, Water Resources indicates hiring an analyst who will be responsible for ensuring that project budget-tracking sheets are accurate and kept up to date.

Finding #3: Water Resources failed to adequately monitor the \$5 million project with the city of Santee.

Even though Water Resources executed what appears to be a strong letter of agreement with the city of Santee, its efforts to enforce the fiscal and reporting provisions governing the project were minimal. Proposition 13 specifically earmarked \$5 million to Santee for flood protection of its streets and highways, of which Water Resources withheld \$250,000 for its administrative costs. We found that Water Resources had not contacted the city of Santee since March 2004, when it disbursed the

remaining \$3.65 million to the city. Although Water Resources' agreement with Santee required the city to submit semiannual progress reports detailing the project's progress and expenditures, we noted that Santee had submitted only two progress reports to Water Resources since November 2000, when the agreement between them was executed. Water Resources issued a letter in March 2004 asking the city to provide an accounting of its spending, but did not follow up or take any further action when it did not receive the requested information. Additionally, Water Resources has not received from Santee an audit report with an accounting of how the \$4.75 million disbursed to the city was spent or a final inspection report by a registered civil engineer, even though they are required in the letter of agreement. Our inquiry of Santee resulted in obtaining expenditure records that were not always consistent with the invoices the city had previously submitted to Water Resources for payment.

We recommended that Water Resources follow up with Santee to determine how the city spent its allocated funds. Additionally, because Water Resources has not spent most of the \$250,000 withheld for its administrative costs, it should release these funds to the city only after Santee demonstrates it can use the funds for flood protection purposes, provides an audit report with an accounting of how the city used the \$4.75 million previously disbursed, and submits a final inspection report by a registered civil engineer as the letter of agreement with Santee requires.

Water Resources' Action: Corrective action taken.

Water Resources reports that this project is now complete and that the grant recipient has provided its final progress report detailing accomplishments and project expenditures. Water Resources was able to provide a letter dated July 30, 2008, from a civil engineer employed by the city of Santee certifying that the project was completed as planned. Further, Water Resources provided a copy of a report from an independent auditor indicating that the project's expenditures were allowable under the grant agreement. As a result, Water Resources reported that the remaining \$250,000 available for the project is included in the Governor's fiscal year 2009–10 budget, and it will release these funds when the budget is approved.

Finding #4: Water Resources needs to develop a process for reporting future costs of the flood protection program.

Although Water Resources has informally reported project status in the past, it lacks an adequate internal reporting process on the flood protection program. Because the flood protection program will administer additional grants and projects with the \$330 million it will receive from propositions 84 and 1E, Water Resources will need to develop processes to report to the Legislature and the Department of Finance to comply with the State General Obligation Bond Law and a January 2007 executive order from the governor that directs agencies to exhibit greater accountability over expenditures financed by bonds.

To comply with reporting requirements for projects it funds with propositions 84 and 1E, and to ensure that its management is kept apprised of key issues, we recommended that Water Resources develop a process for reporting project status. This process should include regular reporting of each project's budget and costs, progress in meeting the goals and time schedules of the grant agreement, and any key events affecting the project.

Water Resources' Action: Corrective action taken.

Water Resources states it has been providing quarterly updates to its management showing project status. Water Resources provided us with copies of these status reports, which describe each project's status, expenditures, and the anticipated completion date.

Finding #5: Although it is not legally required to do so, Water Resources has voluntarily chosen to seek General Services' advice on some land acquisition grants.

Water Resources is not legally required to obtain the advice of the Department of General Services (General Services) on appraisals for land acquisitions unless it is taking title to property valued at \$150,000 or more. Nevertheless, on several occasions Water Resources did seek General Services' advice but did not always heed it, potentially resulting in overpaying for land. In the case of the acquisition of Staten Island, Water Resources did not resolve the concerns noted by its staff or General Services that the appraised value of the land was too high. Specifically, both its staff and General Services noted problems with the appraisal for Staten Island, which General Services noted at that time could be a basis for negotiating a lower overall value for the island.

To avoid paying more than fair market value for properties, we recommended that before disbursing funds, Water Resources take steps to ensure that it resolves concerns about the quality of appraisals raised by its staff, and General Services, when its advice is sought.

Water Resources' Action: Corrective action taken.

In its six-month response to the audit, Water Resources indicated that all appraisals are being reviewed by department staff or staff at General Services. To the extent that disagreement exists between its staff and General Services, Water Resources indicates that such disagreement will be elevated to upper management for resolution.

Department of Corporations

It Needs Stronger Oversight of Its Operations and More Efficient Processing of License Applications and Complaints

REPORT NUMBER 2005-123, JANUARY 2007

Department of Corporations' response as of January 2008

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to review the operations of the Department of Corporations (Corporations) to ensure that it is effectively fulfilling its responsibilities. Generally speaking, we were asked to evaluate Corporations' progress toward meeting the goals and performance measures outlined in its strategic plan as well as its progress toward implementing any changes needed to fulfill its goals effectively. We were also asked to review Corporations' workload studies and fee analyses to determine the extent to which it has implemented any recommendations from these efforts. Furthermore, the audit committee requested that we evaluate Corporations' education and outreach efforts in achieving its goals.

We were also asked to evaluate Corporations' licensing policies and practices to determine if they are efficient, protect consumers, and prevent fraudulent applications from being processed. The audit committee requested that we review a sample of each type of license issued to determine whether the policies are applied consistently and to determine the length of time it takes to issue a license. It also asked that we assess Corporations' policies and practices related to the monitoring of licensees, including the number and frequency of licensee audits that are conducted and the effectiveness of the audits. Finally, we were asked to identify the number of complaints Corporations receives annually and to evaluate its policies and practices for handling complaints, including its process for monitoring the ongoing investigation of complaints, the types of enforcement actions taken, Corporations' ability to enforce actions taken as a result of complaints, and its criteria for deciding to reject a complaint or to turn it over to another enforcement agency.

Finding #1: The fees Corporations collects result in an inequitable distribution of charges among licensees and an excessive fund reserve.

Corporations, which does not receive support from the State's General Fund, supports its operations through revenues earned from fees charged for processing applications for notices, registration certificates, permits, and the initial issuance and renewal of licenses. We found that since 2001, Corporations has not analyzed the licensing and examination fees it charges businesses to determine whether the fees matched its costs of providing the related services. As a result, certain licensees are subsidizing costs for others because Corporations overcharges for some fees and undercharges for others. For example, revenues from securities fees have exceeded the related service costs for six of the last seven fiscal years. The amount of excess revenues from these fees ranged from \$750,000 to \$9.1 million and totaled \$22.2 million during this time. By contrast, the service costs for nine other business activities Corporations regulates have exceeded

Audit Highlights . . .

Our review of the Department of Corporations (Corporations) revealed the following:

- » *Corporations' current fee structure results in certain licensees subsidizing the administrative costs for others. For example, revenues from securities fees have exceeded the related service costs by \$22.2 million over the last seven years.*
- » *Corporations has taken important steps in strategic planning for its operations, however, these efforts are undercut by inaccurate statistical information about its actual performance as reported in its monthly and quarterly performance reports.*
- » *Corporations does not always process applications within the time limits set by state law. In fact, for applications submitted between January 2004 and May 2006, the average processing time exceeded the time allowed by law for many of the application types we reviewed.*
- » *Although there is no legal requirement dictating the length of time Corporations has to resolve complaints, we found examples of unnecessary delays in a sample of complaints we reviewed.*
- » *Corporations has three primary information systems for capturing complaint related data; however, none of them are reliable for determining the number, type, and status of its complaints because the systems contain too many blank fields, duplicate records, and errors.*
- » *Corporations did not conduct required examinations of at least 170 licensed escrow offices and 899 licensed finance lenders within its four-year goal.*

the revenues generated from their respective fees by \$21 million over the last seven fiscal years. The overcharging of certain licensees has not only covered the undercharges for other services but has also contributed to the buildup of a large reserve in the State Corporations Fund. We anticipate that this reserve will exceed statutory limits at the end of the current fiscal year.

Fees for the licenses processed by Corporations are generally set by statute. Although Corporations has limited authority to set fees below the statutory maximum for businesses that deal with certain securities transactions, offer investment advice, or act as broker-dealers, the only way it can increase fees above the statutory cap is to seek a change in the law.

To strengthen its operational oversight, we recommended that Corporations seek legislative authority allowing it to set fees by regulation. This legislative authority should require that Corporations annually assess its fee rates and establish fees that are reasonably related to its cost of providing the services supported by its fees. Corporations should also factor in the amount of any excess reserves when conducting its annual assessment.

Corporations' Action: Partial corrective action taken.

Corporations submitted a placeholder bill, Assembly Bill 1516, which would have allowed the commissioner to adjust fees to reflect the actual cost of regulatory services for each law and program. However, the Legislature chose to maintain the existing structure outlined in statute.

Corporations currently has statutory authority to make the adjustments necessary to eliminate deficits in some programs and indicated it has done so to the extent possible. For those programs where there is a cap on the assessed fee that limits its ability to make adjustments, Corporations stated it has adjusted the fee to the extent it could to eliminate the deficit in two fiscal years. Additionally, Corporations stated it would annually review its other rates to determine if the fees are sufficient to support program activities. Corporations also stated it would request a fee adjustment from the Legislature for programs that have fees set in statute and have a deficit or surplus. Finally, Corporations has completed its review of the reimbursement rate for examinations performed and the appropriate adjustments have been made.

Finding #2: Corporations has made a good start on its strategic planning but needs better information about its actual performance.

Corporations has taken important steps in strategic planning for its operations, establishing a framework to identify its strengths and weaknesses with the goal of eliminating inefficiencies and increasing productivity through an examination of its current policies and procedures. Corporations' efforts include creating three interrelated documents—a strategic plan, a program-level action plan, and periodic statistical performance reports—designed to establish its goals and measure its effectiveness in meeting those goals. However, the effectiveness of its strategic planning effort is undercut by inaccurate statistical information about its actual performance as well as by the cumbersome methods used to compile the information for the performance reports. We found errors in the manual compilation of three of the 10 performance measures we reviewed. For instance, Corporations reported that the percentage of other securities regulation applications actually processed on time was 96.5 percent, but we calculated it to be 89.5 percent. Although this relatively small difference might not change Corporations' assessment of the need for change in the area, it does illustrate the need for more accurate reporting.

Corporations' systems for collecting its actual performance information are also cause for concern, because of inefficiencies and the potential for errors. Depending on the performance measure, Corporations uses both manual and automated systems to collect the information, and it then manually compiles that information for summary in a performance report. An automated system, with all necessary information accurately reported, would be more efficient and reliable. Currently, the information used to produce the reports comes from a variety of sources, such as forms, data system queries, spreadsheets maintained by team leaders, and other documents that may or may not be

reviewed for accuracy. We found one instance in which staff used informal notes, rather than standard time sheets, to report the time worked on applications. Each month, certain Corporations' staff must generate statistics by performing time-consuming manual calculations and then must input the results into a separate form for the report.

To improve the efficiency and effectiveness of its system for collecting actual performance measure information, we recommended that Corporations do the following:

- Consider assessing the need for new automated data systems or determining whether its current systems are capable of collecting the necessary information.
- Ensure the accuracy and completeness of the information in its automated systems by requiring staff to enter the information and requiring supervisors to review it periodically. For data not currently available in automated format, Corporations should develop stronger procedures to ensure that staff accurately report and supervisors review the information. Corporations should also consider calculating and reporting performance measures quarterly, rather than monthly, until it has a more efficient data collection system.
- To ensure that it has identified all necessary performance measures and appropriately focused its current performance measures, Corporations should continue to assess the reasons for performance deficiencies and add or adjust performance measures as needed.

Corporations' Action: Partial corrective action taken.

Corporations indicated it has met with the Department of Finance (Finance) to discuss the process to obtain or update its automated data systems and has issued a Request for Proposal for a needs assessment and feasibility study. Corporations selected a contractor, and planned to submit the completed feasibility study report to Finance in July 2008.

Corporations indicated it has implemented procedures that require staff to confirm the accuracy of information posted in its automated systems prior to exiting the system. Further, Corporations stated that under its new procedures managers or supervisors will review source documents on a sample basis and ensure that information on the source documents matches information in the electronic file. Managers and supervisors will also review their automated systems monthly for blank fields and request that staff research and complete the data fields with the appropriate information. Further, Corporations indicated that managers will counsel and provide training to employees who consistently make errors when posting information to the automated systems.

Additionally, Corporations stated that it modified its procedures that previously allowed more than one complaint file to be created in the data system for the same complaint. Among other things, these procedures require a supervisor to review the listing of complaints for duplicate files. Additional procedures are also being developed for the review of other data related to complaints. Finally, Corporations stated that its legal counsel will perform a monthly review of the data fields in the Enforcement Case Management System to ensure that all fields are completed and any deficiencies will be discussed with the assigned counsel and the correct information will be posted in the system.

Corporations indicated that the Securities Regulation Division (securities division) has completed an initial review of performance measures to identify deficiencies and determine what caused the deficiencies and develop corrective action plans to meet performance measures. The securities division will also re-evaluate performance measures, baselines and targets for appropriateness, and accuracy. Managers will evaluate and report quarterly to executive staff performance deficiencies and their corrective action plans.

The Financial Services Division (financial division) will review and monitor processing times and compare them with benchmarks on a monthly basis. Further, the financial division will develop corrective measures to address any issues identified and develop new, more appropriate measures that are achievable.

Finding #3: The effectiveness of Corporations' outreach unit is uncertain.

Corporations does not collect enough data or identify sufficient goals to effectively assess its education and outreach efforts. One of Corporations' Education and Outreach Unit's (outreach unit) primary programs is its Seniors Against Investment Fraud (seniors program), which is designed to educate senior citizens about investment fraud and how to protect their finances from predatory schemes. In its budget change proposal for fiscal year 2005–06, Corporations requested \$400,000 in ongoing permanent funding for the seniors program (and received \$225,000). The proposal identified 12 performance measures intended to aid Corporations in evaluating the achievement of the objectives of the seniors program. However, Corporations does not collect data for four of these measures. For example, when it sought funding for the program in fiscal year 2005–06, Corporations stated that it planned to track the number of seniors program volunteers by geographical area; however, it had not done so as of December 2006. Corporations does not track any data for three other performance measures because, according to the director of the outreach unit, the measures are not clear. Further, although Corporations collects data for eight of the 12 performance measures, it measures its effectiveness for only two—the number of publications disseminated and the number of presentations given—by comparing them to established goals. However, without sufficient data and relevant benchmarks, it is impossible for Corporations to effectively assess its overall performance in protecting senior citizens from investment fraud.

Moreover, Corporations has not developed any formal goals to effectively measure the success of its other primary program—the Troops Against Predatory Scams Investor Education Project (troops program). The troops program was funded by a grant that requires that Corporations collect data and report the results on seven performance metrics. However, Corporations has not established any formal benchmarks to gauge whether or not its efforts are successful. As a result, Corporations cannot assess whether the program is achieving the desired results.

To ensure that the outreach unit can effectively measure its success, we recommended that Corporations ensure that it collects all of the necessary data and establishes reasonable benchmarks.

Corporations' Action: Partial corrective action taken.

According to Corporations, in January 2007, the outreach unit developed a monthly reporting form that will capture the number of Seniors Against Investment Fraud partners and training kits distributed. Corporations also stated that the outreach unit also revised existing performance measures and benchmarks based on relevancy and accuracy. The outreach unit eliminated six of the existing 12 performance measures and replaced them with four new performance measures. Data will be collected monthly and measured against the benchmarks. Conversely, Corporations did not provide any information regarding its efforts to better measure the success of the troops program.

Finding #4: Corporations does not always process applications within the time limits set by state law.

State law requires Corporations to assess the completeness of applications and notify applicants in writing of any deficiencies in the applications within specific time frames, and either issue or reject the application within a specified time period. We found that Corporations does not always process applications within the time limits set by state law. For example, of the 35 applications we reviewed, we noted 10 instances where Corporations did not comply with the statutory time frame for processing applications. Delays could result in entities being unable to conduct business. Delays may also increase the likelihood that businesses will conduct unlicensed financial transactions. However, while Corporations is responsible for the delays in processing some license applications, other factors outside of its control also contribute to lengthy processing times. For instance, license applicants do not always provide the required information when submitting applications. Deficiencies in applications and delays in correcting them create additional work for Corporations' staff and can substantially delay the issuance of licenses. We found that Corporations issued deficiency notices for 32 (91 percent) of the 35 applications we reviewed. Although application requirements can be somewhat daunting, they did

not appear to be overly complex. According to Corporations, these delays generally occurred because of a backlog resulting from a large increase in the number of applications submitted in recent years and some applications requiring a more extensive review.

In addition, Corporations does not have complete data for some of its license applications. We found that the application system data related to corporate securities and franchises contain omissions and inaccuracies, hampering Corporations' ability to compile accurate performance statistics.

To ensure that all applications are reviewed promptly and sufficiently, we recommended that Corporations do the following:

- Continue to monitor the progress of applications through the review and approval process to identify any that have stalled, and investigate the reason for the delay.
- Follow the law in notifying applicants once their applications are complete.
- Follow up with applicants that do not promptly respond to deficiency notices.
- Assess whether it needs additional staff to process applications.
- Maintain all necessary data in its information management systems so that it can effectively calculate the number of days it takes to process applications.

Corporations' Action: Partial corrective action taken.

Corporations stated that it reviewed its procedures for processing applications submitted to its securities division in order to streamline the process to focus on the most critical factors in an application. According to Corporations, this process, along with hiring a retired annuitant, has eliminated the securities division's backlog of applications pending review.

Additionally, Corporations stated that the financial division has revised its procedures for processing applications to include having staff notify supervisors when an application has stalled. The reason for the stall will be determined and corrective action taken. Managers will also review a log or aging schedule to determine if any applications have stalled. These revised procedures will be written and included in an applications procedures manual for the financial division. Further, Corporations indicated that it has developed and will maintain the data necessary to calculate the number of days it takes to process applications.

According to Corporations, it has revised the letter it sends to applicants notifying them that their application has been approved. The revised letter will now include both a reference that the application is complete and has been approved. Corporations also stated that it has developed a tracking mechanism that notifies staff at established intervals that an applicant has not responded to a deficiency notice. Staff will prepare a follow-up letter notifying the applicant that Corporations will close the application if the requested information is not received by a given date. A second notice will be sent if the information is not received and, if no response is provided, Corporations will close the application.

Corporations indicated that it is in the process of identifying the average number of staff needed to handle its normal workload. Corporations will also review the log of outstanding applications to determine if a backlog is developing and, if so, redirect resources if possible, to prevent a further buildup of applications. Additionally, Corporations developed an overall plan to determine if additional resources are needed in various program areas and, if so, request those additional resources in the fiscal year 2008–09 budget process.

Finally, Corporations stated that it has developed policies and procedures for ensuring that all applications received are logged for date of receipt, date approved/license issued, and the number of days for completion. The policies and procedures also require documenting the reasons for any extraordinary issues that delay processing.

Finding #5: Corporations is working to improve its handling of complaints.

Either the securities division or the enforcement division typically handles complaints related to securities regulation. Of the 20 complaints related to securities regulation we reviewed that were closed between May 20, 2005, and July 18, 2006, nine were referred to the securities division. It took the securities division an average of 312 days, ranging from 55 to 531 days, to resolve these nine complaints. The remaining 11 complaints related to securities regulation were referred to the enforcement division and took an average of 170 days to resolve, ranging from 20 days to 383 days.

The time Corporations takes to resolve complaints is contingent on many factors. For instance, the complexity of the case, the availability of staff, and the time it takes for complainants to respond to Corporations' inquiries all may contribute to the length of the process. Moreover, there is no legal requirement dictating the length of time Corporations has to resolve complaints. Thus, we expected the number of days Corporations took to resolve securities regulation complaints to vary depending upon the circumstances of each case. Nonetheless, during our review, we identified four complaints in which unnecessary delays increased the length of the process. For example, the securities division did not begin its investigation of one complaint until 277 days after the complaint was received. In another instance, the enforcement division took 176 days to refer a complaint to the securities division for further action, during which time nothing was done to address the complainant's concerns. Corporations' management could not explain these delays.

Moreover, we reviewed a sample of 20 complaints related to financial services that were closed between November 29, 2004, and August 8, 2006. We found that Corporations took between 35 and 232 days to close these complaints, averaging 106 days. Unlike its process for handling complaints related to securities regulation, Corporations handles financial services complaints by sending letters to licensees requesting them to respond in writing to the complaint allegations within 15 days. Delays can occur if the licensee does not respond within the 15-day time frame. However, we found some instances in which unnecessary delays on Corporations' part increased the length of the process. For example, in four of the 20 complaints we reviewed, Corporations took between 34 and 210 days to send letters to the complainants notifying them that it had begun its review, exceeding its 30-day goal. In two of the four cases, Corporations' staff did not forward the complaints to its financial division for handling for 28 and 38 days, respectively. However, Corporations' staff forwarded the two remaining cases in less than six days.

Corporations has recently modified its procedure for handling complaints. In addition to developing formal policies for rejecting and referring complaints, it has centralized the intake of all complaints by forwarding them to a new complaint team. Corporations believes that this new process will allow it to respond immediately to complaints and prepare each complaint for referral to the appropriate division. Because Corporations initiated this process near the end of our fieldwork, we were unable to test whether it will correct any of the weaknesses we identified. However, it appears that the process contains some good business practices.

To improve the efficiency of its complaint-handling process, we recommended Corporations do the following:

- Develop procedures to track the progress of complaints to ensure that they continue to move through the process without unnecessary delay.
- Monitor its newly established complaint-referral process and develop procedures, if necessary, to decrease the length of time it takes to refer cases to the appropriate division.

Corporations' Action: Corrective action taken.

Corporations stated it established a complaint team in August 2006 that revised the processing of complaints. As a result, Corporations stated that the time to respond to a complaint has been shortened. The complaint team also developed a monthly report that tracks the number of complaints received, the backlog of complaints, responses to complainants, and the average number

of days it takes to process complaints. Additionally, the enforcement division has developed plans and goals that involve completing case investigations and either taking action or closing a case, as appropriate.

Corporations also stated that it will continue to monitor its complaint-referral process to look for additional ways to decrease the time frames for processing complaints. Additionally, an executive staff member will review the complaint-referral procedures and protocols and provide recommendations to the commissioner on how to improve the process.

Finding #6: Information systems containing data regarding complaints are unreliable.

Although it has three information systems for tracking complaint data, Corporations undercuts these efforts by failing to ensure that any of the three systems contain reliable data. Several of the critical data fields in Corporations' Customer Relationship Management (CRM) system and Corporations' Customer Service System (CSS) were often left blank, limiting the usefulness of these systems as management tools. For example, the fields needed to calculate complaint processing times, such as date received, date assigned, and date opened, were blank 9.5 percent, 25 percent, and 68 percent of the time, respectively, for the CRM system. Consequently, these fields cannot be used to determine where a complaint is in the resolution process or to monitor and evaluate complaint-processing times. In addition, we found that the field identifying the specific law a complaint was related to was left blank for more than 24 percent of the 2,876 complaint records in the CSS and for 50 percent of the 2,461 complaint records in the CRM system. Without this information, Corporations cannot determine how many complaints it receives about alleged violations of various laws and cannot effectively identify problem areas or adjust its workforce to handle them.

Moreover, we found several types of data entry errors in Corporations' complaint systems. For example, the CRM system did not reflect the correct status for many of the complaints we reviewed. The status field can be used to indicate the disposition of a particular case, such as closed, in progress, or referred. However, the CRM system listed an incorrect status for 13 of the 20 complaints we reviewed. In each of these cases, the CRM system indicated that the case was still in progress, even though all of them had been closed. Thus, Corporations cannot rely on the system to determine the number of complaints still in progress, completed, or referred to another division. We also found that the CRM system did not reflect the correct date received for eight of the 20 complaints we reviewed. Specifically, the date entered into the CRM system as the date received did not agree with the supporting documentation for four of these complaints, and it was left blank for the others. Similarly, we found data entry errors for the field intended to capture the date a complaint was received in three of the 20 complaints we reviewed in the CSS. In addition, six of the 34 enforcement actions we tested in the Enforcement Case Management System reflected an incorrect date for when the action occurred, limiting the usefulness of the system as a management tool.

To improve the usefulness of its information systems, we recommended that Corporations review its existing complaint records and eliminate duplicates and correct any inaccurate fields. Further, Corporations should maintain accurate and complete data to ensure that the information systems can be used more effectively as management tools.

Corporations' Action: Pending.

Corporations did not fully address our recommendations in its response. Specifically, it noted that the enforcement division is reviewing its case management system to determine how to improve it. Options include more fields of data and creating reports that would capture data to assist management with trends and workload issues. However, its response did not directly address our recommendation to review its existing complaint records and eliminate duplicate records and correct any inaccurate fields.



Finding #7: Corporations failed to perform required examinations of some licensees.

Corporations did not conduct examinations of many of its escrow licensees within the time frames required by law. Additionally, Corporations did not conduct examinations of its licensed finance lenders as frequently as required by its internal policy. Consequently, Corporations' ability to protect consumers against potential fraudulent lending and financing scams was weakened.

The California Financial Code requires Corporations to conduct examinations of licensed escrow offices and mortgage lenders at least once every four years. In addition, although not required by law, Corporations has established a goal for examining every licensed finance lender at least once every four years. However, Corporations did not conduct examinations of many escrow offices and finance lenders within the last four years. Specifically, we found that at least 170 licensed escrow offices and 899 licensed finance lenders—representing 37 percent and 35 percent, respectively, of all such licensees that required examinations—have not had an examination for at least four years. Corporations was more effective with its examinations of mortgage lenders; only two licensed mortgage lenders—less than 2 percent—did not receive the required examination within at least the last four years.

Corporations also lacks clear guidance for conducting examinations and following up on the deficiencies it identifies. For example, it does not have any policies or procedures on the time frames within which examiners must follow up on licensees' responses to deficiencies identified during an examination. In a sample of 20 examinations performed by the financial division, Corporations' examiners identified a total of 112 deficiencies related to 17 of the examinations; the remaining three did not identify any deficiencies. The identified deficiencies included improper charges, unauthorized disbursements from accounts, and altered checks. When we followed up on six of the 17 examinations that identified deficiencies, we found that in four cases the examiners took between 79 days and 187 days to provide a response to the licensees after they had responded to the deficiencies. We expected Corporations to have established response time frames to ensure the prompt resolution of any deficiencies.

We recommended that Corporations develop a plan to conduct examinations of licensees in accordance with state law and its own internal policy. Corporations should also establish clear guidance and response time frames for following up on deficiencies identified in examinations.

Corporations' Action: Corrective action taken.

Corporations stated that it has identified the number of licensees that need to be examined based on statutory requirements or internal policy, as well as determined the average hours per exam. Based on this information, Corporations received additional examiner and enforcement positions in the fiscal year 2007–08 budget and requested additional examiner and enforcement positions in the fiscal year 2008–09 budget. Corporations will continue to evaluate current staffing levels to determine whether sufficient staff exists to perform the required exams. If staffing levels are insufficient after staff redirections from other programs, Corporations will pursue additional staffing through the budget process. Corporations also indicated that it developed procedures and a risk-based process to review enforcement actions taken to determine compliance by licensees, to evaluate the enforcement action, and to identify high-risk candidates for follow-up nonroutine examinations.

California Department of Corrections and Rehabilitation

It Needs to Improve Its Processes for Contracting and Paying Medical Service Providers as Well as for Complying With the Political Reform Act and Verifying the Credentials of Contract Medical Service Providers

REPORT NUMBER 2006-501, APRIL 2007

California Prison Health Care Receivership Corporation's¹ response as of June 2008

The state auditor has the authority to audit contracts involving the expenditure of public funds in excess of \$10,000 entered into by public entities, at the request of the public entity. The court-appointed receiver requested that the Bureau of State Audits (bureau) conduct an audit of a variety of issues related to existing contracts between the California Department of Corrections and Rehabilitation (Corrections) and certain medical care providers. Specifically, the receiver requested that the bureau review Corrections' processes for procuring medical registry services and its practices involving these services for fiscal year 2005–06 and to determine whether the process is fair and adequate and complies with all applicable laws and regulations, whether the language used in medical registry contracts is adequate and complete and written in the best interests of the State, and whether conflicts of interest exist related to procuring the medical services.

Additionally, the bureau was asked to examine Corrections' medical registry contracts and payment practices for fiscal year 2005–06 and to determine whether contractors comply with the terms and conditions of the contracts, and whether Corrections' accounting and payment practices for contracts comply with laws, regulations, and industry practices. Finally, the bureau was directed to review the medical registry contracts and compare the rates Corrections pays contractors with the amounts the contractors pay their medical care providers, and to determine whether the contractors and medical care providers rendering services in the prisons meet all applicable licensing and certification requirements.

¹ In May 2005, four years after the Plata Davis (Plata) lawsuit was filed, and after meeting regularly with the parties to the Plata settlement, the court conducted hearings to determine if it was necessary to appoint an interim receiver. In February 2006 the court appointed a receiver. The court order making the appointment gave the receiver the authority to "provide leadership and executive management of Corrections' medical health care delivery system with the goal of restructuring day-to-day operations and developing, implementing, and validating a new, sustainable system that provides constitutionally adequate medical care to all members of the class action lawsuit as soon as practicable." To achieve those goals, the receiver has the duty to control, oversee, supervise, and direct all administrative, personnel, financial, contractual, legal, and other operational functions of Corrections' medical health care delivery system. In making these recommendations to Corrections, we understand that they would be implemented at the direction of the court-appointed receiver. We do, however, expect that if control and management of Corrections' medical health care delivery system is returned to it, that Corrections would then become responsible for implementing these recommendations.

Audit Highlights . . .

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

- » *Corrections improperly awarded nine of 18 competitively bid contracts with a total maximum amount of more than \$385 million.*
- » *Corrections did not provide complete justifications for awarding two noncompetitively bid contracts totaling almost \$80 million.*
- » *Some aspects of Corrections' treatment of some medical providers raises concerns about whether they are, in fact, treated more as employees than independent contractors, which may expose the State to potential liability and penalties.*
- » *Only 16 of the 21 contracts we reviewed contained terms that meet the standard of medical care called for in Corrections' regulations.*
- » *Many of the contracts we reviewed did not contain terms that Corrections considers standard in medical service contracts to adequately protect the confidentiality, privacy, and handling of inmate medical records under the federal Health Insurance Portability and Accountability Act.*
- » *Although all contracts in our sample gave Corrections the ability to inspect and monitor the quality of contractor performance, only five of the 21 contracts imposed a similar obligation on the medical care service providers.*

continued on next page . . .

- » *Corrections overpaid registry contractors by \$4,050 for five invoices because prisons did not consistently ensure that payment amounts agreed with contract terms.*
- » *Corrections failed to ensure that prisons require their consultants to complete statements of economic interests or to document why it was appropriate for them not to do so.*
- » *Corrections did not verify the credentials of providers who treat inmates outside of Corrections' facilities because it incorrectly believed these reviews were being conducted by the Department of Health Services.*
- » *Of the 22 physicians and nurse practitioners for which we requested credentialing files, Corrections was only able to provide 12. Of these 12, eight were credentialed after they had begun providing services to inmate patients.*

Finding #1: Corrections did not always award contracts according to state policy or its own policy.

Corrections awarded nine of 18 competitively bid contracts incorrectly. Specifically, in awarding these nine contracts, Corrections assigned incorrect hierarchy positions to bidders, primarily because its practice was to apply the small business preference—a 5 percent preference given to small businesses bidding on state contracts—to the bidders' hourly rate rather than the bid price. As a result, for seven contracts Corrections failed to limit the preference to \$50,000, as state law and regulations require, and for all nine contracts it gave bidders a larger preference than allowed, causing some bidders to incorrectly receive higher-ranking positions.

Corrections uses a cost threshold to limit the number of contract awards for its registry contracts but it does not have any written policies or procedures for determining the cost thresholds. Additionally, Corrections' solicitation documents did not inform the bidders of its use of a cost threshold or its methodology for calculating the threshold. Further, Corrections did not always apply the cost thresholds properly according to its stated methodology and, as a result, improperly awarded one contract and excluded another bidder from the opportunity to provide services. Finally, we found that Corrections did not always calculate the cost threshold using the methods it described to us and based on our calculations, it improperly awarded contracts. When Corrections does not apply the small business preference or its cost threshold properly, it may be unfairly preventing contractors from providing registry services or selecting contractors who do not meet its criteria.

We recommended that Corrections ensure that staff receive proper training on bidding methods, including the appropriate application of the small business preference, so that bidders are awarded contracts in the correct order. We also recommended that Corrections establish policies and procedures for determining the cost threshold used to limit the number of awards made to registry contractors and implement a quality control process to ensure staff calculate the cost threshold correctly and retain documentation to support their calculations in the contract files. Further, we recommended that Corrections notify potential bidders of its use of a cost threshold to determine the awards to be made and its methodology for calculating the threshold. Finally, we recommended that Corrections implement a quality control process to identify errors in the ranking of bidders before awarding contracts.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated that it agrees that staff should receive additional training on bidding methods and its managers are currently providing informal training in the area of bidding and application of small business preferences. Although the Office of the Receiver anticipated developing formal training materials by March 2008, it stated that this process was delayed to May 2008 due to additional time required to enhance the Excel spreadsheet it uses to process calculations and improve its training materials and presentations. Formal training will begin in June 2008.

The Office of the Receiver stated that its Plata Contract Branch has developed and implemented an interim methodology to determine the cost threshold when establishing the number of contract awards. Staff are required to complete spreadsheets that capture and tabulate bid calculations. Staff then consider multiple requirements such as number of bids falling within the criterion, current contract rates and current civil service compensation, if applicable, to determine the number of awards. Staff submit the rate approval packages to managers for review and approval. After manager approval, the rate package is sent to a second level for review and approval.

Regarding our recommendation to implement a quality control process to ensure staff calculate the cost threshold correctly and retain documentation to support their calculations in the contract files, the Office of the Receiver stated that management oversight and review of the spreadsheets that capture and tabulate bid calculations is one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes. According to the Office of the Receiver, the Post Review Unit developed its infrastructure, workforce, and initial documentation necessary to perform internal post reviews of individual contract processes with preliminary testing of documentation utilized to review individual contracts commencing in April 2008.

Regarding our recommendation to notify potential bidders of its use of a cost threshold to determine the awards to be made and its methodology for calculating the threshold, the Office of the Receiver stated that it issues a notification of contract awards and the bid matrix it utilized in determining the cost threshold to contractors who submitted bids or contractors requesting copies through the California Public Records Act. However, this information does not reflect the methodology it used for cut-off purposes. The Plata Contract Branch has no immediate plans of providing pre-notification to potential bidders of methodologies used to determine cost thresholds due to the complexity in determining the number of awards to be made which varies by medical specialty.

Finally, the Office of the Receiver stated that it obtained a consultant to provide a review of its current staffing resources and functions in the near future. The Post Review Unit only provides review of a contract after it is fully executed. Therefore, the current quality control process used to identify errors in the ranking of bidders before awarding contracts continues to be addressed through management oversight and review of the spreadsheets staff complete to rank bidders.

Finding #2: Corrections' justifications for awarding two competitively bid contracts were incomplete.

State policy requires a minimum of three competitive bids except in certain circumstances. Corrections did not always retain complete justifications for awarding contracts when receiving fewer than three bids. Specifically, for two of 18 competitively bid contracts, Corrections did not receive three bids and did not justify the reasonableness of the award amounts. Also, although Corrections advertised these two contracts in the California State Contracts Register, it could not demonstrate that it solicited all known potential contractors as state policy requires. Consequently, Corrections was not exempt from complying with state policy requirements for awarding contracts with fewer than three bids.

We recommended that Corrections fully comply with state policy, including justifying and documenting the reasonableness of its contract costs, when it receives fewer than three bids. We also recommended that Corrections retain documentation of its efforts to solicit all known potential contractors when it advertises in the California State Contracts Register.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it is currently tracking approved rates by discipline using an Excel spreadsheet. A component of the standardized rate package is verification of civil service pay scales and benefits, if applicable; inclusion of rate information from prior or active contracts; and documentation justifying reasonableness of rates and why current providers (for bid services) are unable to provide services. The Office of the Receiver also stated that staff continue to receive informal contract process training, and staff will be receiving formal training commencing in

June 2008 in the bid and contract packaging processes. Documentation including, but not limited to, list of bidders who requested bid packages through the Plata Contract Branch or accessed bid documents via the Department of General Services' Contracts Register will be maintained in the bid or contract files.

Finding #3: Corrections could not justify the prices contained in two noncompetitively bid contracts.

Corrections did not retain justifications for the rates found in two of three noncompetitively bid contracts we reviewed. For one contract, with a maximum amount of almost \$79 million, Corrections did not have documentation to support that the rates determined were fair and reasonable. For the second contract, with a maximum amount of \$1 million, Corrections obtained approval from the Department of General Services (General Services) using a special category noncompetitively bid exemption request. However, Corrections was unable to produce documentation to support compliance with specific conditions of approval including following the price analysis and methodology requirements of the special category exemption. When Corrections does not justify and document the reasonableness of the contract rates it agrees to pay, in accordance with the methodology approved by General Services, it is unable to demonstrate that the rates are appropriate and reasonable.

We recommended that Corrections fully comply with state policy including justifying and documenting the reasonableness of its contract costs when it chooses to follow a noncompetitive process. We also recommended that Corrections adhere to the price analysis and methodology approved by General Services when using the special category noncompetitively bid request process. For example, it should use Medicare rates as a benchmark for determining the reasonableness of its rates paid to contractors.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated it is providing informal training to staff on General Services' Standardized State Contracting process for noncompetitive bid contracts. Additionally, the Office of the Receiver is scheduled to commence formal training in June 2008.

According to the Office of the Receiver, Medicare does not apply to registry contracts, which are typically based on hourly rates. Staff who process noncompetitive bid contracts submit rate approval packages that include documentation pertaining to the reasonableness of rates, market survey, and the reason for the noncompetitive bid contract if outside of a current approved rate package for the same services and geographic area. The Office of the Receiver stated that rates are approved using the Rate Approval Process guidelines it approved in April 2008. The Receiver's consultant submitted a report, dated September 2006, which provided a recommendation to convert exempt medical rates for physician, medical group, and hospitals to a percentage of Medicare. The Office of the Receiver implemented this recommendation and is currently tracking information pertaining to exempt medical rates in an Excel spreadsheet. Additionally, the related documentation on approved rate packages is scanned and stored on shared network drives.

Finding #4: Corrections paid some contractors for services provided before their contracts were approved by General Services.

For four contracts we reviewed, we noted seven instances, totaling almost \$20,000, in which registry contractors were performing service at prisons before Corrections obtained General Services' final approval of the contracts. When Corrections does not ensure that it obtains proper approval before allowing contractors to perform services, it exposes the State to potential litigation if General Services does not approve the contract.

We recommended that Corrections ensure that it establishes internal control processes that prevent prisons from allowing contractors to perform services before receiving General Services' approval of the contract.

Corrections' Action: Corrective action taken.

The Office of the Receiver stated that its Plata Contract Branch is striving to ensure contracts are fully executed before services are provided at the institutions. However, adequate medical care must be provided in order to mitigate mortality and morbidity based on various federal court cases.

Finding #5: Some contracts did not contain Corrections' standard contract terms.

Three of 21 contracts in our sample did not contain terms that required Corrections to provide 24 hours notice to a medical registry if services had been scheduled but were not needed for a particular shift. Our legal counsel advised us that the reviewing court would likely find that reasonable notice would be an implied term of the contract. However, litigation can be averted if the parties define what constitutes reasonable notice in the contract.

We recommended that Corrections' medical registry contracts contain express provisions related to the required notice period for cancellation.

Corrections' Action: Corrective action taken.

The Office of the Receiver agrees with this recommendation and stated that it has developed and incorporated standardized contract cancellation language into its renewal or new exempt and bid medical contracts.

Finding #6: Some contracts lack Business Associate Agreements that ensure compliance with federal requirements related to privacy, confidentiality, and transfer of inmate medical records.

Under the Health Insurance Portability and Accountability Act (HIPAA), Corrections may act as a covered entity in the provision of medical care to inmates and the various contractors with whom it does business may act as "business associates." As business associates, those contractors are obligated to follow HIPAA, which imposes various obligations related to the confidentiality and handling of prisoner medical information. HIPAA also requires that a business associate enter a Business Associate Agreement that imposes specific obligations designed to ensure compliance with HIPAA. Only six of 21 contracts we reviewed contained the required Business Associate Agreement.

We recommended that Corrections include Business Associate Agreements in all contracts subject to HIPAA and amend existing contracts to include those agreements.

Corrections' Action: Corrective action taken.

The Office of the Receiver agrees with this recommendation and has developed an exhibit that includes standard language pertaining to HIPAA. The Office of the Receiver stated that its Plata Contract Branch has developed a public-access Web site with anticipation that the HIPAA exhibit and other standard documents attached by reference will be available for public use beginning in September 2008.

Finding #7: Corrections' treatment of its independent contractors raises concerns about whether they are, in fact, employees.

Although all the contracts in our sample contained terms that indicate medical registries act as independent contractors, we surveyed each of the contracting medical registries in our sample to evaluate their relationship with Corrections based on 20 general factors that the U.S. Department of the Treasury, Internal Revenue Service (IRS), uses to determine whether a worker is an employee or an independent contractor. Most of the contractors noted that they are not required to comply with

specific instructions from Corrections on how to perform their services and half noted that they pay their workers directly, rather than having them paid by Corrections, which indicates a level of autonomy associated with that of an independent contractor. Other factors, however, suggest several areas in which Corrections appears to maintain a significant degree of control over the manner and means of performing the work. We noted that the IRS and the courts do not expressly state a single, definitive rule regarding what constitutes an independent contractor. Instead, the courts and the IRS make each decision based on the totality of the circumstances. As such, it is difficult to say whether medical registries would be deemed independent contractors or Corrections' employees.

Potential liability and penalties for misclassification of an employee include substantial taxes, back pay, and reimbursement of expenses. Furthermore, California does not make a distinction between intentional and unintentional misclassification of an employee. Thus, the responsibility for proper conduct and classification of an independent contractor falls upon the employer.

To ensure that there is no uncertainty surrounding the legal status of contract employees, we recommended that Corrections seek expert advice and legal counsel to determine whether its current treatment of certain medical registry service providers is such that those medical registry service providers should be considered employees rather than independent contractors.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver stated that the issue as to whether or not registry employees are employees versus independent contractors is a statewide issue that will be referred to the State Personnel Board. This question has statewide implications and is beyond the scope of the Receiver.

The Office of the Receiver also stated that it is in the process of hiring full-time permanent civil service clinical staff, and there will be, over time, an elimination or significant reduction in Corrections' reliance on registries.

Finding #8: Contract terms related to the standard of care are inconsistent and sometimes ambiguous.

All 21 contracts in our sample contained terms related to the standard of care. However, only 16 contained terms that appear to meet the legally required standard contained in regulation. Even then, the language used to describe the standard of care in these 16 instances varies widely. Despite this variation, we considered all these terms to be essentially the same in that they appeared to call for the legally required standard of care set out in regulation. In four other contracts, the contracts contained terms that appear to have been drafted in an attempt to be consistent with the standard of care set out in regulation, but rather than requiring the contractor to meet that standard, they required the contractor to provide medical care "necessary to prevent death or permanent disability." According to our legal counsel, this language does not meet the minimum standard set out in regulation and appears to establish a potentially lower standard of care. In addition, one contract contained only a requirement that the contractor provide services consistent with scope of practice and did not prescribe a standard that was specific to a prison setting.

We also noted that many of the contracts in our sample contained multiple terms related to the standard of care within the same contract. In some cases, these terms appear to be inconsistent with one another. For example, 14 of 21 contracts contained terms requiring contracting medical care providers to follow the legally required standard in regulation and to follow generally accepted professional standards or national standards. We do not in any way question the value of following generally accepted professional standards or national standards. However, because it is not necessarily clear that Corrections' regulatory standard and the standard of care called for by professional or national standards are the same, this inconsistency may create an ethical dilemma and confusion on the part of medical care providers and may even result in litigation. We also noted a lack of consistency across our sample in terms of the standard of care being required. For example, only seven of 21 contracts required the contractors to meet national standards.

Finally, we found that some contracts contained terms related to the standard of care that were inconsistent with the American Medical Association's (AMA) recommendations. The AMA recommends that a contracting physician not obligate himself or herself to a standard of care that is higher than that required by law. Several contracts we reviewed called for the provider to meet Corrections' standard of care and called for "high quality" or even the "highest level of treatment within the scope of available resources" as the standard of care. Although we do not in any way question the importance of providing high-quality medical care to inmates, drafting contracts containing multiple terms that may suggest differing standards of care creates an ambiguity that may result in uncertainty on the part of the provider, and potential disagreement among the contracting parties, about just what is required under the contract.

We recommended that Corrections' medical registry contracts contain clear and consistent requirements related to the standard of care called for under the contract. At a minimum this standard of care must meet the standard of care needed in order to satisfy Corrections' obligations under the Plata settlement agreement. Also, to ensure that Corrections' contracts contain terms for standard of care that meet its constitutional obligations as well as the standard of care that a practicing physician would provide if adhering to generally accepted ethical norms, Corrections should seek legal counsel and other expert advice to determine whether the standard of care currently prescribed in state regulations allows contracting physicians to provide medical care in a manner that is consistent with the generally accepted standard of care in the medical community. If the standard of care is not consistent with the generally accepted standard of care in the medical community, Corrections should revise its regulatory standard to require that the standard of care called for in the State's prisons is, at a minimum, consistent with medical ethics and with the State's constitutional obligations.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it will ensure that Corrections' contracts include constitutional levels of care for prisoners, as the Receiver's mandate is to establish constitutional levels of medical care in California's prisons. However, the remainder of the recommendations that involve community standards of care may be more suitable for state consideration after the Receiver's work is completed and authority over Corrections' medical system is returned to the State.

Finding #9: Contract terms should impose clearer obligations for contractors to be insured against civil rights claims.

We found that all the contracts we reviewed called for the recommended level of liability coverage as specified by the State. However, although some of the contracts contained terms requiring the contractor to notify the insurance carrier that the contractor regularly provides services to inmates, it is not clear that this term necessarily would ensure that the contractor was insured against civil rights claims.

We recommended that Corrections require medical registries to submit proof that their insurance company has agreed explicitly to insure them against civil rights claims.

Corrections' Action: None.

According to the Office of the Receiver, no evidence has been provided that this recommendation is based upon specific cases of monetary loss. For example, no evidence has been submitted that the State has experienced losses due to civil rights violations by registry personnel. The Office of the Receiver states that while it agrees that a contract provision requiring an insurance company represent clinical registries concerning civil rights claims may seem desirable in theory, this requirement in practice is not one of the Receiver's top priorities for several reasons, including the following: (1) mandating such a clause may drive up the cost of registry contracts to a degree that is not fiscally justified; (2) private insurance carriers may not offer civil rights coverage because civil rights liability is, under certain circumstances, driven by "deliberate indifference" rather than negligence; and (3) given the existing unconstitutional conditions at many prisons, the insurance

carrier may defend claims against registry staff by cross-complaining against the State because of the situation the registry clinician was placed. Therefore, we do not intend to implement this recommendation at this time.

Finding #10: Although many contracts require Corrections to inspect and monitor performance, few impose obligations on contractors to monitor or assess their quality of service.

All of the contracts in our sample enabled Corrections to inspect and monitor the quality of contractor performance. However, only five contracts imposed a corresponding obligation on the part of medical registries to monitor and assess the quality of their own performance.

We recommended that Corrections require registry contractors to monitor and assess the quality of services they provide under the contract.

Corrections' Action: None.

- ➔ The Office of the Receiver stated that while it agrees that a contract provision requiring registries to monitor and assess the quality of their services may seem desirable in theory, in practice this requirement is not one of the Receiver's top priorities for several reasons, including the following: (1) mandating such a clause may drive up the cost of registry contracts to a degree that is not fiscally justified, (2) the monitoring and assessing of quality is a Receivership function and should not be delegated to private providers, and (3) there is no guarantee that the registry will perform this task adequately and therefore the Receiver will need to monitor the monitoring by the registry, which may be a fiscally unsound method of ensuring adequate clinical quality by registry staff. The Office of the Receiver also stated that it is in the process of hiring full-time permanent civil service clinical staff, and there will be, over time, an elimination or significant reduction in Corrections' reliance on registries.

Finding #11: Prisons did not always follow Corrections' procedures and contract terms for using registry contractors.

When prisons need to hire a service provider under a medical registry contract, Corrections requires them to follow the hierarchy outlined in the registries' contracts. For 22 of 38 invoices we reviewed that were subject to the hierarchy requirement, prisons did not provide us with sufficient documentation to demonstrate that they followed the hierarchy when obtaining services from registry contractors. When prisons do not consistently document their attempts to contact registry providers in accordance with the hierarchy, they expose the State to potential lawsuits from registry contractors for breach of contract terms and they hinder Corrections' ability to terminate registry contractors for nonperformance.

Also, we found that Corrections' policy allows prisons to send requests for services concurrently to all registries listed in the hierarchy. During our interviews with the 16 contractors in our sample, a few commented that, as a result of this practice, the providers do not respond to the contractors with the lowest bid but instead wait to be called by the contractors with the higher bids because they can receive more money.

We recommended that prison staff consistently follow procedures requiring them to document their efforts to obtain services from registry providers. We also recommended that Corrections reevaluate its policy of allowing prisons to send out service requests concurrently to all registry contractors listed in the hierarchy.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver reiterated the response it provided to us in finding number one to describe the efforts it has taken to ensure prison staff consistently follow procedures requiring them to document their efforts to obtain services from registry providers. Also, related to the recommendation that Corrections reevaluate its policy of allowing prisons to send out service requests concurrently to all registry contractors listed in the hierarchy, the Office of the Receiver stated that using the concurrent process to request services is effective, as once the deadline has passed and requests are received (or not), institutions follow the hierarchy ranking order to request services based on response received.

Finding #12: Prisons sometimes fail to monitor invoices for medical services adequately.

Prisons could not provide sufficient evidence of their verifications that services were performed before they authorized payment for three of 50 invoices we reviewed. Prisons also did not always identify and adjust discrepancies between contract rates and providers' invoice charges resulting in overpayment of \$4,050 for five invoices that totaled \$458,346. In addition, prisons paid overtime on seven invoices even though contractors did not adhere to the contract provisions for overtime. Further, prisons and regional accounting offices failed to take available discounts or took the wrong discounts for the wrong amounts in 14 instances, and paid contractors late penalty payments in four instances because they failed to pay the invoices in compliance with the California Prompt Payment Act (CPPA).

We recommended that Corrections ensure that prisons verify the services they receive from registry contractors before authorizing payment of invoices and continue to implement the draft of a departmentwide policy reiterating the need for prison medical staff to adhere to proper procedures for verifying registry contractors' hours before authorizing payment.

We also recommended that Corrections ensure that prisons obtain the necessary documentation for the services they were unable to verify or seek reimbursement from the registry contractors for the overpayments identified in this report and establish a quality control process to ensure that prisons pay rates that are consistent with contract terms.

Further, we recommended Corrections ensure that prison staff responsible for authorizing overtime adhere to overtime policies and contract terms. Corrections should also evaluate its prisons and regional accounting offices' processes for paying invoices and identify weaknesses that prevent it from maximizing the discounts taken and complying with the CPPA.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it directed its invoice processing staff to ensure that all invoices are routed to the proper authorizing personnel for authorization of services before the invoices are sent to accounting for payment. The Office of the Receiver stated that its invoice processing system and processes require separate electronic review and approval steps prior to invoices being routed to accounting for processing of payment.

Regarding our recommendation to continue to implement the draft of a department-wide policy reiterating the need for prison staff to adhere to proper procedures for verifying registry contractors' hours before authorizing payment, the Office of the Receiver referred us to its previous discussion regarding management oversight and review of the spreadsheets that capture and tabulate bid calculations as one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes.

The Office of the Receiver also stated that it conducted a review of the overpayments identified in our report and the total reimbursement amount was less than \$60 and that collection would likely cost more. However, we disagree with the Office of the Receiver's conclusion that the reimbursement amount was less than \$60. In fact, one of the overpayments we identified, Corrections' staff requested reimbursement from the contractor for \$160 during our audit. Additionally, our review of invoices indicated that Corrections did not pay invoices according to the contract rates resulting in overpayments to one contractor totaling \$3,890. Corrections indicated that it reviewed the invoices and that the contractor either billed according to the contractor or the net errors amounted to small amounts. However, Corrections did not provide us with documentation to support its conclusions that the errors did not exist or were minimal. Therefore, we stand by our original analysis and conclusion that the contractor was overpaid. Further, related to our finding that Corrections paid seven invoices that included overtime even though it could not demonstrate compliance with overtime provisions, the Office of the Receiver stated that six invoices were paid at the appropriate rates. However, as we state in the report, our finding was that the contractors must obtain written approval for overtime from the prison's health care manager, chief medical officer, or designee and must submit a copy of the written approval with the monthly invoice. Our review found that Corrections paid invoices without this documentation.

Related to our recommendation that Corrections establish a quality control process to ensure that prisons pay rates that are consistent with contract terms, the Office of the Receiver stated that the Healthcare Invoice, Data and Provider Services Branch (HIDPSB) has developed and trained invoice processing staff to utilize resources to research contracts and rate agreements in order to ensure invoices are paid in accordance with contract or rate agreements terms and conditions. The Office of the Receiver also stated that it has implemented a two-phased system to ensure all existing and new contracts, contract amendments, and interim rate agreements are readily available for all invoice processing analysts including actively transmitting all rate information electronically to each analyst and placing the same information into labeled folders on the division server for easy access reference. In addition, single points of contract have been identified within the entities producing rate-related documents from which HIDPSB receives that data.

Regarding our recommendation to ensure that prison staff responsible for authorizing overtime adhere to Corrections' overtime policies and contract terms, the Office of the Receiver referred us to its previous discussion regarding management oversight and review of the spreadsheets that capture and tabulate bid calculations as one of the current quality control processes utilized to ensure accurate calculation of cost threshold and document retention for the bid process. Also, the Office of the Receiver stated that it created a Post Review Unit in the fall of 2007 to address overall quality control issues in contract processes.

Finally, related to our recommendation that Corrections evaluate its prisons and regional accounting offices' processes for paying invoices and identify weaknesses that prevent it from maximizing the discounts taken and complying with the CPPA, the Office of the Receiver stated it agrees with the recommendation. Specifically, its new contracting and invoice processing system that was being piloted at four institutions has been expanded to include three more prisons. This expansion will continue and additional prisons will be centralized at headquarters at the rate of approximately two every four weeks, to the extent unforeseen software, hardware, or other delaying barriers are not encountered, until all 33 prisons are centralized. The Office of the Receiver expects that when the system is completed, Corrections will gain efficiencies that will improve the payment time frames and thereby maximize the discounts taken. The Office of the Receiver anticipates completing implementation of the system by June 30, 2009.

Finding #13: Corrections fails to demonstrate that it complies fully with certain political reform act requirements.

Corrections lacks adequate controls to ensure that it complies with the duties and responsibilities outlined in the political reform act for filing officers. Specifically, Corrections could not demonstrate that all employees and consultants required to file statements of economic interests and seek approval before engaging in outside employment did so. We reviewed 124 statements and found

that seven employees did not complete their statements correctly and 78 filed their statements late. Also, we found that 14 employees did not file statements at all. Further, seven of nine prisons did not submit a copy of the statements for their health care consultants or the chief executive officer's written determination that their consultants were not required to comply with disclosure requirements.

We recommended that Corrections establish an effective process for tracking whether its designated employees, including consultants, have filed their statements of economic interests timely. We also recommended that Corrections review the statements of economic interests to ensure their accurate completion and to identify potential conflicts of interests. Further, we recommended that Corrections ensure that the chief executive officer retains his or her written determinations for consultants.

Corrections' Action: Partial corrective action taken.

The Office of the Receiver agrees with the recommendations to establish an effective process for tracking whether its designated employees, including consultants, have filed their statements of economic interests timely, and to review the statements of economic interests to ensure their accurate completion and to identify potential conflicts of interests. According to the Office of the Receiver, it determined that current Corrections' regulations do not specifically cover positions in the California Prison Health Care Services Division. However, it has established an action plan for the 2009 filing period that will entail the development of regulations to cover these positions. The Office of the Receiver also reported that it identified 122 designated positions similar to those that would be designated as subject to filing in accordance with Corrections' regulations and that employees in the designated positions were asked to complete Form 700, Statement of Economic Interests for the 2008 annual filing year. Additionally, the Office of the Receiver completed a database that identifies and tracks established, assuming, and departing designated positions. Furthermore, the Office of the Receiver stated that it has developed an action plan for the 2009 annual filing year that includes the following: (1) working collaboratively with the Fair Political Practices Commission to develop training classes for designated filers to ensure their understanding of the process, law, and filing requirements; (2) enhancing the current tracking database to ensure follow-up activities are conducted timely and add a compliance component to ensure the California Prison Health Care Services Division adheres fully to all applicable laws and regulations; (3) implementing a newly developed personnel management system to establish an alert process for all assuming and departing positions for Form 700 filing purposes; and (4) working closely with the California Prison Health Care Services Division contract unit to identify and track consultants for Form 700 filing purposes and potential conflict-of-interest activities.

Finally, the Office of the Receiver does not agree that registry consultants should be interpreted as "consultants" for purposes of annual conflict of interest disclosure purposes. According to the Office of the Receiver, it requested a legal opinion from Corrections' legal office in October 2007 but has not received a response. Therefore, the Office of the Receiver plans to request a legal opinion from attorneys of the California Prison Health Care Receivership Corporations no later than August 15, 2008.

Finding #14: Corrections' credentialing unit often failed to verify properly the credentials of registry contractors' providers.

The credentialing unit does not verify the status of all providers who treat inmate patients. Specifically, the credentialing unit does not perform database searches for providers who treat inmate patients outside of Corrections' facilities. The credentialing unit also does not perform database searches of providers who it classifies as allied health professionals, such as pharmacists, registered nurses, laboratory technicians, radiological technicians, dietitians, and physical therapists.

In addition, Corrections does not have a departmentwide policy directing the prisons to verify the credentials of these providers, which creates confusion and the risk that providers will not undergo any credentialing before performing services. The credentialing unit also does not perform database searches on all physicians and nurse practitioners who provide services to inmate patients. The credentialing unit performs a search only after the prisons submit a request.

Finally, the credentialing unit's database search method is inefficient. Specifically, providers' credentials are verified each time they move to another prison. According to Corrections' former credentialing coordinator, who is now the manager of the Plata Support Division's Pre-Employment Clearance Unit, based on information provided by the U.S. Department of Health and Human Services, she believed that because each prison has its own formal peer review process to further quality health care, federal law requires Corrections to register them as separate eligible entities for purposes of querying the databases. She also stated that Corrections' management has not formally adopted a written policy regarding her interpretation of federal law. This current process appears unnecessary and a waste of time and money.

We recommended that Corrections require the credentialing unit to verify the credentials of contracted providers who work in non-Corrections' facilities or, at a minimum, verify that these facilities have a rigorous process for verifying the credentials of their providers. Corrections should also establish a policy to define allied health professionals and to identify professionals who will be credentialed by the credentialing unit versus those credentialed by the prisons. We also recommended that Corrections require the credentialing unit to determine whether the credentials of those medical and allied health providers who are performing services at prisons under registry contracts have been verified. If not, the credentialing unit should verify them. Further, we recommended that Corrections ensure that prisons request National Practitioners Data Bank searches from the credentialing unit before allowing providers to perform services. Finally, we recommended that Corrections seek clarification from the U.S. Department of Health and Human Services regarding the criteria for eligible entities and whether or not all prisons can be combined into one eligible entity.

Corrections' Action: Partial corrective action taken.

According to the Office of the Receiver, it agrees with the recommendations and on August 30, 2007, it disseminated a contract provider policy that outlines the policy and procedure regarding what is required to credential contract providers that provide on-site services. The policy also defines allied health providers and details the providers that require credentialing. The Credentialing and Privileging Unit completes a pre-employment review on all designated licensed independent and allied health providers prior to services being started and for each individual institution the provider requests to work. This is done to gain better control and accountability of the providers, verify work performance of the providers, and ensure that providers that have been released from one prison for less than favorable cause are not gaining employment at another prison. The directive to comply with this pre-employment credential verification has been given to the health care management at all 33 institutions as well as regional and headquarters staff. Additionally, a new contract provider policy, also disseminated on August 30, 2007, instructs the Health Care Management and Institutional Personnel officers that they shall not hire any licensed independent provider until a credential verification has been completed and approved by headquarters' Credentialing and Privileging Unit and the medical contracts have had language added requiring a credential approval prior to a contract provider being allowed to provide services to each prison.

The Credentialing and Privileging Unit also compares reports to verify that a credential review and approval was completed for new hires. The Office of the Receiver reports that there are inconsistencies and compliance issues with the process that are being addressed. The Credentials Committee is developing a process and directive memo to health care management identifying the requirement, time frame to comply, and the consequences for failing to comply. The Receiver anticipates the memo to be completed and distributed by June 2008.

Additionally, related to the recommendation to require the credentialing unit to verify the credentials of contracted providers who work in non-Corrections facilities or, at a minimum, verify that these facilities have a rigorous process for verifying the credentials of their providers, the Office of the Receiver stated that the credentials committee has determined that the off-site services in licensed community hospitals will not require an additional credential review by Corrections as the licensed community facility is responsible for the credentialing and privileging activity and competency monitoring. Independent providers are and will be verified and approved by the Credentialing and Privileging Unit or the Credentials Committee prior to receiving a start or hire date commitment.

Finally, related to the recommendations regarding the National Practitioners Data Bank searches, the Office of the Receiver stated that with the establishment of the Corrections formal peer review structure within the Professional Practices Executive Committee, the Credentialing and Privileging Unit centrally using the National Practitioners Data Bank to complete all pre-employment credential activity, and the current implementation of a web-based credentialing IT solution, the issues we raised regarding the National Practitioners Data Bank reporting will be addressed.

Indian Gaming Special Distribution Fund

Local Governments Do Not Always Use It to Mitigate the Impacts of Casinos, and Its Viability Will Be Adversely Affected by Compact Amendments

REPORT NUMBER 2006-036, JULY 2007

California Gambling Control Commission's and Six County Indian Gaming Local Community Benefit Committees' responses as of September 2008

California Government Code, Section 12717, requires the Bureau of State Audits to conduct an audit every three years regarding the allocation and uses of moneys from the Indian Gaming Special Distribution Fund (distribution fund) by the recipients of the grant money and report its findings to the Legislature and all other appropriate entities. We evaluated the use and administration of distribution fund grants at six counties: Fresno, Placer, Riverside, San Bernardino, San Diego, and Sonoma.

We also compared fiscal year 2005–06 distribution fund contributions to estimated future contributions based on changes in compact provisions in new and amended pending compacts to determine the ability of the distribution fund to continue to fund the programs that depend on it. We then compared estimated contributions to current year expenditures from the distribution fund. Because we are unable to project how fast casinos will expand or forecast the changes to their profitability, we made a conservative estimate based on fiscal year 2005–06 gaming device counts and net win figures.

Finding #1: Local governments did not always use the distribution fund to pay for mitigation projects.

The legislation establishing the distribution fund declares the intent of the Legislature that tribal governments participate in identifying and funding mitigation of the impacts of tribal gaming through the grant process. The legislation also states that the grants are for distribution to local governments impacted by casinos. Finally, the senate floor analysis describes the legislation creating the distribution fund and grant process as establishing “priorities and procedures . . . for the purpose of mitigating impacts from tribal casinos.” However, the legislation does not establish a clear requirement that the grants be used only for projects that actually mitigate the impacts from tribal casinos in all instances.

Based on our review of 30 grants, we determined that often a distribution fund grant financed a project that had the potential of offsetting the repercussions of a casino but was mainly used for activities that benefited the county as a whole. In 10 instances, the goods and services purchased with grant money had the potential for use in mitigating casinos' impact, should the need arise. However the main beneficiaries were the counties as a whole. Even though the potential exists that some of the goods or services acquired with these grant funds could be used to mitigate the impact of a casino, it is unclear whether the Legislature intended distribution fund grants to be used in

Audit Highlights . . .

Our review of the allocation and uses of the Indian Gaming Special Distribution Fund (distribution fund) money revealed the following:

- » *Local governments did not always use distribution fund money to mitigate casino impacts.*
- » *The allocation of distribution fund money in some counties is based, in part, on the number of devices operated by tribes that did not pay into the fund because their compacts require them to negotiate directly with the county to pay for the mitigation of casino impacts. However, these counties continue to receive distribution fund dollars from the State.*
- » *In many instances local governments do not use interest earned on unspent distribution fund money for projects related to casino impacts.*
- » *Although all benefit committee members are required to file statements of economic interests, in our sample counties, 11 of the 13 tribal members that were required to file failed to do so.*
- » *The ratification of compacts in June 2007, along with one that is awaiting ratification, may threaten the future viability of the distribution fund and the programs that depend on it, as they eliminate \$92 million in payments to the fund beginning in fiscal year 2007–08. While we estimate that contributions to the State's General Fund would also total at least \$174 million, almost \$40 million per year could be required to pay for the estimated shortfall in the Revenue Sharing Trust Fund.*

this manner. In other cases grant funds were used for projects totally unrelated to casinos. Specifically, in five instances the money was not used to offset the adverse effects of casinos. Although these and other purchases may be beneficial to the counties, when a distribution fund grant is used for purposes that have little or no relationship to a casino impact, the problems the community experiences because of a casino may not be adequately addressed. The remaining 15 grants we reviewed were used specifically to alleviate casino impacts.

We recommended that the California Gambling Control Commission (gambling commission) seek legislative changes to amend the government code to provide direction to local governments to ensure that they use distribution fund grants only to purchase goods and services that directly mitigate the adverse impacts of casinos on local governments and their citizens.

We also recommended that benefit committees require local governments to submit supporting documentation that clearly demonstrates how proposed projects will mitigate the effects of casinos.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to, among other things, require benefit committees to select only grant applications that mitigate impacts from casinos on local jurisdictions, and cause any grant for expenditures not related to Indian Gaming to terminate immediately and any money not yet spent to revert to the distribution fund. Chapter 754 also provided \$30 million in funding from the distribution fund for grants to local government agencies.

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted new policies and procedures on November 30, 2007, that include codifying more comprehensive descriptions and procedures for the management of funds and for their award and distribution.

Placer County Indian Gaming Benefit Committee's Action: None.

➔ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that through the application process, applicants must fully describe the casino or gaming impact they propose to mitigate and fully describe how they will use grant funds to mitigate the impact. The benefit committee also stated that, in response to our recommendation, during the next grant award cycle, benefit committee staff will review applications and provide an assessment to the committee on each application's apparent relevance to casino and gaming impacts.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that its current grant application process includes the requirement that proposed projects from the grant application contain detailed project descriptions and supporting documentation that clearly demonstrates how proposed projects will mitigate the effects of casinos.

San Diego County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that, since fiscal year 2003–04, its grant application form requires applicants to include a discussion of the impacts on their jurisdiction associated with the particular casino(s) and how the project would be funded. Additionally, the benefit committee stated that, beginning in fiscal year 2006–07, applicants were also required to present their projects at a public meeting so the committee could ask questions about them. The benefit committee also indicated that for the next cycle of grants, the application form would be amended to add a requirement that, if a project proposes in part to mitigate impacts unrelated to casinos, funding for the portion of the project unrelated to the casinos must be found from another source. Finally, applicants will be reminded to fully describe the impacts on their jurisdiction from tribal casinos and explain how their project will mitigate those impacts.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that it has adopted an application form that requires grant applicants to describe how requested funds will be used to offset the impacts of tribal gaming. The application form requires applicants to provide a complete project description, describe impacts on their jurisdiction associated with the casino and include any data to support the request, and explain how the project will mitigate the impacts.

Finding #2: Compacts ratified since 1999 require tribes to directly fund efforts to mitigate casinos' impacts, but local governments continue to receive distribution fund money.

Post-1999 compacts require tribes to negotiate directly with local governments to pay for local mitigation projects in lieu of paying into the distribution fund. However, based on the allocation methodology established in state law in 2004, two counties where casinos under post-1999 compacts are located received roughly \$850,000 in distribution fund money in fiscal year 2005–06. Local governments in those counties received money for projects that, in accordance with the post-1999 compacts, should have been funded directly by the tribes. Consequently, less distribution fund grant money is available to other counties where tribes are not required to provide funding directly to local governments.

We recommended that the gambling commission seek changes to legislation to revise the allocation methodology outlined in the government code so that the allocation to counties is based only on the number of devices operated by tribes that do not negotiate directly with local governments to mitigate casino impacts.

Gambling Commission's Action: None.

The gambling commission states that because it does not have any oversight role related to local mitigation grants and its existing role is purely technical, it declines to seek the recommended legislative changes.

However, our recommendation did not address the gambling commission's oversight role related to local mitigation grants. Rather, it asked the gambling commission to seek a legislative change to the allocation methodology outlined in the California Government Code so that counties that were negotiating directly with Indian tribes to pay for local mitigation projects no longer receive grant funds from the distribution fund because these tribes are not contributing any money to the fund.

Finding #3: Interest that local governments earned on unspent distribution fund money has not always gone toward mitigation projects.

Some local governments have earned interest on distribution funds until the funds are needed for an intended project. In many instances, large amounts of grant money remained unspent for more than a year, and the local governments indicated to us that the interest earned was not always allocated back to the original project or used for similar future projects. In fact, several local governments we spoke to used the interest to pay for general county operational costs. In some cases local governments did not even earn interest, instead depositing the grant funds in accounts that generate no interest.

Our legal counsel advised us that although the law does not specifically require a local government to allocate interest earned on unspent funds to original or future mitigation projects, the government code section cited by local governments states that earned interest may be deposited in their general funds unless otherwise specified by law. The purposes for which distribution fund money may be spent are set forth in the compacts and state law. Accordingly, our counsel advised us that the interest on distribution fund money is subject to the common law rule that unless it is separated by statute from the principal, the interest should be used for the originally intended purpose. Thus, we believe the interest should be used to support mitigation projects. However, several local governments asserted that the government code grants them authority to use interest earned for general purposes. Further, local officials indicated

that a significant number of grants were maintained in accounts that earned no interest. Because the interest on distribution fund money is subject to the common law rule that unless it is separated by statute from the principal, the interest should be used for the originally intended purpose, we believe the interest should be used to support mitigation projects.

We recommended that the gambling commission seek changes to legislation to amend the government code to require that all funds be deposited into interest-bearing accounts, and that any interest earned is used on projects to mitigate casino impacts.

Further, we recommended that benefit committees ensure that local governments spend the interest earned on project funds only on the projects for which the grants were awarded or return the money to the county for allocation to future mitigation projects.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to require a local government jurisdiction that receives a local mitigation grant to deposit all funds received in an interest-bearing account and use the interest from those funds only for the purpose of mitigating an impact from a casino.

Placer County Indian Gaming Benefit Committee's Action: None.

➔ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that it sent letters to all mitigation grant recipients clarifying the need to maintain mitigation grant funds in interest-bearing accounts and use the interest earned for casino/gaming mitigation measures.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

San Bernardino County states that it has changed contract language to ensure that interest earned on distribution funds for long-term projects will remain with the project. Material amounts of grant money for long-term projects that remain unspent will be required to be deposited into an interest-bearing account. All interest earned will be allocated back to the original project or used for future mitigation projects.

San Diego County Indian Gaming Benefit Committee's Action: Pending.

In its six-month response, San Diego County officials stated that in the next cycle of grants, the benefit committee would be asked to include a directive to applicants, if state law allows their jurisdictions to do so, to either spend the interest earned on projects that mitigate impacts of tribal casinos or return the money to the county for allocation to future mitigation projects.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that if state law is amended to require interest earned on unspent grant funds to be used only for mitigation purposes, it will notify all grant recipients of this requirement. As stated above, legislation has since been enacted that requires a local government jurisdiction that receives a local mitigation grant to deposit all funds received in an interest-bearing account and use the interest from those funds only for the purpose of mitigating an impact from a casino.

Finding #4: Grant allocations have generally been properly calculated, but some local governments were not awarded the amounts they were allocated through the Nexus test.

State law requires a county receiving distribution fund money to allocate a portion of its funding to local governments based on the Nexus test criteria described in the text box. In Riverside County, we identified two instances where the Nexus test criteria were not consistently applied. County officials agreed with our assessment and stated that the county would revise its application of the Nexus criteria. Further, Riverside County did not even adhere to its inaccurate Nexus test calculation. We identified several instances where cities in Riverside County were awarded less money than they should have been allocated under the Nexus test.

We recommended that benefit committees correct the inconsistent application of Nexus test criteria and ensure that local governments receive at least the minimum amounts they are allocated under the government code requirements.

Nexus Test Criteria

1. The local government jurisdiction borders Indian lands on all sides.
2. The local government partially borders Indian land.
3. The local government maintains the highway, road, or predominant access route to a casino within four miles.
4. All or a portion of the local government is located within four miles of a casino.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the Riverside County benefit committee stated that it has updated the table identifying the percentages for which local government jurisdictions are eligible for 60 percent nexus grants. Additionally, the benefit committee stated that in an effort to ensure that local governments receive at least the minimum amounts they are allocated under the California Government Code requirements, the 60 percent nexus category of individual tribal casino account balances would be applied to the corrected percentages.

Finding #5: Some grantees were not eligible for funding.

Although state law defines the intended recipients of distribution fund money—cities, counties, and special districts—some benefit committees provided grant money to ineligible entities. In two cases benefit committees awarded grants to school districts, which state law specifically excludes from the definition of special districts. Because the Legislature has identified specific entities and purposes for distribution fund grant money, counties must ensure that they follow the statutory requirements.

We recommended that benefit committees grant distribution fund money only to eligible entities.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended Section 12712 of the California Government Code to specifically exclude city and county school districts and community college districts from the definition of "special district."

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted new policies and procedures on November 30, 2007, that include codifying more comprehensive descriptions and procedures for the management of funds and for their award and distribution.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee provided a listing of the special districts that are eligible to receive distribution grant money. The listing provided did not include any school districts.

Finding #6: Some benefit committee members fail to meet disclosure requirements.

The Political Reform Act of 1974 (political reform act) requires state and local officials and employees with decision-making authority to file statements of economic interests annually and on assuming or leaving a designated position. These statements are intended to identify conflicts of interest that an individual might have. However, the counties we visited could not provide 11 of the 13 statements of economic interests for tribal representatives on the benefit committees for fiscal year 2005–06.

Three of the six counties we visited informed us that the tribal members of their respective benefit committees asserted that they are exempt from the requirements to submit statements. However, the California Fair Political Practices Commission has issued an advice letter regarding this issue stating that any individual serving in a capacity as a member of a public agency, including tribal members of benefit committees, are subject to the provisions of the political reform act. The remaining three counties indicated that they do not know the reasons tribal members did not file the required statements. When designated individuals do not file statements of economic interests, benefit committees may be unaware of conflicts of interest. Further, the benefit committees cannot ensure that members are aware that they should remove themselves from making decisions that may pose conflicts of interest.

We recommend that benefit committees ensure that all benefit committee members follow the political reform act and file the required statements of economic interests, and inform the appropriate agency if they fail to do so.

Fresno County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it adopted a conflict of interest policy on January 4, 2008, and statements of economic interests have been received from all members.

Placer County Indian Gaming Benefit Committee's Action: None.

➔ Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Pending.

In its six-month response, the benefit committee stated that the county is working with tribal members and anticipated resolution of the issue by October 2007.

Riverside County Officials did not provide a one-year response to the audit.

San Bernardino County Indian Gaming Benefit Committee's Action: Corrective action taken.

The benefit committee states that it will continue to inform members of the requirement to file their statements at intervals before and after the deadline, and will notify the appropriate state agency if they do not file within two weeks of the deadline.

San Diego County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the benefit committee stated that it will remind benefit committee members to submit required statements and will inform the State of any failure by a benefit committee member to do so.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the benefit committee stated that it would continue to ask all members to submit required statements of economic interests and will inform the appropriate state agency if they fail to do so.

Finding #7: Many counties did not properly report their use of distribution fund money.

State law requires each county that receives distribution fund grants to submit an annual report by October 1 detailing, among other information, the specific projects funded by the grants and how current-year grant money has been or will be spent. Nevertheless, many counties fail to submit the reports to all required entities, including two of the six counties we visited. In fact, according to the gambling commission and various legislative committees, in 2006 only nine counties reported to all required entities, which include the gambling commission, the chairs of the Senate and Assembly committees on governmental organization, and the chair of the Joint Legislative Budget Committee. Furthermore, six of the 24 counties receiving funds did not report at all.

Additionally, our review found that at least one county did not include all required information in its most recent annual report. The law requires each county to submit an annual report on its current- and prior-year allocations and expenditures for distribution fund grants. However, in fiscal year 2005–06, Riverside County failed to report its current-year grant allocations and only provided expenditures of prior-year grants.

We recommended that benefit committees submit complete annual reports to all required legislative committees and the gambling commission.

Legislative Action: Legislation enacted.

Chapter 754, Statutes of 2008, amended the California Government Code to include language stating that any county that does not provide an annual report shall not be eligible for funding from the distribution fund for the following year.

Placer County Indian Gaming Benefit Committee's Action: None.

Placer County officials ignored our request to provide 60-day, six-month, and one-year responses to the audit.

Riverside County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its six-month response, the Riverside County benefit committee stated that it would provide all required information for grants funded in its annual report.

Sonoma County Indian Gaming Benefit Committee's Action: Corrective action taken.

In its 60-day response, the Sonoma County benefit committee stated that it would submit annual reports to all required legislative committees and the gambling commission by the deadline specified in state statute.

Sonoma County officials declined our request to provide a six-month and one-year response to the audit.

Finding #8: New compact provisions will change the amount of revenues in the distribution and trust funds.

In June 2007 the Legislature ratified one new compact and four of five amendments to existing compacts—the fifth compact amendment was ratified after our audit. From a review of current operating information and compact terms, we estimated that the one new compact and five amendments (pending compacts) to existing compacts would significantly decrease revenues in the distribution fund and, to a lesser extent, increase Revenue Sharing Trust Fund (trust fund) revenues. We conservatively estimated that annual contributions to the trust fund from these compacts would increase by about \$6.9 million, while annual contributions to the distribution fund would decrease by \$92 million. If the revenue and expenditure levels estimated for fiscal year 2007–08 continue into the future, without additional resources the distribution fund will be unable to meet its obligations by fiscal year 2010–11, approximately four years from now. In addition to the impact on the distribution and

trust funds, we estimated that contributions to the State's General Fund from these compacts would total between \$174.3 million and \$175.1 million for fiscal year 2007–08. Further, as casino operations expand, General Fund revenues will increase.

Finding #9: Post-1999 and pending compacts and amendments provide revenues to the General Fund.

Between 2003 and 2006, the Legislature ratified five new compacts and amendments to eight others (post-1999 compacts), which provided \$128 million in General Fund revenue in fiscal year 2005–06. However, that figure will increase because several casinos operating under post-1999 compacts only recently began operations or will begin operations this year. Overall, we estimated that General Fund revenues for fiscal year 2007–08 from the post-1999 and pending compacts discussed above will total between \$304 million and \$313.5 million. These amounts represent between 4.3 percent and 4.5 percent of the \$7 billion in revenue that Indian gaming in California generated during fiscal year 2004–05. Further, for fiscal year 2007–08, we estimated that trust fund and distribution fund revenue from tribal contributions will total \$39.4 million and \$47 million, respectively, representing 0.6 percent and 0.7 percent of total fiscal year 2004–05 gambling revenue, respectively.

Finding #10: General Fund revenues may be used for many purposes.

Future General Fund revenue contributions from Indian gaming may be used to help reduce the impact of the \$92 million decrease in distribution fund revenue. However, without further clarification in the government code by the Legislature, it is unclear if compact provisions that redirect a portion of their General Fund revenue contributions to the trust fund if there is an insufficient amount in the trust fund to distribute \$1.1 million to each eligible tribe take place before or after the government code requirement for the distribution fund to cover any such shortfalls in the trust fund. Furthermore, the General Fund contributions required by the compacts may also be obligated to repay a California Department of Transportation fund that made loans to the General Fund in prior fiscal years. As such, any increase in General Fund revenue from pending compacts may be obligated to repay the Transportation Congestion Relief Fund and thus would not be available for backfill distributions required by the trust fund or for other purposes.

Safely Surrendered Baby Law

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

REPORT NUMBER 2007-124, APRIL 2008

Department of Social Services' response as of October 2008

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

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

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

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

Legislative Action: None.

Social Services' Action: Partial corrective action taken.

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

Social Services' Action: Pending.

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

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

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

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

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

Social Services' Action: Pending.

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

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

Department of Public Health

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

REPORT NUMBER 2007-040, SEPTEMBER 2008

Laboratory Field Services' response as of November 2008

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

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

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

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

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

Audit Highlights . . .

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

Medical Board of California

It Needs to Consider Cutting Its Fees or Issuing a Refund to Reduce the Fund Balance of Its Contingent Fund

REPORT NUMBER 2007-038, OCTOBER 2007

Medical Board of California's response as of November 2008

Section 2435 of the Business and Professions Code (code) directs the Bureau of State Audits to review the Medical Board of California's (medical board) financial status and its projections related to expenses, revenues, and reserves, and to determine the amount of refunds or licensure fee adjustments needed to maintain the reserve legally mandated for the medical board's contingent fund.

The medical board assesses fees for physicians and surgeons (physicians) according to rates and processes established in the code. In 2005, passage of Senate Bill 231 increased physicians' license fees (fees) from a maximum rate of \$600 to \$790. In addition to establishing the rate, the code also states that the Legislature expects the medical board to maintain a reserve, or fund balance, in its contingent fund equal to approximately two months of operating expenditures.

Finding #1: The medical board does not have the flexibility to adjust fees because they are established in law.

The code requires the medical board to maintain a fund balance that would cover approximately two months of operating expenditures. The code also suggests that if the fund balance becomes excessive, the medical board should take action to reduce the fund balance. However, the code does not provide the medical board the flexibility to adjust fees.

We recommended that the medical board seek a legislative amendment to Section 2435 of the code to include language that allows it the flexibility to adjust physicians' license fees when necessary to maintain its fund balance at or near the mandated level.

Medical Board's Action: Corrective action taken.

In January 2008 Assembly Bill 547 (AB 547) was amended to include language giving the medical board the flexibility to set initial licensing and renewal fees up to a maximum of \$790. On September 23, 2008, AB 547 was enrolled; however, the governor vetoed this bill on September 26, 2008. The medical board indicated that it fully supports our recommendation and is considering pursuing legislation again in 2009.

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) financial status and fund balance revealed that:

- » *The fund balance of the medical board's contingent fund increased by \$6.3 million, to \$18.5 million, in fiscal year 2006–07. This represented 4.3 months of reserves, more than 100 percent above the reserve level mandated in the law.*
- » *The recent increase in the fund balance resulted from variances between actual and estimated expenditures.*
- » *The medical board estimates that its months of reserves will drop to 1.5 months by June 30, 2012, assuming that it spends all of its appropriations in each of the next five fiscal years.*
- » *However, based on the medical board's historical experience of overestimating expenditures, we estimate that it will have 3.8 months of reserves by June 30, 2012, unless it issues refunds or decreases license fees for physicians.*

Finding #2: The fund balance of the medical board's contingent fund increased significantly in fiscal year 2006–07, resulting in reserves well above mandated levels.

The medical board's fund balance increased by \$6.3 million to \$18.5 million in fiscal year 2006–07, which equates to 4.3 months of operating expenditures. The increase was caused mostly by the variance between estimated and actual expenditures in fiscal year 2006–07, primarily related to a planned expansion of medical board programs that was not fully realized in that year.

We believe the fund balance is unlikely to return to the level legally mandated unless fees are reduced or refunded. In particular, while the medical board's estimated revenues consistently approximated actual revenues in the last four fiscal years, the medical board has consistently overestimated expenditures by at least \$2 million each year over the same period. Based on the medical board's future revenue and expenditure estimates, adjusted downward by \$2 million for the expenditure difference just described, we estimate that the medical board still would have 3.8 months of reserves on June 30, 2012.

We recommended that the medical board consider refunding physicians' license fees or, if successful in gaining the flexibility to adjust its fees through an amendment to existing law, consider temporarily reducing them to ensure that its fund balance does not continue to significantly exceed the level established in law.

Medical Board's Action: Pending.

The medical board said it considered reducing or refunding license fees but instead initiated several other actions that would bring its fund balance into line with mandated levels. These are:

- Seek legislation to increase the mandated two-month reserve to four or six months.
- Seek budget authority to reestablish the Operation Safe Medicine Unit, to expand the Probation Program, and to replace its information technology infrastructure.
- Conduct a study to determine whether seeking an increase in salaries for investigators is warranted.
- Increase spending in fiscal year 2008–09 related to a new telephone system, office relocations, and rent.
- Decrease revenues in fiscal year 2008–09 by eliminating a convenience fee for on-line cashiering.

➔ We note that as of June 30, 2008, the medical board's reserves had grown to \$23.9 million or 5.6 months of reserves according to the State Budget Status and Budget Expenditures Status Report provided by the medical board's executive director to the medical board in November 2008.

California Highway Patrol

It Followed State Contracting Requirements Inconsistently, Exhibited Weaknesses in Its Conflict-of-Interest Guidelines, and Used a State Resource Imprudently

REPORT NUMBER 2007-111, JANUARY 2008

California Highway Patrol's and the Department of General Services' responses as of November 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the California Highway Patrol's (CHP) purchasing and contracting practices and its use of state resources. Specifically, the audit committee asked us to:

- Review the CHP contracts awarded since January 1, 2004, for helicopters, motorcycles, guns and accessory equipment, patrol car electronics, and counseling services to determine whether the CHP had complied with laws related to purchasing and whether the contracts were cost-beneficial and in the best interest of the State.
- Ascertain whether the State could cancel any noncompetitive purchasing agreements that were not compliant with laws or in the best interest of the State and repurchase goods using competitive bidding.
- Examine relevant internal audits and personnel policy or financial reviews to determine whether the CHP responded to the issues raised and took recommended corrective actions.
- Evaluate the CHP's contracts for specified goods and services and determine whether conflicts of interest existed.
- Identify the CHP's policies and practices for using state equipment, including aircraft, and determine whether the CHP complied with these policies and laws and whether its employees reimbursed the State for any personal use of state property.

Finding #1: The CHP and the Department of General Services (General Services) insufficiently justified awarding a \$6.6 million handgun contract.

In early 2006 the CHP submitted documents to General Services to purchase more than 9,700 handguns of a particular make and model. By specifying a particular make and model, the CHP intended to make a sole-brand purchase, which required it to justify why only that make and model would fulfill its needs. However, the CHP did not fully justify the sole-brand purchase. For example, the CHP did not fully explain the handgun's unique features or describe other handguns it had examined and rejected and why. Rather than explain how the specifications and performance factors for this model of handgun were unique, the CHP focused on the projected service life of the previous-model handgun, the CHP's inventory needs, officer safety, the costs for a new weapons system, and the time it would need

Audit Highlights . . .

Our review of the California Highway Patrol's (CHP) purchasing and contracting practices and use of state resources revealed the following:

- » *The CHP did not include all the justifications recommended by the State Administrative Manual in its \$6.6 million handgun purchase request, nor did it sufficiently justify the cost of its planned \$1.8 million patrol car electronics purchase.*
- » *The Department of General Services approved the CHP's purchases even though the CHP's purchase documents did not provide all the requisite justifications for limiting competition or for the cost of the product.*
- » *Despite the deficiencies in the handgun and patrol car electronics procurements, our legal counsel advised us that those deficiencies did not violate the provisions of law that would make a contract void for failure to comply with competitive bidding requirements.*
- » *The CHP has weaknesses in its conflict-of-interest guidelines including not requiring employees who deal with purchasing to make financial interest disclosures, and not consistently following its procedures to annually review its employees' outside employment.*
- » *Between 1997 and 2007, the CHP owned and operated a Beechcraft brand King Air airplane (King Air), but could not substantiate that it always granted approval to use the King Air in accordance with its policy, and its decisions to use the King Air were not always prudent.*

to procure a new weapons system.¹ None of these issues describe the new-model handgun's unique performance factors or why the CHP needed those specific performance factors. The CHP's sole-brand justification also did not explain what other handguns it examined and rejected and why. Further, despite its oversight role, General Services approved the CHP's purchase request, although the CHP did not fully justify the exemption from competitive bidding requirements. Because the CHP did not fully justify the handgun purchase, and General Services did not ensure that the purchase was justified, neither can be certain that the purchase was made in the State's best interest.

Moreover, General Services' procurement file for the CHP handgun purchase did not contain sufficient documentation showing how the CHP chose its proposed suppliers or how those suppliers would meet the bid requirements. According to a General Services acquisitions manager, when conducting the CHP's handgun procurement, General Services relied on a list of potential bidders supplied by the CHP and did not verify whether the bidders were factory-authorized distributors. Because it did not adequately document how the CHP chose its proposed suppliers, General Services did not fulfill its oversight role of ensuring that various bidders could compete and that the State received the best possible value.

We recommended that the CHP provide a reasonable and complete justification for purchases in cases where competition is limited, such as sole-brand or noncompetitive bidding purchases. Further, we recommended that it plan its contracting activities to allow adequate time to use the competitive bid process or to prepare the necessary evaluations to support limited-competition purchases. We also recommended that the CHP fully document its process for verifying that potential bidders are able to bid according to the requirements in the bid solicitation document and that General Services verify that the lists of bidders that state agencies supply it reflect potential bidders that are able to bid according to the requirements specified in the bid.

CHP's Action: Corrective action taken.

The CHP told us that it has implemented a new documentation process for its sole-brand purchases requiring authorization through its Administrative Services Division with final approval by the assistant commissioner for staff operations. CHP also noted that it takes the same approach with noncompetitive bid documentation to ensure that its noncompetitive justification documents address all the necessary factors.

The CHP reported that it is verifying potential bidders through General Services' Small Business/Disabled Veteran Business Enterprise Web site and other on-line searches, and through speaking directly with potential bidders. The CHP updated staffs' desk procedures to reflect the necessary verification.

General Services' Action: Corrective action taken.

General Services told us that verifying the bidder list represents existing procedures and best practices. In January 2008 it issued instructions to acquisitions staff reemphasizing the requirement to verify that potential bidders are able to bid according to bid requirements. Further, General Services held meetings with acquisitions staff during February 2008 to emphasize the importance of verifying potential bidders lists to ensure adequate competition for the requirements specified in the bid. General Services used the CHP's handgun procurement as a case study during those meetings.

Finding #2: The CHP supplied insufficient price justification for spending \$1.8 million for TACNET™ systems (TACNET™), and General Services was inconsistent in approving the purchase.

In 2005 the CHP submitted to General Services a \$1.8 million purchase estimate for a sole-brand purchase of 170 TACNET™s, which consolidate radio and computer systems in patrol cars to allow for a single point of operation.² General Services appropriately denied the CHP's sole-brand request to purchase the TACNET™ when it found a lack of competition among the bidders. The CHP resubmitted

¹ A weapons system comprises the handgun and the ammunition the handgun fires.

² TACNET™ stands for tactical network and is a registered trademark of Visteon Corporation.

the procurement as a noncompetitive purchase request but did not include an adequate cost analysis demonstrating that it had determined that the TACNET™'s unit price was fair and reasonable. For example, the CHP stated in its noncompetitive justification that an actual cost comparison was not possible because the TACNET™ was not duplicated elsewhere in the industry. Thus, rather than conducting an actual cost comparison of the TACNET™ with other systems, the CHP compared the cost of the TACNET™ to the cost of separate products that offered at least one of the features of the system. The CHP then concluded that the price for a TACNET™ system was fair and reasonable. The cost analysis is an important part of the contract justification and serves to ensure that state agencies receive a fair and reasonable price in the absence of price competition.

Moreover, General Services did not ensure that the revised procurement documents contained the required analysis. General Services' policy states that it will reject an incomplete noncompetitive justification, but it did not do so in this instance. Also, General Services did not fulfill its procurement oversight role by ensuring that the State received fair and reasonable pricing on a purchase contract in which the marketplace was not invited to compete. We recommended that the CHP provide a complete analysis of how it determines that the offered price is fair and reasonable when it chooses to follow a noncompetitive bid process.

CHP's Action: Corrective action taken.

CHP reported that it has included in its procurement checklist steps for staff to follow in a noncompetitive procurement. These steps include staff documenting their efforts to identify similar goods and providing an evaluation for why the similar goods are unacceptable. Additionally, staff must examine the California State Contracts Register to identify suppliers and document the examination. CHP stated that when it can identify no other suppliers, it will use the information gathered from similar goods to justify the cost of a noncompetitive procurement is fair and reasonable.

Finding #3: The sole-brand procurement method may sometimes allow state agencies to avoid the stricter justification requirements for noncompetitive procurements.

Although state law requires General Services to review state agencies' purchasing programs every three years, General Services cannot specifically screen for sole-brand purchases because data related to these procurements is kept only in the individual department's purchasing files. The justifications and authority needed for a sole-brand purchase are less stringent than those needed for a noncompetitive procurement. For example, state agencies must document more information for a noncompetitive bid, such as why the item's price is appropriate. In addition, state agencies are typically authorized to make sole-brand purchases with higher values than are allowed for noncompetitive purchases. For example, when making a sole-brand purchase of information technology goods and services, the purchase limit is \$500,000, but the limit for making a noncompetitive purchase is only \$25,000. As a result, the opportunity exists for state agencies to inappropriately use the sole-brand procurement method as a way to limit competition and avoid the more restrictive criteria associated with a noncompetitive bid.

We discussed the need to review sole-brand purchases with General Services, and it agreed that the information necessary to target sole-brand procurements is not currently available. However, General Services told us that it recently added specific steps to its review procedures related to sole-brand purchases and indicated that if it determines that an individual state agency has risk in this area, General Services will include sole-brand purchases in its review.

To ensure that state agencies use the sole-brand procurement method appropriately and not in a manner to avoid the stricter justification requirements for noncompetitive procurements, we recommended that General Services study the results from its review procedures related to sole-brand purchases. Based on the results of its study, General Services should assess the necessity of incorporating specific information on sole-brand purchases into its existing procurement reporting process to evaluate how frequently and widely the sole-brand purchase method is used.

General Services' Action: Partial corrective action taken.

General Services reported that it conducted a survey during July and August 2008 and found that a significant number of state agencies conduct sole-brand procurements. General Services is drafting revisions to the State Contracting Manual to include a requirement for state agencies to justify, document, and report sole-brand procurement requests in the same manner as noncompetitive procurements.

Finding #4: The State does not have sufficient justification to cancel the CHP's handgun or TACNET™ contracts.

The State has several ways that it can end its contractual relationship with a contractor, two of which could be applicable for the contracts we reviewed. The State's standard contract provisions allow the State to terminate a contract for specified reasons, and state law provides that a contract that is formed in violation of law is void. Based on the contractors' performance under the handgun and TACNET™ contracts, our legal counsel has advised us that General Services would not have a basis for relying on the standard contract provisions to cancel these contracts. Moreover, although a broadly worded contract provision permits termination of a state contract when it is in the interest of the State, our legal counsel advised us that it is unlikely that the State could successfully cancel the handgun and TACNET™ contracts on that basis, particularly because the contractors have already provided the goods called for under the contract and have otherwise performed their duties.

In addition, although we identified deficiencies in the procurements of the handguns and TACNET™, our legal counsel advised us that those deficiencies did not violate the provisions of law that would make a contract void for a failure to comply with competitive bidding requirements. The State Administrative Manual, Section 3555, recommends, but does not require, that the statements justifying sole-brand procurements and noncompetitive bids address certain questions, such as what other comparable products were examined and why they were rejected. Because these statements are merely recommended and not legally required, a failure to provide them did not constitute a violation of law that would make these contracts void. Nonetheless, we believe that it is important for state agencies to demonstrate to General Services that they examined other comparable products and to explain why the products were rejected or, if there are no other comparable products, to explain how the state agency reached that conclusion, to ensure that competitive bidding occurs whenever possible.

To ensure that state procurements are competitive whenever possible, we recommended that General Services revise Section 3555 to require that state agencies address all of the factors listed in that section when submitting justification statements supporting their purchase estimates for noncompetitive or sole-brand procurements. In addition, if General Services believes that the law exempting provisions in the State Administrative Manual and the State Contracting Manual related to competitive procurement requires clarification to ensure that the requirements in those publications are regulations with the force and effect of law, General Services should seek legislation making that clarification.

General Services' Action: Corrective action taken.

In March 2008 General Services revised the State Administrative Manual, Section 3555, to require state agencies to fully address all of the factors listed in the section when submitting justification statements supporting a sole-brand purchase estimate. In addition, General Services reported that it issued information to state agencies explaining the need to adequately justify sole-brand procurements and gave staff additional direction for processing such requests internally. Finally, General Services told us that it believed it had sufficient enforcement authority in current statute and that additional clarifying legislation was unnecessary.

Finding #5: The CHP could not demonstrate that all employees complied with the necessary disclosures in its conflict-of-interest policies.

Although the CHP has policies on conflicts of interest, it could not show that it consistently applied those policies. The CHP carries out its conflict-of-interest procedures through employee submission of the following four documents: the Fair Political Practices Commission's (FPPC) Form 700, Statement of Economic Interests (Form 700); the secondary-employment request; the vendor/contractor/consultant business relationships memorandum (business relationships memo); and an inconsistent and incompatible activities statement. The CHP's conflict-of-interest policies and procedures rely heavily on employee disclosure, yet the policies do not encompass all of the individuals involved with its purchasing and contracting process. In addition, the CHP could not demonstrate that all employees required to do so made the necessary disclosures. As a result, neither we nor the CHP is able to fully determine whether potential conflicts of interest exist at the CHP.

For example, the CHP has not designated as Form 700 filers employees in key positions with purchasing responsibility or approval authority, such as the staff in its purchasing services unit, a position within the Office of the Commissioner that has purchasing approval authority, or positions in which employees develop product specifications used as the basis for purchasing necessary goods.

The CHP's secondary-employment policy requires its employees to disclose employment outside of the CHP by submitting a request for approval of secondary employment. The requests and the CHP's reviews give the agency an ongoing opportunity to evaluate whether employees' second jobs create a conflict of interest; however, the CHP does not always adhere to this policy. The CHP also uses a business relationships memo and its inconsistent and incompatible activities statement to inform employees of their conflict-of-interest responsibilities and remind them of the policy surrounding conflicts of interest. Based on our testing, the CHP follows its procedure for having employees sign a statement regarding inconsistent and incompatible activities, but it does not always obtain a signed business relationships memo.

Furthermore, the CHP's draft conflict-of-interest policy does not adequately define the employees and procurements to which the policy applies, nor does the policy address vendor conflicts of interest.

To ensure that it informs employees about and protects itself against potential conflicts of interest, we recommended that the CHP include as designated employees for filing the Form 700, all personnel who help to develop, process, and approve procurements. In addition, we recommended that the CHP ensure that it documents, approves, and reviews secondary-employment requests annually in accordance with its policy. We also recommended that the CHP revise its employee statement regarding conflicts of interest to include employees involved in all stages of a procurement. In addition, the CHP should reexamine its reasons for developing the conflict-of-interest and confidentiality statement for vendors, and ensure that this form meets its needs.

CHP's Action: Partial corrective action taken.

The CHP stated that its major departmental reorganization, finalized in June 2008, invalidated the draft conflict-of-interest code it had submitted to the FPPC. The CHP further noted that its Personnel Management Division has recommenced working on the conflict-of-interest code, including embarking on an extensive analysis and review of positions required to be included in the code that will require notification to be given to collective bargaining units. When submitted to the FPPC, the CHP anticipates its conflict-of-interest code will be approved and implemented by September 2009.

The CHP reported that its Office of Investigations has included in its annual citizens' complaint review an examination of secondary employment requests and that the reviews for 2008 will be complete in December 2008.

In July 2008 the CHP published its policy addressing which procurements require the Conflict of Interest Statement – Employee, and which employees are required to complete the statement.

The CHP updated the Conflict of Interest and Confidentiality Statement for its vendors and included the revised form in its Highway Patrol Manual.

Finding #6: Conflicts of interest caused General Services to declare void two motorcycle contracts.

During 2002 and 2004, General Services formed two statewide contracts with a single motorcycle dealership for CHP to acquire motorcycles for its use. These two contracts generally covered the period from January 2002 to April 2006 and allowed the CHP to purchase motorcycles as needed, for a total amount not to exceed \$13.7 million. The CHP purchased motorcycles, obtained warranty services, and exercised a motorcycle buyback provision under these contracts. However, General Services determined that the contracts were entered into in violation of the California Government Code, Section 1090, which prohibits state employees from having a financial interest in contracts they make. Therefore, in June 2005 General Services declared the contracts void.

Although General Services secured a \$100,000 monetary settlement from the motorcycle dealer, General Services did not finalize a settlement with the manufacturer, BMW Motorrad USA, a division of BMW of North America, LLC (BMW Corporation), which had provided assurances related to the contracts. The CHP estimates that it has incurred \$11.4 million in lost buyback opportunities and motorcycle maintenance costs because General Services declared the two contracts void. This estimate covers the period October 2005 to October 2007 and reflects that the CHP and General Services were not successful in securing another motorcycle contract in 2006. General Services told us in November 2007 that it had reestablished negotiations with BMW Corporation. In its initial response to this audit, General Services disclosed the BMW Corporation had no interest in buying back the existing motorcycles. We are unaware of any other points General Services and BMW Corporation may be negotiating. Therefore, it is unclear if or when a settlement will be reached and what benefits, if any, will be derived from it.

We recommended that General Services continue negotiating with BMW Corporation regarding the canceled contracts for motorcycles to develop a settlement agreement that is in the State's best interest.

General Services' Action: Corrective action taken.

General Services' disclosed that it had concluded in January 2008 its negotiations with BMW Corporation when BMW Corporation informed General Services that it had no interest in initiating a buyback program.

Finding #7: The CHP's broad policies for using its King Air aircraft may have led to some imprudent decisions.

Between 1997 and 2007, the CHP owned and operated an eight-passenger aircraft: a Beechcraft brand model A200 King Air (King Air). The CHP's policies for using the King Air consisted of both an air operations manual that applies to all of the CHP's aircraft and standard operating procedures specific to the King Air. These policies stated that the CHP could use the King Air for missions that supported the agency or for unofficial use, as authorized by the Office of the Commissioner.

Based on our review of the CHP's flight logs from calendar years 2006 and 2007, the purposes of some flights do not seem prudent. For example, the CHP's management used the King Air for two round-trips to destinations in close proximity to Sacramento. Given the State's reimbursement rate at the time of 48.5 cents per mile, the cost to the State of driving to these two locations would have been about \$150. Using the CHP's calculation from January 2005 that the King Air's operating cost was \$1,528 per hour of flight time, the cost of flying the King Air was at least \$1,980 for these two round trips, more than 13 times the cost of driving.

For 14 of the King Air's 69 mission flights during 2006, the purpose of the flight was not aligned well with the CHP's function, as its policy dictates, or for state business. For example, on one occasion, the commissioner's wife accompanied her husband and four of his staff on a round-trip flight between Sacramento and Burbank to attend a function hosted by a nonprofit organization affiliated with the CHP. Although the presence of the commissioner's wife on the flight could be questioned, the commissioner later reimbursed the State \$254, the amount of a commercial flight, for his wife's share of the flight. Furthermore, the CHP used the King Air to transport from Portland, Oregon, the family of an officer killed while on duty to that officer's memorial service and the subsequent sentencing hearing of the responsible motorist. Although we understand the CHP's desire to provide support to the officer's grieving family, the CHP's choice to use the King Air for this purpose was not the best use of a State resource. Twelve of the King Air's 69 mission flights during 2006 transported these family members to various destinations, or the flights were required to position the plane to accommodate the family's transportation. Using the CHP's operating cost calculation, the total cost of all the flights we questioned exceeded \$24,000 and, other than the reimbursement for the commissioner's wife, the CHP was not reimbursed for these costs.

To ensure that the use of state resources of a discretionary nature for purposes not directly associated with the CHP's law enforcement operations receives approval through the Office of the Commissioner, we recommended that the CHP develop procedures for producing, approving, and retaining written documentation showing approval for these uses.

CHP's Action: Partial corrective action taken.

The CHP told us that it has revised its policy to emphasize usage of state resources for business purposes and that any exceptions must be approved in writing by the Office of the Commissioner. The CHP is planning a meeting with one of its bargaining units and pending that meeting will approve the policy. CHP anticipates issuing the new policy by December 2008.

State Board of Chiropractic Examiners

Board Members Violated State Laws and Procedural Requirements, and Its Enforcement, Licensing, and Continuing Education Programs Need Improvement

REPORT NUMBER 2007-117, MARCH 2008

State Board of Chiropractic Examiners' responses as of September and December 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the State Board of Chiropractic Examiners' (chiropractic board) enforcement, licensing, and continuing education programs; to determine the role of the chiropractic board as defined by state laws and regulations and the board's policies and procedures; and to assess whether board members consistently act within their authority. The audit committee also asked us to analyze the role, function, and use of the chiropractic quality review panels (review panels) and the chiropractic board's compliance with the initiative act requirement to aid attorneys and law enforcement agencies in enforcing the initiative act.

Finding #1: The chiropractic board's lack of understanding resulted in violations of some Bagley-Keene Open Meeting Act requirements.

The Bagley-Keene Open Meeting Act (Bagley-Keene) is the state law that specifies the open meeting requirements for all boards and commissions. Between January 2006 and August 2007 some actions that board members took before and during chiropractic board meetings violated Bagley-Keene requirements. In the most egregious example, board members convened a closed-session meeting on March 1, 2007, at which they fired the former executive officer without providing written notice to her at least 24 hours in advance of the meeting. At the following public session, board members failed to disclose the action they had taken during the closed session as required by Bagley-Keene. In three earlier instances, board members held closed-session meetings to consider another personnel issue without giving the employee the required 24-hour advance written notice of the employee's right to a public hearing. The violations to Bagley-Keene nullified the decisions the board members made in the closed session regarding the former executive officer on March 1, 2007. Using remedies provided in Bagley-Keene, the board started the process over by providing proper notice to the former executive officer, holding a public hearing on March 23, 2007, regarding her continued employment with the chiropractic board, and voted to terminate her without cause. These steps fulfilled Bagley-Keene requirements.

Board members also violated Bagley-Keene requirements that allow the board to hold closed sessions in limited circumstances. Although the chiropractic board's December 2006 meeting agenda included a closed-session item for discussion of personnel matters—a topic allowed in closed session—the board's closed session discussion did not include personnel matters and in fact did not meet any of the criteria for a closed session.

Audit Highlights . . .

Our review of the State Board of Chiropractic Examiners' (chiropractic board) enforcement, licensing, and continuing education programs and the role and actions of the chiropractic board members revealed the following:

- » *Board members' lack of understanding about state laws related to their responsibilities as board members, including the Bagley-Keene Open Meeting Act, resulted in some violations of state law and other inappropriate actions.*
- » *The chiropractic board did not ensure that its designated employees, including board members, complied with the reporting requirements of the Political Reform Act of 1974.*
- » *Board members inappropriately delegated responsibility to approve or deny licenses to chiropractic board staff.*
- » *The chiropractic board has not developed comprehensive procedures, such as the length of time it should take to process complaints and, as a result, staff do not always process complaints promptly.*
- » *The board's weak management of its enforcement program may have contributed to inconsistent treatment of complaints as well as unreasonable delays in processing.*
- » *The chiropractic board does not ensure that staff process priority complaints promptly. Of 11 priority complaints we reviewed, staff took from one to three years to process nine of them.*

continued on next page . . .

- » *Although the chiropractic board's regulations require that it establish chiropractic quality review panels, it has never complied with its regulation.*
- » *The chiropractic board has insufficient control over its licensing and continuing education programs.*

We found other examples of actions that risked violating Bagley Keene. Specifically, for the 13 board meetings held between January 2006 and August 2007, the guest register did not indicate that signing in was voluntary. By not doing so, it is violating Bagley-Keene requirements and is not serving the interests of the general public or the public's ability to monitor and unconditionally participate in the decision-making process. Staff modified the sign-in sheet to indicate that it is voluntary to sign in before attending the meeting and began using the modified sign-in sheet at the 2008 board meetings. In addition, the chiropractic board does not have a mechanism in place to document its compliance with the Bagley-Keene requirement that it provide public notice of chiropractic board meetings at least 10 days in advance. Finally, the minutes of chiropractic board meetings, videotapes, and e-mail correspondence reflect a number of instances when board members disregarded warnings and engaged in communications that could have triggered violations of Bagley-Keene requirements. Although these instances are not violations, they demonstrate that board members disregarded warnings and risked violations.

We recommended that the chiropractic board continue to involve legal counsel in providing instruction and training to board members at each meeting. We also recommended that the chiropractic board continue to retain documentation of the steps it takes to publicly announce its meeting.

Chiropractic Board's Action: Corrective action taken.

According to the chiropractic board, in March 2007 it recognized that board members did not fully understand the requirements of Bagley-Keene and in April 2007 the former chair instructed the acting executive officer to place Bagley-Keene training on the agenda of every board meeting. The chiropractic board's legal counsel provides interactive training at each board meeting, which is documented in the meeting minutes. In addition, to confirm the timely postings of board meeting agendas, the chiropractic board instituted a checklist that is signed by the board member liaison and confirmed by the executive officer. The board member liaison also prints the agenda from the Web site, which includes the posting date.

Finding #2: Board members lack knowledge of the California Administrative Procedure Act.

The California Administrative Procedure Act (administrative procedure act) is the state law that prohibits ex parte communication.¹ If ex parte communication occurs, the board member involved may be required to stop participating in the case and disclose that a communication violation occurred. We found instances where board members invited ex parte communication by referencing a pending accusation and by encouraging licensees to contact the board members

¹ Ex parte communication is direct or indirect communication with a board member, outside the formal hearing process by agency staff or anyone having an interest in a pending licensing or disciplinary matter that affects the rights of individuals who appear before board members, about an issue in the case, without providing notice and an opportunity for all parties to participate in the communication.

if their problems were not addressed by staff.² Board members also invited ex parte communications when they inappropriately inserted themselves into the chiropractic board's enforcement process by asking to discuss and receive information from staff about enforcement cases during board meetings. When board members invite ex parte communication, they risk receiving impermissible communications about pending enforcement cases and not being impartial when or if they hear a matter that comes before the board.

Moreover, at the December 2006 meeting, a board member presented a proposal to amend board regulations to improperly give board members the authority to both file accusations and judge their merit. When board members have the option to be involved in filing an accusation, it could threaten the fairness and transparency of a case if it later comes before the board members for formal disciplinary action.

We recommended that the chiropractic board members limit their communications related to board business so they do not engage in ex parte communications or compromise their ability to fulfill their responsibilities in enforcement hearings.

Chiropractic Board's Action: Partial corrective action taken.

In its response to the audit report, the chiropractic board reported that since April 2007, the board members have received extensive training on the requirements of Bagley-Keene and the administrative procedure act. The chiropractic board also reported that board members are committed to conducting themselves in accordance with laws related to ex parte communications and seeking legal advice whenever they have a question. The minutes of the May 2008 board meeting reflect one of the board members asking the board's legal counsel how board members recuse themselves from an agenda item. Based on our review of the chiropractic board's meeting minutes from May, July, and September 2008, the chiropractic board's legal counsel continues to guide and instruct the board members on appropriate actions related to their duties governed by the administrative procedure act. However, the board's response did not address whether any attempts at inappropriate communication have occurred and what the board members did to avert it if, in fact, such communication was attempted.

Finding #3: The chiropractic board did not fully comply with the requirements of the Political Reform Act of 1974.

The Political Reform Act of 1974 (political reform act) is the central conflict-of-interest law governing the conduct of public officials in California. Under the political reform act, the chiropractic board must ensure that board members and designated employees comply with the act's reporting and disclosure requirements. The chiropractic board lacks adequate controls to ensure that its designated employees, including board members, comply with the reporting requirements. Specifically, the chiropractic board did not ensure that all designated employees and board members filed statements of economic interests as required and on time. For example, nine of the 16 employees and board members we reviewed filed their statements of economic interests after the deadline. The political reform act also requires the board to designate one employee as a filing official and give that employee the responsibility of ensuring that the chiropractic board meets the requirements of the political reform act, and state regulation requires the filing official to carry out specific duties. However, the employee whom the chiropractic board designated as its filing official asserted she was unaware of her role and responsibilities. Because the chiropractic board did not implement proper protocols to ensure that the employee it designates as the filing official is notified of his or her appointment and responsibilities, it cannot be sure that it meets all the requirements of the political reform act. Furthermore, because it did not ensure that all designated employees and board members filed statements of economic interests, and that all designated employees and board members filed them correctly or on time, the chiropractic board may be unaware of conflicts of interest.

² An accusation is a written statement of charges against a licensee that specifies the laws and regulations allegedly violated.

In addition, some employees appeared to make decisions on behalf of the chiropractic board and the board had not required them to file statements of economic interests. Because the chiropractic board has not established policies and procedures to adequately ensure that only designated employees make critical decisions, or at least review and approve decisions made by employees in nondesignated positions, it cannot ensure that it prevents potential conflicts of interest.

We recommended that the chiropractic board ensure that its filing official is aware of the role and responsibilities of the position and, similarly, promptly inform anyone replacing the filing official. We also recommended that the board establish an effective process for tracking whether all designated employees, including board members, have completed and filed their statements of economic interests on time, thereby identifying potential conflicts of interest. Additionally, we recommended that the chiropractic board periodically review its employees' responsibilities to ensure that all individuals who are in decision-making positions are listed as designated employees in its conflict-of-interest code.

Chiropractic Board's Action: Partial corrective action taken.

The board's executive officer updated the filing officer's duty statement and explained the role, duties, and responsibilities of the position to the employee. According to the chiropractic board, in February 2008, the filing officer attended training provided by the Fair Political Practices Commission on the role of a filing officer. In addition, the chiropractic board established written procedures and a tracking tool to ensure that designated employees, including board members, complete and file their statements of economic interests on time. The written procedures also include a provision for the filing officer to meet with the executive officer annually to review the chiropractic board's conflict-of-interest code to ensure that individuals in decision-making positions are given notification of the filing date. Because the expected time for this meeting had not occurred when the board provided its response, the board has not had the opportunity to document that it has implemented this procedure.

Finding #4: Board members did not always understand other legal requirements.

In the minutes of certain meetings of the chiropractic board and in several communications among board members, the executive officer, and the deputy attorney general, board members attempted actions that were inappropriate. For example, at the June, August, and September 2006 meetings of the chiropractic board, a single personnel matter was on the agenda and discussed during closed session. On November 20, 2006, the board chair responded in an e-mail to a request from a board member for further discussion on the matter. The board chair explained the item had already been discussed at the last meeting and that further action would violate the employee's due process rights as a civil service employee. When board members do not understand the legal requirements of the chiropractic board, they may not always comply with state laws and requirements or serve the best interests of the public.

In October 2007 board members adopted an administrative manual to serve as a guide for board members. The new manual outlines board policies, procedures, and state laws that govern chiropractic board business.

We recommended that the chiropractic board members continue to use their newly adopted administrative manual as guidance for conducting board business and to continue improving their knowledge and understanding of state laws and board procedures.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board stated that it plans to update its administrative manual as needed to address issues as they arise. The chiropractic board provided minutes from its March 2008 board meeting, which indicated the board members voted to update the administrative manual.

Finding #5: Board members inappropriately delegated their responsibility to approve license applications to staff.

Staff reviewed license applications and made decisions to issue licenses without the approval of board members, contrary to the requirements of the Chiropractic Initiative Act of California (initiative act). Additionally, whenever a license applicant did not request a formal hearing to appeal a denial, board members did not review and approve that denial, as the initiative act requires. The initiative act does not contain provisions that allow the chiropractic board to delegate to staff the authority to approve or deny licenses. Because staff rather than board members made final decisions to approve licenses and board members did not review staff-determined denials when applicants did not formally appeal those denials, the chiropractic board did not comply with the initiative act. Our legal counsel has advised us that board members could easily remedy this noncompliance by subsequently ratifying any license approvals and denials granted by staff, thus making those approvals and denials their responsibility.

We recommended that the chiropractic board modify its current process so that board members make final decisions to approve or deny all licenses. Additionally, we recommended that board members ratify all previous license decisions made by staff.

Chiropractic Board's Action: Partial corrective action taken.

In its May 2008 response, the chiropractic board provided meeting minutes showing that the board members voted to ratify license approvals granted by staff since July 1, 2007. Additionally, our review of the board's July and September 2008 meeting minutes found that board members voted to ratify staff approvals of licenses.

In December 2008 the chiropractic board reported that it had established procedures that include the board members ratifying staff denials of applicants who did not request a hearing in response to a denial. The chiropractic board reported that in those instances when an applicant requests a hearing, the board members review and vote on a proposed decision of an administrative law judge. The chiropractic board provided us with a copy of its procedures, dated December 2008, demonstrating the establishment of these procedures. However, as of December 2008, the board had not yet voted to ratify staff denials of licenses.

Finding #6: Board members do not use state e-mail accounts when conducting board business.

As a state agency, the chiropractic board is subject to the Public Records Act (public records act), which requires a state agency to respond to all requests for public records and defines public records as any writing containing information relating to the conduct of the public's business and includes electronic mailings. When the chiropractic board receives a public records request, it must notify the requester within 10 days whether it has records that may be disclosed in response to the request, and the board must provide an estimate as to when it can provide disclosable records. The executive officer told us that the chiropractic board had not considered assigning state e-mail accounts to board members and that this is consistent with all other licensing boards within the Department of Consumer Affairs (Consumer Affairs). However, he agreed that the concept might improve board governance and will be a proposed agenda item for the board's administrative committee. Because board members do not use state e-mail accounts when conducting board business, we question how the chiropractic board can ensure that it fully complies with public records requests and the prompt time frames required to respond to such requests. We also questioned how the chiropractic board ensures the protection of any confidential information board members might have or discuss by e-mail.

We recommended that the chiropractic board consider providing state e-mail accounts to board members to enable them to conduct their chiropractic board business in a secure and confidential environment and make their actions and correspondence accessible when requested in accordance with the public records act.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board voted at its May 2008 board meeting to approve the chiropractic board's implementation of state e-mail accounts for board members effective June 1, 2008. According to the chiropractic board, it initially established e-mail accounts for each of the board members around the beginning of June 2008. However, due to problems with the chiropractic board's transition to a new e-mail system approximately one month later, the chiropractic board has transitioned only board staff to ensure that daily operations were not affected. The chiropractic board plans to train the board members and fully implement this recommendation by January 1, 2009.

Finding #7: Staff could not demonstrate that all board members received copies of Bagley-Keene, attended training required by state law, and received appropriate orientation.

Although state law requires that board members receive copies of Bagley-Keene on their appointment to office, staff were unable to show us that the chiropractic board consistently met that requirement. Staff could demonstrate that only three of the 12 board members who held office during the period we reviewed received a copy of Bagley-Keene within one month of their appointments. The former executive officer also asserted that she maintained a separate file and checklist for each board member that indicated the documents provided to the new appointee, but current staff could not locate those files. Staff retained the board member appointment checklists to document the information they provided to the three most recently appointed board members. Staff also could not always demonstrate that board members attended required ethics training within the prescribed deadline. State law requires board members and designated employees to receive ethics training within six months of assuming office and every two years thereafter. Further, state law requires each state agency to maintain records of ethics training attended by its board members and designated employees for at least five years.

Board members have not attended sexual harassment prevention training as required by state law. Staff were also unable to show that all board members received appropriate orientation within a reasonable time after their appointments to office. Although all but one of the 12 board members who held office during our review period attended orientation, one board member attended the orientation nearly two years after assuming office, and another was in office for four years before attending orientation. Best practices indicate that new board members should receive orientation within one year of assuming office.

Because the chiropractic board does not have policies and procedures for keeping records that board members have received required training or appropriate orientation, it cannot demonstrate its compliance with state laws or that it follows best practices. The executive officer told us that as of October 2007 all new board members will attend the orientation that Consumer Affairs provides within one year of assuming office. If board members do not receive required and appropriate training or receive it late, they are less able to fulfill their responsibilities to the public during their period of service on the board.

We recommended that the chiropractic board ensure that staff retain documentation when they provide a copy of Bagley-Keene to a newly appointed board member. We also recommended that the chiropractic board continue to use the member appointment checklist and establish procedures to periodically record and monitor board member training and to continue to send new board members to the orientation that Consumer Affairs provides.

Chiropractic Board's Action: Partial corrective action taken.

In its response to the audit report, the chiropractic board stated that in approximately March 2007, the board member liaison began maintaining a file that documents when copies of Bagley-Keene are provided to board members. Additionally, in its subsequent responses the chiropractic board provided us with documentation of its board member appointment checklist and stated that it plans to develop written procedures for recording and monitoring board member training by the end of December 2008. The chiropractic board also plans to update its board member

administrative manual to include a list of required training with specific time frames. Finally, the chiropractic board reported that all current board members have completed orientation training and the three newest board members completed the training within the first year of appointment.

Finding #8: Lack of standard procedures and management oversight resulted in slow resolution of many complaints we reviewed.

Because the chiropractic board lacks adequate internal controls over its complaint review process, it cannot ensure that its staff process consumer complaints accurately and promptly. Although the chiropractic board has established some policies and procedures for how it processes complaints, it has not developed benchmarks for the length of time it should take to complete various phases of the complaint review process. Our review of 25 complaints found many instances where the chiropractic board failed to take action on complaints for excessive periods of time in all phases of the complaint process, including the initial opening of the complaint, referring complaints to contracted investigators, obtaining investigation reports, referring complaints to experts, and closing complaints. In addition, management generally did not review the complaints or staff decisions on those complaints to determine whether staff processed them promptly and correctly. When the chiropractic board unreasonably delays processing complaints, it allows chiropractors accused of violating chiropractic laws and regulations—including those accused of what the chiropractic board considers the most egregious violations—to continue practicing longer than necessary without the violations being addressed, potentially exposing the public to further risk. In addition, when the board does not ensure that staff properly document decisions made and actions taken on complaint cases, it is unable to justify the length of time it takes to process complaints.

The initiative act requires the chiropractic board to assist attorneys and law enforcement agencies in enforcing the act's provisions. Although the executive officer told us that all staff are expected to cooperate fully with other law enforcement agencies when called on to assist, the chiropractic board has not established the types of complaints and evidence that should exist before referring cases to law enforcement agencies or attorneys. Because of this and the lack of benchmarks, two of the 25 complaints we reviewed that the chiropractic board referred to the attorney general were 655 and 844 days old, respectively. When the chiropractic board does not promptly refer complaints to the attorney general, it may not enable the attorney general to file viable accusations within reasonable periods of time and thus allows licensees who may pose a threat to the public to continue practicing.

We recommended that the chiropractic board develop procedures to ensure that staff process and resolve complaints as promptly as possible by establishing benchmarks and more-structured policies and procedures specific to each step in its complaint review process. We also recommended that the chiropractic board establish time frames for staff to open a complaint case, complete an initial review, refer the case to an investigator or expert if necessary, and close or otherwise resolve the complaint by implementing informal discipline or referring for formal discipline to ensure that all complaint cases move expeditiously through each phase of the complaint review process. In addition, we recommended that the chiropractic board periodically review the status of all open complaints and investigations and identify and resolve any delays in processing. Finally, we recommended that the chiropractic board strengthen its enforcement policies and procedures to minimize the amount of time it takes staff to process consumer complaints before forwarding them to the attorney general or other law enforcement agency to ensure that it adequately assists attorneys and law enforcement agencies in enforcing the laws relating to the practice of chiropractic.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of its new detailed procedures, dated September 2008, for staff to process and resolve complaints as promptly as possible. The procedures provide guidance for staff on various steps in the complaint process, including complaint intake, complaint analysis, criminal filings, information and fact gathering, complaint closure and recommendations, case referrals, and arrest and conviction cases. Additionally, the procedures establish time frames for

the phases of the complaint review process, including minimizing the amount of time it takes staff to process complaints before forwarding them to the attorney general or other law enforcement agency. Finally, the chiropractic board provided a copy of its new monitoring procedures and responsibilities, dated September 2008, for managers to use to periodically review the status of all open complaints and investigations and to resolve delays in processing. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #9: The chiropractic board's enforcement procedures do not provide sufficient guidance to staff processing complaints.

Although the chiropractic board has some good enforcement procedures, it has not established adequate policies and procedures to ensure management oversight of complaint processing and resolution. For instance, it does not ensure that only designated employees make final decisions on cases or that such decisions are reviewed and approved by a designated manager. Without proper policies and procedures, the chiropractic board cannot ensure that staff process complaints in a consistent manner or that it avoids possible conflicts of interest in its complaint review process. Additionally, we found that the chiropractic board issued citations in two cases but failed to report the citations to other states' chiropractic boards and other regulatory agencies as required by its regulations.

The chiropractic board's current policies and procedures also do not provide clear instructions to guide staff about when it is appropriate to open and process a complaint that is internally generated. Staff opened one complaint we reviewed based on a newspaper article asserting that a chiropractor was claiming to hold an advanced degree from an unaccredited school. Despite the apparent minor nature of this internal complaint, staff spent considerable time and effort pursuing it. Nearly four months after opening the case, the executive officer advised staff that because the school was accredited at the time the degree was awarded, this was not a violation of the law and closed the case. Because it has not established clear instructions for staff to follow when considering whether they should open an internal complaint, the chiropractic board's resources are diverted from working on more serious complaints, which is not efficient.

We recommended that the chiropractic board develop policies and procedures requiring that only a manager or a designated employee are allowed to make the final decisions on complaint resolution. We also recommended that the chiropractic board develop procedures to ensure that staff report the issuance of citations to other states' chiropractic boards and regulatory agencies. In addition, we recommended that the chiropractic board develop procedures instructing staff when to open and how to process complaints generated internally.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of new procedures, dated September 2008, requiring managers or designated employees to make the final decisions on complaint resolutions. The procedures also include requirements for staff to report the issuance of citations to other states' chiropractic boards and regulatory agencies. Finally, the procedures instruct staff when to open and how to process complaints generated internally.

Finding #10: The chiropractic board's weak management of its enforcement program may have contributed to inconsistent decisions on similar cases.

The chiropractic board did not adequately supervise enforcement staff and review their decisions on cases. Specifically, many of the 25 cases we reviewed showed no evidence of management review. As a result, we found that staff resolved differently two cases alleging the same violation. However, because the chiropractic board did not clearly document its reasons for resolving each case the way it did, we were unable to determine if the resolutions were reasonable. Staff also did not always process

complaints in accordance with its internal procedures. When management does not ensure that staff process complaints consistently and according to its policies and procedures, it can result in the inefficient use of staff time and the chiropractic board may be unable to later justify decisions it made.

We recommended that the chiropractic board strengthen its existing procedures to provide guidance for staff on how to process and resolve all types of complaints and to ensure appropriate management oversight.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of new procedures, dated September 2008, for staff to follow when processing and resolving consumer complaints regarding licensees. The procedures provide guidance to staff on how to process all types of complaints and also address management oversight of the process. Although the chiropractic board has added a field operations unit to perform investigations, it has not yet provided written procedures for its field operations staff.

Finding #11: The chiropractic board's system for prioritizing consumer complaints is seriously flawed.

The chiropractic board took excessive amounts of time to process the 11 priority complaint cases we reviewed—complaints alleging sexual misconduct, gross negligence or incompetence, use of alcohol or drugs when performing the duties of chiropractic, or insurance fraud. Although the board has identified the types of complaints it considers priority, staff frequently have not labeled such complaints as priority, and the board's system for processing complaints lacks any controls to ensure that staff correctly designate complaints as priority and process them promptly. Consequently, we noted allegations of sexual misconduct or fraud that went unresolved from more than one year to more than three years, potentially leading to repeat offenses and failures by the chiropractic board to protect the public. The chiropractic board's lack of management and supervision of its enforcement staff may also contribute to the staff's failure to consistently give priority to complaints. Failing to properly assign and process priority complaints as quickly as possible undermines the board's ability to protect the public, one of its primary responsibilities.

Moreover, we found some allegations that we believe the board should be categorizing as priority or processing more diligently. For example, the board did not consider allegations of practicing without a license to be a priority. In fact, until May 2007, the chiropractic board considered those allegations to be outside its jurisdiction. Additionally, when the chiropractic board receives a malpractice settlement notification, it simply solicits the patient to file a complaint and if the patient does not file a complaint within the deadline specified, the board closes the case without any further effort to determine if the licensee deviated from the standard of care. When the chiropractic board does not give priority to processing complaints requiring priority attention or process other complaints more diligently, it may be unnecessarily putting the public at risk.

We recommended that the chiropractic board implement tracking methods, such as flagging priority cases during complaint intake, using multiple levels of priority categories, and assigning specific time frames to process those priority categories. We also recommended that the chiropractic board establish procedures that direct board management to monitor the status of open complaints regularly, especially those given priority status, to ensure that they do not remain unresolved longer than necessary.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided a copy of procedures, dated September 2008, for its complaint intake process, which outline multiple levels of priority categories for assigning to complaints received. The procedures also establish specific time frames for processing each priority level. Additionally, the chiropractic board provided a copy of procedures, dated September 2008, for managers establishing responsibility for monitoring the status of all open complaints and ensuring that cases, investigations, and applications are proceeding in an efficient and effective manner. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #12: For years the chiropractic board has not adhered to its own regulation to establish chiropractic quality review panels.

Since June 1993 the chiropractic board's regulations have required it to establish review panels throughout California. According to the historical documentation, the board's original intent was to reduce the amount of time between complaint intake and resolution. The chiropractic board planned to refer certain complaints—those alleging minor violations of the initiative act that do not meet the criteria for referral to the attorney general for formal discipline—to a program in which a less formal review and early corrective action could possibly prevent the cases from moving down the path of formal discipline. The board's rule making file shows that over the years, when changes in executive officers and board members occurred, so did priorities and efforts to establish the review panels. The chiropractic board's current executive officer does not believe the review panels are the right solution for the board. In September 2007 he prepared a memo to the chair of the board's enforcement committee recommending that the board repeal the regulation related to the review panels, citing concerns with the cost-effectiveness of review panels, the potential for the review panels to make rulings that are inconsistent with the board's enforcement policies, and the potential for the review panels to be viewed as a peer review system. Moreover, at the November 2007 board meeting, the executive officer noted that the board has considered only the options of using the chiropractic consultant or the review panels for the processing of complaints and that other options need to be considered. We recognize that the issues surrounding the review panels are not simple, but it is clear that the chiropractic board must take some action to remedy its noncompliance with its regulation. In determining what that action might be, we believe the board must consider its complaint review process more broadly. By instituting a stronger system for reviewing and taking action on complaints, the board will be better able to determine what other processes it should add to complement its ability to promptly and appropriately respond to complaints about chiropractors.

We recommended that the chiropractic board carefully consider the intended purpose of the review panels and whether implementing them is the best option to fulfill that intent. If the chiropractic board decides that another option would better accomplish the intended purpose of the review panels, we recommended that it implement the process for revising its regulations.

Chiropractic Board's Action: Corrective action taken.

At its May 2008 meeting, the chiropractic board voted to adopt regulatory language that repeals the regulation that established the chiropractic quality review panels. The chiropractic board has begun the process for making a regulatory change. Specifically, following the board's decision, staff developed and in August 2008, filed the regulation package with the Office of Administrative Law, and noticed the public pursuant to state law applicable to the rulemaking process.

Finding #13: The chiropractic board's recently vacant chiropractic consultant position leaves a gap in its available technical expertise.

The chiropractic consultant position, under the supervision of the executive officer, provided chiropractic expertise to help staff review complaints against and evaluate the professional conduct of licensees who may have violated chiropractic laws and regulations. During our review, we found that the chiropractic board's enforcement process and its staff relied heavily on the chiropractic consultant to complete its reviews and make decisions on complaints and punishment when violations occurred. The chiropractic consultant position has been vacant since August 10, 2007, and the executive officer explained that because of the current budget situation, the chiropractic board is not planning to fill the position. He also said that based on the chiropractic board's initial assessment of the enforcement program and the chiropractic consultant position in particular, it had concerns about the duties and use of the position and did not plan to fill the vacancy until a job analysis was conducted. At the same time, board members expressed concerns about filling the position before instituting a significant change in duties. Instead, the chiropractic board is developing a group of expert consultants or witnesses to bridge the gap in technical expertise. Although we acknowledge the concerns that the executive officer and board members have expressed about the chiropractic consultant position and the way that it was

relied on and used in the past, the chiropractic board can establish processes to limit the autonomy of the position while still gaining invaluable expertise that is readily available to staff rather than having to rely on referrals to outside experts. For example, the chiropractic consultant could be used much like legal counsel to provide opinions to the executive officer, who would remain the final decision maker.

We recommended that the chiropractic board fill its chiropractic consultant position. We also recommended that the chiropractic board require the chiropractic consultant to act only in an advisory capacity and the executive officer to make all final enforcement decisions.

Chiropractic Board's Action: Alternative action taken.

The chiropractic board reported that effective July 1, 2008, the chiropractic consultant position was abolished by operation of law and it does not have plans currently to reestablish the position. The chiropractic board reported that it has the technical resources necessary to investigate quality of care issues and allegations of improper treatment through a network of expert reviewers and expert witnesses. The chiropractic board developed a new expert reviewer and expert witness application to assess qualifications and identify potential conflicts of interest. According to the chiropractic board, it began recruiting candidates in April 2008, and published a manual that provides instructions, guidelines, and expectations that the experts will use to perform their services. The chiropractic board also reported that it conducted mandatory training for all the experts in conjunction with the Office of the Attorney General. The chiropractic board reported that the experts may be called upon to review a complaint prior to the board's initiating an investigation. However, most often the experts will review the evidence at the conclusion of an investigation and render an opinion. The chiropractic board management stated that it makes the final decision on all complaint cases.

Finding #14: The chiropractic board did not adequately control the use of expert witnesses.

Chiropractic board policies and procedures for assigning a complaint case to an expert require the chiropractic consultant to conduct a telephone interview to assess an expert's experience and expertise with the relevant procedure or treatment. This assists the chiropractic board in ensuring that the expert is qualified and has no conflicts or disqualifying criteria such as personal or financial conflicts of interest, complaint history, or insufficient years of practice. Our review of five complaints referred to experts revealed no evidence in the files demonstrating that staff performed telephone interviews before assigning the cases to experts. In addition, the chiropractic board told us that it does not enter into contracts with experts for services. Such contracts would include standard language that informs contracting parties about their responsibilities regarding conflicts of interest. Further, the chiropractic board does not require staff to obtain documentation from experts attesting that they are free of conflicts of interest. Therefore, we could not confirm whether the staff appropriately assigned the cases we reviewed to qualified experts who are free of conflicts of interest.

In addition, experts did not always complete their reviews within 30 days as expected. According to the chiropractic board's procedures, it expects an expert to finish reviewing the assigned case and file a written report within 30 days of assignment. In one case, the expert took more than 200 days to provide a report. Staff told us they perform no follow-up procedures, thus allowing unnecessary delays in the processing of complaints. By not ensuring that its experts adhere to the expected 30-day deadline, the chiropractic board imposes unnecessary delays in its complaint review process and may be putting the public at risk. We also found that the chiropractic board does not evaluate experts' reports as required by its policies and procedures. When the chiropractic board does not perform evaluations and record the results of the experts it uses, staff may improperly assign future cases to an expert who has not provided quality work.

We recommended that the chiropractic board establish policies and procedures requiring its staff to document interviews with experts, including the content of those discussions, to ensure that it refers cases to qualified experts with no conflicts of interest. We also recommended that the chiropractic

board consider entering into formal written contracts for services from experts or require experts to attest in writing that they have no conflicts of interest in cases assigned and strengthen its policies and procedures to ensure that its staff monitor experts on their adherence to the established 30 day deadline for reviewing complaint cases and submitting written reports. Finally, we recommended that the chiropractic board consistently evaluate experts' written reports and thoroughly document the results of the evaluations to ensure that the chiropractic board does not inappropriately refer complaint cases to experts who have not demonstrated quality work in the past.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided a copy of its application for expert witnesses as well as procedures, dated September 2008, for staff to follow when selecting, contacting, and monitoring the expert witnesses. Although the procedures require staff to document their contacts with the experts, the procedures do not require either a contract with or a written statement from the experts attesting that they have no conflict of interest in the cases assigned. The procedures do include steps and time frames for monitoring the progress of the experts. Finally, the chiropractic board established a requirement in its procedures for each expert witness to have an evaluation form completed by the referring board staff analyst after each case is returned. However, the procedures indicate that the chiropractic board has not yet developed the evaluation form.

Finding #15: Lack of documentation makes it difficult to determine the qualifications of chiropractic board staff and investigators.

Although the board's record retention schedule requires it to retain all standard personnel forms for three years after staff leaves employment, the board could not provide current job applications for six of the nine employees we reviewed. For about half of the employees, we were unable to determine whether the staff met the minimum qualifications for their classifications. The executive officer stated that he was unable to explain why the documents are unavailable because he was not employed at the chiropractic board at the time these personnel transactions occurred. For one employee, the chiropractic consultant, we were unable to determine whether the employee met the qualifications. According to the job description, the minimum qualifications for that classification are having a valid license to practice chiropractic and "five years of experience, within the last seven years, in the practice of chiropractic." The chiropractic board contracted with the Department of General Services for personnel functions until September 2006. On her application, the chiropractic consultant stated that she had been a self-employed chiropractor for the previous 17 years. However, when detailing the duties she performed, she stated she had acted as a "consultant to [the] chiropractic community" and had "limited medical-legal consultation." Because the minimum qualifications do not clearly define the phrase practice of chiropractic, we were unable to determine whether the applicant met the minimum qualifications. In contrast, the board requires an expert to have a minimum of three years of experience to be in "active practice" or retired from active practice for no more than two years at the time of appointment. This clearly articulates the requirement for the expert to be actively practicing chiropractic and seeing patients on a regular basis or recently retired from active practice. Because the job description for the chiropractic consultant does not provide this type of clarity, the chiropractic board is unable to ensure that its consultants have the type of qualifications desired.

Moreover, we were unable to determine whether the four investigators with whom the chiropractic board contracted met the minimum qualifications for the position because the board was unable to provide us with documentation to support that it verified bidders' minimum qualifications as required. The board could find only two bids, and the documentation for those did not include any information that would allow us to verify whether each investigator met the minimum qualifications. When the chiropractic board is unable to show that its investigators have the experience necessary to investigate individuals suspected of violating chiropractic law, the board may weaken its ability to defend its disciplinary actions.

We recommended that the chiropractic board retain personnel documentation on all employees according to its record retention policy and to require its contractor for personnel services to comply with the same requirements. Additionally, we recommended that the chiropractic board consider revising the chiropractic consultant position's minimum qualifications to provide additional clarity on the phrase practice of chiropractic, similar to the board's current requirements for experts.

Chiropractic Board's Action: Corrective action taken.

In its response to the audit, the chiropractic board agreed to retain personnel documentation on all employees according to its record retention policy and to require its personnel contractor to comply with the same requirements. Additionally, in a subsequent response, the chiropractic board reported that it established a personnel liaison within its office who maintains copies of job applications and other personnel documentation, pursuant to the record retention policy, for all board staff appointed after February 2008. The chiropractic board reported that its personnel liaison works closely with its personnel contractor to ensure that the contractor maintains original personnel documents pursuant to the record retention policy. The chiropractic board provided copies of personnel documents for new hires and promotions.

As discussed previously, the chiropractic board's chiropractic consultant position was abolished effective July 1, 2008, and the board does not plan to reestablish the position. Instead, the board reported that it obtains technical expertise through a network of expert reviewers and expert witnesses.

Finding #16: The chiropractic board has not established timelines for processing some applications.

When we reviewed a sample of 29 licensing decisions generally completed in fiscal year 2006–07, we found that the chiropractic board has not established policies and procedures in some areas and needs to bolster current policies and procedures in others. Specifically, the board lacks processing timelines for more than half the types of applications and petitions it processes. The chiropractic board processes some types of applications and petitions more promptly than others. For seven of the 10 chiropractic license applications we reviewed, the board failed to adhere to its established timelines for processing licensee applications. In addition, although its procedures outline specific steps for processing an applicant's request for appeal, the board has not established timelines for processing appeals. The chiropractic board has also established timelines for certain phases of processing petitions for reinstatement of a revoked license and petitions for early termination of probation, however, it does not always adhere to them. Finally, the chiropractic board also has not established time frames for processing satellite office certificates, corporation certificates, referral service applications, reciprocal licenses, and applications for restoration after license cancellation and forfeiture. When the chiropractic board does not establish goals and measures for processing applications, appeals, and petitions or work within its established time frames, it cannot measure the overall efficiency and productivity of chiropractic board staff. Additionally, unlicensed applicants are unable to begin practicing chiropractic until the board makes a final decision and notifies them.

We recommended that the chiropractic board establish time frames for all the types of applications and petitions it processes. We also recommended that the chiropractic board establish a tracking system for applications and petitions to analyze where delays are occurring and ensure that applications and petitions are processed promptly. Finally, we recommended that the board establish a time frame for resolving appeals that includes milestones for each phase of the process.

Chiropractic Board's Action: Partial corrective action taken.

The chiropractic board provided copies of procedures, dated September 2008, for staff to follow when processing licensing applications and petitions. These procedures also include time frames for processing each phase of a license denial appeal. Additionally, the chiropractic board developed tracking spreadsheets for application and petition processing to analyze where delays are occurring and ensure that applications and petitions are processed promptly. The chiropractic board

anticipated implementing the tracking spreadsheets on October 1, 2008. Because of the relative newness of these procedures, it is too early for the board to document the effect of their implementation.

Finding #17: The chiropractic board approved a reciprocal license despite evidence the applicant was practicing without a license.

For one of the two reciprocal license applications we reviewed that the board approved in fiscal year 2006–07, we question the chiropractic board’s decision to grant a reciprocal license without first resolving questions raised by its investigation into a complaint against the individual. Even though the applicant met the minimum licensing requirements, our review of the applicant’s file indicated that the chiropractic board had received a complaint in June 2005, before the applicant applied for a reciprocal license, alleging that the applicant was practicing without a chiropractic license. In October 2006, 16 months after receiving the complaint, the chiropractic board referred it to an investigator. Based on his visit to the business location, the investigator concluded that the applicant “is in all probability conducting chiropractic services at [the] location” and recommended that the board subpoena patient records or allow him to conduct an undercover operation. However, the chiropractic board elected to approve the applicant for licensure.

We recommended that the chiropractic board develop specific policies and procedures for staff to follow when the board receives a complaint against an applicant seeking licensure.

Chiropractic Board’s Action: Corrective action taken.

The chiropractic board provided a copy of specific procedures, dated September 2008, for staff to follow when addressing complaints against an applicant seeking licensure.

Finding #18: The chiropractic board lacks documentation to show it verified the status of licenses before approving applications.

State law and board regulations require each shareholder of a chiropractic corporation and each participating member of a referral service to hold a valid chiropractic license. The chiropractic board’s procedures require staff to ensure that applicants for corporation and satellite office certificates and referral services hold valid chiropractic licenses. In our review of certificates the chiropractic board approved in fiscal year 2006–07, we found that none of the four satellite office certificate application files and only one of the four corporation certificate application files contained documentation indicating that staff verified the eligibility of the chiropractors’ licenses before approving the applications. Licensing staff asserted that they followed the verification process, indicating that they either shredded the documents they reviewed or performed reviews using electronic files. However, to the extent it does not retain documentation, the board cannot demonstrate that it complied with procedures designed to protect consumers.

In addition, we reviewed the most recent referral service application the chiropractic board approved, which was in 2005. The board’s documentation did not clearly demonstrate which chiropractors it approved to participate in the referral service. When the chiropractic board does not retain documentation of its efforts to verify licenses of referral service license applicants, it cannot demonstrate that its approval was proper.

We recommended that the chiropractic board implement a standard of required documentation that includes identifying when and who conducted eligibility verifications.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of specific procedures, dated September 2008, which include required documentation identifying when and who conducted eligibility verifications.

Finding #19: The chiropractic board can strengthen its administration of forfeited licenses by improving procedures.

We found one instance where the chiropractic board's inadequate procedures for handling invalid payments from licensees resulted in staff making several errors in processing one of the two applications for license restoration that we reviewed. Specifically, staff did not place the license in forfeiture status and collect penalty payments, and they did not always follow up with the licensee promptly. The initiative act states that the failure, neglect, or refusal of any person holding a license or certificate to pay the annual fee during the time the license remains in force shall, after a period of 60 days from the last day of the month of his or her birth, automatically forfeit the license or certificate, and it shall not be restored except on the written application and payment of a fee equal to twice the annual amount of the renewal fee. However, the chiropractic board's procedures do not provide guidance on how to handle forfeited licenses. As a result of its poor administrative practices, staff inappropriately allowed a license to remain on active status for 447 days longer than it should have and failed to collect \$300 in penalty payments.

We recommended that the chiropractic board establish specific procedures for staff to follow when a licensee submits invalid payment with a license renewal. We also recommended that the chiropractic board establish a tracking method to ensure that requests for repayment are sent promptly and all penalties are paid.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided copies of specific procedures, dated September 2008, for staff to follow when a licensee submits an invalid payment when renewing a license. The procedures also include a tracking spreadsheet for staff to document and ensure that requests for repayments are sent promptly.

Finding #20: The chiropractic board did not follow regulations and written policies and procedures in administering its continuing education program.

The chiropractic board's regulations require continuing education providers (providers) to submit applications in which they outline their objectives and commit to conform to the standards specified in the continuing education regulations. Subsequent to the initial approval of a provider, the chiropractic board requires that the provider also seek approval for each course it wishes to offer licensed chiropractors for continuing education. Staff told us in July 2006 the chair of the continuing education committee and the executive officer instructed staff to stop forwarding provider applications to board members for final review. However, because the chiropractic board has not taken formal action to change its regulation, the current process is not in compliance with existing chiropractic board regulations. As a result, the chiropractic board may be challenged for failure to comply with its own regulations. According to our legal counsel, the chiropractic board can remedy this problem by ratifying any provider application approvals granted by staff at a subsequent board meeting, but in the absence of that ratification, the approvals may be subject to challenge.

We also found one instance when a provider did not include five of the required 10 points in the mission statement included in his application, but the chiropractic board ultimately approved the applicant. According to staff, the chiropractic board does not necessarily require all 10 points to be included, even though its regulations indicate that each is required. Because the board's regulations specify what is to be included in a mission statement, we believe staff should uniformly apply that criteria in determining whether the applicant should be approved as a provider.

Further, although the chiropractic board must notify applicants that their provider applications are incomplete within three weeks of receipt, for one of the two incomplete provider applications that it eventually denied, the chiropractic board notified the applicant of the deficiencies 28 days after receiving the application. Chiropractic regulations also state that each provider submitting a completed application will be provided “notification of the board’s decision . . . in writing within two weeks following the board meeting.” The chiropractic board did not comply with this regulation for six of the 10 approved provider applications we reviewed.

Chiropractic board regulations also require that provider applications include certain documentation to prove the provider has furnished education to licensed health care professionals for the five consecutive years immediately preceding the date of the application. For one of the 10 approved provider applications we reviewed, the chiropractic board could not locate the relevant documentation. When the chiropractic board does not retain documentation indicating providers’ eligibility and experience to teach continuing education courses, it is unable to defend its decisions to approve providers.

Finally, the chiropractic board’s regulations require each approved provider to furnish the board with a roster of persons completing each course within 60 days of course completion. However, board staff do not always ensure that providers comply with this requirement. When the chiropractic board does not ensure that providers promptly submit attendance logs, it may be unable to corroborate information regarding completion of continuing education requirements for license renewal.

We recommended that the chiropractic board ensure its continuing education program complies with current regulations including requiring board members to ratify staff approvals of providers and ensuring that its process to approve providers conforms to its regulations. We also recommended that the chiropractic board comply with requirements for notifying a provider of board approval within two weeks following a scheduled board meeting and for notifying a provider of application deficiencies within three weeks of receiving the application. In addition, we recommended that the chiropractic board establish a process to track and monitor whether providers submit attendance rosters within 60 days of course completion.

Chiropractic Board’s Action: Partial corrective action taken.

Regarding the recommendation of having board members ratify staff approvals of continuing education providers, at the July 2008 board meeting, the executive officer stated that board approval of course providers would be a standing agenda item. The meeting minutes for September 2008 indicate that the board members voted to approve the list of staff-approved continuing education course providers.

The chiropractic board provided a copy of its procedures, dated December 2008, related to our recommendation that it comply with requirements for notifying providers of board member approval within two weeks following a scheduled board meeting and for notifying providers of application deficiencies within three weeks of receiving the application. The chiropractic board reported that it plans to demonstrate compliance with these requirements by retaining copies of the written correspondence beginning in January 2009. Finally, the chiropractic board provided a copy of its procedures, dated September 2008, which include a tracking spreadsheet for documenting the timing of receipt of attendance rosters from continuing education providers.

Finding #21: Some of the chiropractic board’s audits do not conclusively show that licensees met their continuing education requirements.

Its regulations require the chiropractic board to conduct random audits of active licensees to verify their compliance with continuing education requirements. The chiropractic board’s record retention schedule does not specifically address the retention of licensee audits; it does indicate, however, that the board will retain license files permanently. Because license files include renewal documents, we would expect an audit to become part of a licensee’s file. We randomly selected for review 19 licensee audits that staff performed during fiscal year 2006–07. The chiropractic board could not provide

documentation for three of the licensee audits we selected, and for another 10 audits, the board did not retain copies of the top portion of the audit notification letters that informs the licensee about the audit and requests proof of continuing education by a specified date. In two other cases, the chiropractic board inappropriately concluded licensee audits. As a result of the errors made in reviewing the audit results in these cases, staff did not forward the licensees' audit results to the enforcement unit for possible disciplinary action, as they should have. When the chiropractic board does not follow its procedures to verify information it receives from the audited licensees, it fails to adequately ensure that licensees are taking the necessary continuing education courses to practice in California.

We recommended that the chiropractic board establish procedures for maintaining accurate documentation of continuing education audits of licensees. We also recommended that the board establish a mechanism to ensure that all relevant steps are taken before continuing education audits are considered complete.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided a copy of its procedures, dated September 2008, for staff to follow when completing continuing education audits of licensees. Further, the procedures include a tracking spreadsheet for staff to record the completion of relevant steps before considering the audit complete.

Finding #22: The chiropractic board has not established complete procedures for its audits of continuing education courses.

The chiropractic board's regulations allow any board member or board designee to inspect or audit any approved chiropractic course in progress. Course audits are similar to class evaluations and cover topics such as the registration process, appropriateness of subject matter, and evaluation of the instructor's teaching style. Although the board conducts some course audits, we were unable to determine the total number of audits it performed because it does not track such audits. Of the five course audits conducted between February 2005 and June 2007 that we reviewed, only one reported negative results, and the chiropractic board did not follow up on them. Although chiropractic board regulations give it the power to withdraw approval of any continuing education course, staff told us the board has no procedures for responding to a negative course evaluation. As a result, the chiropractic board did not take any corrective action, thus missing an opportunity to improve the continuing education courses available to its licensed chiropractors.

We recommended that the chiropractic board establish a process to track course audits conducted and a procedure for taking corrective action when the course reviewer identifies a deficiency.

Chiropractic Board's Action: Corrective action taken.

The chiropractic board provided a copy of its procedures, dated September 2008, for staff to record course audits conducted. The procedures also include a process for referring course complaints for further review and action.

Electronic Waste

Some State Agencies Have Discarded Their Electronic Waste Improperly, While State and Local Oversight Is Limited

REPORT NUMBER 2008-112, NOVEMBER 2008

Responses from eight audited state agencies as of November 2008

The Joint Legislative Audit Committee asked the Bureau of State Audits to review state agencies' compliance with laws and regulations governing the recycling and disposal of electronic waste (e-waste). The improper disposal of e-waste in the State may present health problems for its citizens. According to the U.S. Environmental Protection Agency (USEPA), computer monitors and older television picture tubes each contain an average of four pounds of lead and require special handling at the end of their useful lives. The USEPA states that human exposure to lead can present health problems ranging from developmental issues in unborn children to brain and kidney damage in adults. In addition to containing lead, electronic devices can contain other toxic materials such as chromium, cadmium, and mercury. Humans may be exposed to toxic materials from e-waste if its disposal results in the contamination of soil or drinking water.

Finding #1: State agencies appear to have improperly discarded some electronic devices.

In a sample of property survey reports we reviewed, two of the five state agencies in our audit sample—the Department of Motor Vehicles (Motor Vehicles) and the Employment Development Department (Employment Development)—collectively reported discarding 26 electronic devices in the trash. These 26 electronic devices included such items as fax machines, tape recorders, calculators, speakers, and a videocassette recorder that we believe could be considered e-waste. The property survey reports for the other three state agencies in our sample—the California Highway Patrol (CHP), the Department of Transportation (Caltrans), and the Department of Justice (Justice)—do not clearly identify how the agencies disposed of their electronic devices; however, all three indicated that their practices included placing a total of more than 350 of these items in the trash.

State regulations require waste generators to determine whether their waste, including e-waste, is hazardous before disposing of it. However, none of the five state agencies in our sample could demonstrate that they took steps to assess whether their e-waste was hazardous before placing that waste in the trash. Further the California Integrated Waste Management Board (Waste Management Board) has advised consumers, "Unless you are sure [the electronic device] is not hazardous, you should presume [that] these types of devices need to be recycled or disposed of as hazardous waste and that they may not be thrown in the trash."

Audit Highlights . . .

Our review of five state agencies' practices for handling electronic waste (e-waste) revealed that:

- » *The Department of Motor Vehicles and the Employment Development Department improperly disposed of electronic devices in the trash between January 2007 and July 2008.*
- » *The California Highway Patrol, Department of Transportation, and Department of Justice did not clearly indicate how they disposed of some of their e-waste; however, all indicated that they too have discarded some e-waste in the trash.*
- » *The lack of clear communication from oversight agencies, coupled with some state employees' lack of knowledge about e-waste, contributed to these instances of improper disposal.*
- » *State agencies do not consistently report the amount of e-waste they divert from municipal landfills. Further, reporting such information on e-waste is not required.*
- » *State and local oversight of e-waste generators is infrequent, and their reviews may not always identify instances when state agencies have improperly discarded e-waste.*

To avoid contaminating the environment through the inappropriate discarding of electronic devices, we recommended that state agencies ascertain whether the electronic devices that require disposal can go into the trash. Alternatively, state agencies could treat all electronic devices they wish to discard as universal waste and recycle them.

State Agencies' Actions: Pending.

According to their responses to our audit report, the five state agencies we sampled—CHP, Motor Vehicles, Caltrans, Employment Development, and Justice—indicated that they were taking steps to implement our recommendation. CHP stated that it will establish internal policies and procedures to ensure future compliance with e-waste standards. Motor Vehicles stated that as of August 1, 2008, its property and equipment control unit does not allow any electronic equipment to be disposed of in a landfill; it donates this equipment to public schools or, if in bad condition, disposes of it through a recycler that will properly dispose of the equipment. Caltrans stated that it will issue a memorandum to staff responsible for e-waste disposal, clarifying responsibilities and providing direction on implementation of new electronic disposal procedures to include managing all electronic equipment as if it contains hazardous waste. Employment Development stated that it will evaluate the opportunity to dispose of all its electronic devices as universal waste. Finally, Justice stated that it concurs with the report's recommendations and will continue to dispose of surplus equipment through recycling.

Finding #2: Opportunities exist to efficiently and effectively inform state agencies about the e-waste responsibilities.

Because all five state agencies in our sample had either discarded some of their e-waste in the trash or staff asserted that the agencies had done so, we concluded that some staff members at these agencies may lack sufficient knowledge about how to dispose of this waste properly. We therefore examined what information oversight agencies, such as the Department of Toxic Substances Control (Toxic Substances Control), the Waste Management Board, and the Department of General Services (General Services) provided to state agencies and what steps state agencies took to learn about proper e-waste disposal. Staff members at the five state agencies we reviewed—including those in charge of e-waste disposal, recycling coordinators, and property survey board members who approve e-waste disposal—stated that they had received no information from Toxic Substances Control, the Waste Management Board, or General Services related to the recycling or disposal of e-waste.

Further, based on our review of these three oversight agencies, it appears they have not issued instructions specifically aimed at state agencies describing the process they must follow when disposing of their e-waste. At most, we saw evidence that General Services and the Waste Management Board collaborated to issue guidelines in 2003. These guidelines state: "For all damaged or nonworking electronic equipment, find a recycler who can handle that type of equipment." However, the Waste Management Board indicated that state agencies are not required to adhere to these guidelines; General Services deferred to the Waste Management Board's opinion.

Alternatively, some state agencies we spoke with learned about e-waste requirements through their own research. For example, the recycling coordinator at Justice conducted her own on-line research to identify legally acceptable methods for disposing of e-waste. Through her research of various Web sites at the federal, state, and local government levels, she determined which electronic devices Justice would manage as e-waste and located e-waste collectors who would pick up or allow Justice to drop off its e-waste at no charge.

While Justice's initiative is laudable, we believe that it is neither effective nor efficient to expect staff at all state agencies to identify e-waste requirements on their own. Some state agencies may not be aware that it is illegal to discard certain types of electronic devices in the trash, and it may never occur to them to perform such research before throwing these devices away. Further, having staff at each of the more than 200 state agencies perform the same type of research is duplicative.

The State could use any of at least five approaches to convey to state agencies more efficiently and effectively the agencies' e-waste management responsibilities. One approach would be to have Toxic Substances Control, the Waste Management Board, or General Services, either alone or in collaboration with one or more of the others, directly contact by mail, e-mail, or other method the director or other appropriate official, such as the recycling coordinator or chief information officer, at each state agency conveying how each agency should dispose of its e-waste. Other approaches include:

- Having the Waste Management Board implement a recycling program for electronic devices owned by state agencies.
- Including e-waste as part of the training related to recycling provided by the Waste Management Board.
- Having General Services, Toxic Substances Control, and the Waste Management Board work together to amend applicable sections of the State Administrative Manual that pertain to recycling to specifically include electronic devices.
- Modifying an existing executive order or issuing a new one related to e-waste recycling that incorporates requirements aimed at e-waste disposal.

To help state agencies' efforts to prevent their e-waste from entering landfills, we recommended that Toxic Substances Control, the Waste Management Board, and General Services work together to identify and implement methods that will communicate clearly to state agencies their responsibilities for handling and disposing of e-waste properly and that will inform the agencies about the resources available to assist them.

State Agencies' Actions: Pending.

The three oversight agencies included in our audit concurred with our recommendation and agreed to work collaboratively with each other to implement solutions for ensuring that e-waste from state agencies is managed legally and safely. Further, General Services stated that after consulting with other entities, it will amend applicable sections of the State Administrative Manual to ensure that they clearly require the recycling or disposal of e-waste in accordance with applicable laws, regulations, and policies.

Finding #3: State agencies report inconsistently their data on e-waste diverted from municipal landfills.

Most of the five state agencies in our sample reported diverting e-waste from municipal landfills. Waste diversion includes activities such as source reduction or recycling waste. In 1999 the State enacted legislation requiring state agencies to divert at least 50 percent of their solid waste from landfill disposal by January 1, 2004. State agencies annually describe their status on meeting this goal by submitting reports indicating the tons of various types of waste diverted. A component of the report pertains specifically to e-waste. Between 2004 and 2007, four of the five state agencies in our sample reported diverting a combined total of more than 250 tons of e-waste. The fifth state agency, Caltrans, explained that it reported its e-waste diversion statistics in other categories of its reports that were not specific to e-waste.

Several factors cause us to have concerns about the reliability and accuracy of the amounts that these state agencies reported as diverted e-waste. First, these state agencies were not always consistent in the way they calculated the amount of e-waste to report or in the way they reported it. For example, Employment Development's amount for 2007 include data only from its Northern California warehouse; the amount did not include information from its Southern California warehouse. Also for 2007, the CHP included its diverted e-waste in other categories, while Caltrans did so for all years reported. Further, although instructions call for reporting quantities in tons, for 2007 Justice reported 3,951 e-waste items diverted. Moreover, diversion of e-waste does not count toward compliance with

the solid waste diversion mandate, so state agencies may not include it. The Waste Management Board explained that e-waste is not solid waste, and thus state agencies are not required to report how much they divert from municipal landfills.

The Waste Management Board also allows state agencies to use various methods to calculate the amounts that they report as diverted. For instance, rather than conduct on-site disposal and waste reduction audits to assess waste management practices at every facility, a state agency can estimate its diversion amounts from various sampling methods approved by the Waste Management Board.

If the Legislature believes that state agencies should track more accurately the amounts of e-waste they generate, recycle, and discard, we recommended it consider imposing a requirement that agencies do so.

Legislative Action: Unknown.

We are not aware of any legislative action at this time.

Finding #4: State agencies' compliance with e-waste requirements receives infrequent assessments that are simply components of other reviews.

A state agency's decision regarding how to dispose of e-waste is subject to review by local entities, such as cities and counties, as well as by General Services. We found that the Sacramento County program agency and General Services perform reviews infrequently, and these reviews may not always identify instances in which state agencies have disposed of e-waste improperly.

Local agencies certified by the California Environmental Protection Agency are given responsibility under state law to implement and enforce the State's hazardous waste laws and regulations, which include requirements pertaining to universal waste. These local agencies, referred to as program agencies, perform periodic inspections of hazardous waste generators. The inspections performed by the program agency for Sacramento County are infrequent and may fail to include certain state agencies that generate e-waste. According to this program agency, which has the responsibility to inspect state agencies within its jurisdiction, its policy is to inspect hazardous waste generators once every three years. For the five state agencies in our sample, we asked the Sacramento County program agency to provide us with the inspection reports that it completed under its hazardous waste generator program. The inspection reports we received were dated between 2005 and 2008. We focused on the hazardous waste generator program because Sacramento County's inspectors evaluate a generator's compliance with the State's universal waste requirements under this program (universal waste is a subset of hazardous waste, and it may include e-waste). In its response to our request, the Sacramento County program agency provided seven inspection reports that covered four of the five state agencies in our sample. The Sacramento County program agency provided three inspection reports for Caltrans, one report for Justice, one for the CHP, and two inspection reports for Motor Vehicles. The program agency did not provide us with an inspection report for Employment Development, indicating that this department is not being regulated under the program agency's hazardous waste generator program. The Sacramento County program agency explained that it targets its inspections specifically toward hazardous waste generators and not generators that have universal waste only, although the program agency will inspect for violations related to universal waste during its inspections. As a result, the Sacramento County program agency may never inspect Employment Development if it generates only universal waste.

The State Administrative Manual establishes a state policy requiring state agencies to obtain General Services' approval before disposing of any state-owned surplus property, which could include obsolete or broken electronic devices. In addition to reviewing and approving these disposal requests, General Services periodically audits state agencies to ensure they are complying with the State Administrative Manual and other requirements. General Services' reviews of state agencies are infrequent and it is unclear whether these reviews would identify state agencies that have inappropriately disposed of their e-waste. According to its audit plan for January 2007 through June 2008, General Services conducts "external compliance audits" of other state agencies to determine whether they comply with requirements that are under the purview of certain divisions or offices within General Services.

One such office is General Services' Office of Surplus Property and Reutilization, which reviews and approves the property survey reports that state agencies must submit before disposing of surplus property. According to its audit plan, General Services' auditors perform reviews to assess whether state agencies completed these reports properly and disposed of the surplus equipment promptly. General Services' audit plan indicates that it audited each of the five state agencies in our sample between 1999 through 2004, and that it plans to perform another review of these agencies within the next seven to eight years.

When General Services does perform its reviews, it is unclear whether General Services would identify instances in which state agencies improperly discarded e-waste by placing it in the trash. General Services' auditors focus on whether state agencies properly complete the property survey reports and not on how the agencies actually dispose of the surplus property. For example, according to its audit procedures, General Services' auditors will review property survey reports to ensure that they contain the proper signatures and that the state agencies disposed of the property "without unreasonable delay." After the end of our fieldwork, General Services revised its audit procedures to ensure that its auditors evaluate how state agencies are disposing of their e-waste. General Services provided us with its final revised audit guide and survey demonstrating that its auditors will now "verify that disposal of e-waste is [sent] to a local recycler/salvage company and not sent to a landfill."

If the Legislature believes that more targeted, frequent, or extensive oversight related to state agencies' recycling and disposal of e-waste is necessary, we recommended that the Legislature consider assigning this responsibility to a specific agency.

Legislative Action: Unknown.

We are not aware of any legislative action at this time.

Finding #5: Some state agencies use best practices to manage e-waste.

During our review we identified some state agencies that engage in activities that we consider best practices for managing e-waste. These practices went beyond the requirements found in state law and regulations, and they appeared to help ensure that e-waste does not end up in landfills. One best practice we observed was Justice's establishment of very thorough duty requirements for its recycling coordinator. These requirements provide clear guidelines and expectations, listing such duties as providing advice and direction to various managers about recycling requirements, legal mandates, goals, and objectives. The duties also include providing training to department staff regarding their duties and responsibilities as they pertain to recycling. In addition, the recycling coordinator maintains current knowledge of recycling laws and works with the Waste Management Board and other external agencies in meeting state and departmental recycling goals and objectives. Three of the remaining four state agencies in our sample did not have detailed duty statements specifically for their recycling coordinators. These three state agencies—the CHP, Motor Vehicles, and Employment Development—briefly addressed recycling coordination in the duty statement for the respective individual's position. Caltrans, the remaining state agency in our sample, indicated that it did not have a duty statement for its recycling coordinator. The creation of a detailed duty statement similar to the one used by Justice would help state agencies ensure that they comply with mandated recycling requirements, that they maintain and distribute up-to-date information, and that agencies continue to divert e-waste from municipal landfills.

A second best practice we noted was state agencies' use of recycling vendors from General Services' master services agreement. General Services established this agreement to provide state agencies with the opportunity to obtain competitive prices from prequalified contractors that have the expertise to handle their e-waste. For a contractor to be listed on General Services' master services agreement, it must possess three years of experience in providing recycling services to universal waste generators, be registered with Toxic Substances Control as a hazardous waste handler, and ensure that all activities resulting in the disposition of e-waste are consistent with the Electronic Waste Recycling Act of 2003.

The master services agreement also lists recycling vendors by geographic region, allowing state agencies to select vendors that will cover their area. Many recycling vendors under the agreement offer to pick up e-waste at no cost, although most require that state agencies meet minimum weight requirements. Based on a review of their property survey reports, we saw evidence that the CHP, Caltrans, Justice, and Employment Development all used vendors from this agreement to recycle some of their e-waste.

We recommended that state agencies consider implementing the two best practices we identified.

State Agencies' Actions: Pending.

Regarding a thorough duty statement for a recycling coordinator, as we mentioned in our audit report, Justice already follows this best practice. In their responses to our audit report, Motor Vehicles, Caltrans, and Employment Development stated that they would take steps to implement this best practice; CHP thanked us for suggesting it.

Regarding the use of recyclers from the master services agreement, we noted in our audit report that CHP, Caltrans, Justice, and Employment Development all used vendors from the master services agreement. Motor Vehicles stated that in the future, its property and equipment control unit will make an effort to use the master services agreement when disposing of obsolete equipment and that its asset management section will adopt the recommendation and develop guidelines on the use of the master services agreement. Motor Vehicles stated that the guidelines will be disseminated to all divisions by February 2009.

Department of Consumer Affairs, Contractors State License Board

Investigations of Improper Activities by State Employees, January 2008 Through June 2008

INVESTIGATION I2007-1046 (REPORT I2008-2), OCTOBER 2008

Contractors State License Board's response as of October 2008

An employee with the Contractors State License Board (board) used a state vehicle for personal reasons and falsified board records to hide her actual activities when she was supposed to be performing field inspections for the board. The State incurred an estimated \$1,896 loss due to her personal use of a state vehicle from April 2007 to August 2007.

Finding: An employee used a state vehicle for purposes unrelated to her state employment and falsified board records to hide her engaging in activities unrelated to her board work during state time.

From April 2007 to August 2007, a board employee drove her assigned state vehicle 1,922 miles more than her job required. Using the standard mileage reimbursement rate applicable to state employees at the time, we estimate that this difference of 1,922 unauthorized miles cost the State \$932. In addition, the employee improperly claimed 29 hours of excess travel time for which she received compensation. Based on the employee's salary for that period, we estimate that this travel time, which the employee incorrectly reported, cost the State \$872. The employee also drove her state vehicle 189 miles during three days that she was on medical leave, at a cost to the State of \$92. Finally, in her daily activity log, the employee regularly misrepresented her physical location and work activities in order to hide that she was apparently engaging in activities not related to her job with the board.

Contractors State License Board's Action: Partial corrective action taken.

The board informed us in October 2008 that it is seeking reimbursement from the employee for the \$1,896 loss to the State resulting from the employee's personal use of the state vehicle and compensation for excess travel time. The board previously informed us that it had taken several corrective measures, including issuing the employee a counseling memorandum and a copy of the current departmental policy pertaining to incompatible work activities. The board also terminated the telecommute agreements of the employee and other board employees, and counseled the employee's supervisor to regularly review daily activity logs and other reports prepared by employees for accuracy and completeness.

Investigative Highlight . . .

An employee of the Contractors State License Board (board) used a state vehicle for personal reasons when she was supposed to be performing field inspections for the board, at a loss to the State of \$1,896.

California's Postsecondary Educational Institutions

Stricter Controls and Greater Oversight Would Increase the Accuracy of Crime Statistics Reporting

REPORT NUMBER 2006-032, JANUARY 2007

Responses from those of the institutions we visited and the California Postsecondary Education Commission as of January 2008; University of California—Los Angeles, as of September 2008; and California State University—Long Beach and American River College as of November 2008

Chapter 804, Statutes of 2002, which added Section 67382 to the California Education Code (code section), requires us to report to the Legislature the results of our audit of not less than six California postsecondary educational institutions that receive federal student aid. We were also directed to evaluate the accuracy of the institutions' statistics and the procedures they use to identify, gather, and track data for reporting, publishing, and disseminating accurate crime statistics in compliance with the requirements of the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act). We evaluated compliance with the Clery Act at American River College (American River); California State University, Long Beach (Long Beach); Leland Stanford Junior University (Stanford); University of California, Berkeley (Berkeley); University of California, Los Angeles (UCLA); and University of Southern California (USC).

The code section also requires the California Postsecondary Education Commission (commission) to provide on its Web site a link to the Web site of each California postsecondary institution that includes crime statistics information.

Finding #1: Failure to correctly classify specific incidents of potentially reportable crime types led institutions to incorrectly report the number of, or miscategorize, crimes.

The Clery Act and federal regulations require eligible postsecondary educational institutions (institutions) to compile crime statistics in accordance with the definitions established by the Uniform Crime Reporting Program of the Federal Bureau of Investigation (FBI). Definitions for crimes reportable under the Clery Act can be found in both federal regulations and the FBI's *Uniform Crime Reporting Handbook* (UCR). If the U.S. Department of Education (Education) finds that an institution has violated the Clery Act by substantially misrepresenting the number, locations, or nature of reported crimes, it may impose a civil penalty of up to \$27,500 for each violation or misrepresentation. Additionally, Education may suspend or terminate the institution's eligibility status for federal student aid funding.

The Clery Act requires institutions to compile crime statistics in accordance with the definitions established in the UCR. Although state definitions of crimes often do not precisely match the crimes described in the UCR, there is no comprehensive list converting crimes

Audit Highlights . . .

Our review of California's postsecondary educational institutions' compliance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (Clery Act), revealed the following:

- » *One institution did not correctly convert crimes defined in California law to crimes the Clery Act requires to be reported in the annual security report.*
- » *Institutions did not review some potentially reportable crimes to determine if they are reportable under the Clery Act.*
- » *Institutions did not correctly identify all reportable locations.*
- » *Institutions have not established a written policy or procedure for some of the items described in their annual reports.*
- » *The California Postsecondary Education Commission does not ensure that the links that it provides lead to institutions' statistics.*

defined in California law to those reportable under the Clery Act, or identifying crimes that cannot be uniformly converted. Consequently, institutions are responsible for ensuring that they include in their annual reports all reportable crimes and correctly classify crimes and their locations in accordance with the definitions of crimes reportable under the Clery Act. One of the six institutions we reviewed did not correctly convert crimes defined in California law to crimes the Clery Act requires institutions to report in their annual reports, and four institutions either did not review or did not correctly report some crimes in potentially reportable categories. When institutions fail to meet these requirements, they can distort the level of crime occurring on the campuses.

To improve the accuracy and completeness of their data, Berkeley, Long Beach, Stanford, UCLA, and USC should establish procedures to identify crimes defined in California law that cannot be directly converted to reportable crimes and take additional steps to determine if a crime is reportable. Berkeley should also ensure that crimes in California law are correctly converted to crimes the Clery Act requires institutions to report.

University of California—Berkeley’s Action: Corrective action taken.

Berkeley indicates that it has developed a procedure to ensure that the crimes identified by the audit as incorrectly included are no longer reported. In addition, Berkeley states that it has created a spreadsheet documenting the review of several types of crimes defined in California law to convert them to Clery Act defined crimes.

California State University—Long Beach’s Action: Corrective action taken.

Long Beach indicates that it has altered its crime reporting software to identify Clery Act reportable crimes.

Leland Stanford Junior University’s Action: Corrective action taken.

Stanford indicates that for crimes that do not have a clear counterpart, the Clery coordinator reviews the incident report and consults with the campus director of public safety and Education as necessary.

University of California—Los Angeles’ Action: Corrective action taken.

UCLA has conducted training and established a single method of coding crime reports to ensure consistency. The records manager conducts monthly audits of crime coding to ensure consistency and accuracy. In addition, the records manager reviews data entered into the records management system and conducts audits of the information on a monthly basis. The analyst and records manager determine the appropriate classification for questionable categories. The analyst reviews the actual crime report, as opposed to the information entered into the record management system, for all Clery reportable crimes, and has created a reference sheet to correctly count alcohol-related crimes. Finally, UCLA has obtained a software upgrade that will enable its record management system to automatically create its Clery report, and continues to work on data conversion procedures necessary to do so.

University of Southern California’s Action: Pending.

USC indicates that it will obtain information from the Los Angeles Police Department to properly categorize these incidents.

Finding #2: Incomplete data led some institutions to underreport crimes.

Each institution we reviewed used some form of an electronic system to record and track crimes. However, a lack of controls in these systems allowed inaccurate or incomplete information to be entered, and led some institutions to incorrectly report their crime statistics. For example, at Stanford we identified crimes that either were not entered into the system or were entered with an incorrect year. In addition, at UCLA we found instances when the type of crime was not entered in the crime-tracking

system for Clery Act reportable crimes, and UCLA subsequently assumed they were not criminal incidents. When institutions do not identify all reportable crimes or enter erroneous information for crimes, they risk misrepresenting the number of crimes occurring on their campuses.

To improve the accuracy and completeness of their data American River, Berkeley, Stanford, and UCLA should establish procedures to verify the integrity of data in their electronic crime-tracking systems.

American River College's Action: Corrective action taken.

American River indicates that it is now using an automated records management system and ensures the integrity of its data through the use of a separate backup server.

University of California—Berkeley's Action: Corrective action taken.

Berkeley now conducts a quarterly “gap check” to identify any crimes that have not been entered into the system. In addition, the records unit supervisor maintains documentation regarding any missing case numbers (for example, cancelled case reports).

Leland Stanford Junior University's Action: Corrective action taken.

Stanford states that its records supervisor conducts periodic audits of the crime tracking systems to ensure the integrity of the data in the system.

University of California—Los Angeles' Action: Corrective action taken.

UCLA states that it now has procedures in place to regularly review the sequential numbering of reports and other critical information—including the incident type, date and location of occurrence, and penal code—to ensure that all crimes are included and properly categorized. Further, weekly checks ensure staff account for all reports that are issued a report number. To ensure consistency, a single staff member now does all report coding and the records manager reviews all reports.

Finding #3: Failing to collect enough information from campus security authorities and local police agencies can affect crime statistics.

The Clery Act requires institutions to collect crime statistics from campus security authorities and local police agencies. The six institutions we reviewed collect information from various campus security authorities throughout the institutions at least annually. Four of these institutions also request necessary details. However, three institutions did not retain complete records of their requests and responses from campus security authorities.

Because local police agencies may be responsible for responding to certain types of crimes or patrolling designated noncampus and public property areas, institutions must also request information that allows them to determine which additional crimes they should include in their annual reports. Two institutions we reviewed either did not maintain original documents provided by local police agencies or documentation of which crimes they included in their annual reports. Although all incidents reported to campus police departments and local police agencies should be considered, institutions should try to obtain detailed information on every incident reported to avoid over- or under-reporting. Without adequate information, an institution could under-report campus crime because it cannot confirm that it is already aware of the crime, or it could over-report as a result of counting an incident more than once.

To improve the accuracy and completeness of their data, we recommended that American River, Long Beach, Stanford, and USC establish procedures to obtain and retain sufficient information from campus security authorities and local police agencies to determine the nature, dates, and locations of crimes reported by these entities. We also recommended that USC establish procedures to identify all campus security authorities and collect information directly from each source, and that it develop

a process to compare the dates that crimes occurred as recorded by the institution to the dates recorded by local police agencies to minimize the potential for duplicate reporting of crimes. Lastly we recommended that Long Beach and USC retain adequate documentation that specifically identifies incidents they include in their annual reports.

American River College's Action: Corrective action taken.

American River indicates that it now sends letters to campus security authorities that explain their role and provide instructions for submitting the requested information. In addition, campus security authorities are provided forms that identify required information and include simple definitions of crimes to help enhance accurate reporting. Further, American River makes all requests for information via e-mail to help document compliance.

California State University—Long Beach's Action: Corrective action taken.

Long Beach indicates that to provide a basis for verification of statistics in its annual report it has revised its process to collect and retain incident information, and has established procedures to ensure data is gathered and retained from local police agencies and campus security authorities for the proper period of time.

Leland Stanford Junior University's Action: Corrective action taken.

Stanford states that its Clery coordinator sent requests for information to all campus security authorities and required responses even if the authority had no crimes to report.

University of Southern California's Action: Partial corrective action taken.

➔ USC states that it maintains original documentation provided by the Los Angeles Police Department. USC did not address our concern regarding developing a process to compare the dates in its records that crimes occurred to the dates recorded by local police agencies to minimize the potential for duplicate reporting of crimes. USC indicates that it revised its list of campus security authorities and will create an incident report form for them to use.

Finding #4: Institutions that lack adequate procedures for determining reportable locations risk confusion and inaccurate reporting.

The Clery Act requires each institution to report statistics for crimes committed in certain geographic locations associated with the campus. Although Education's The Handbook for Campus Crime Reporting (Education handbook), which offers additional guidance on compliance with the Clery Act, provides specific examples of how various locations are to be classified, five of the six institutions we reviewed did not correctly identify all reportable locations. Some institutions did not properly identify public property for all years reviewed; incorrectly classified property meeting the definition of a campus location; did not differentiate in their annual reports between crimes occurring on campus and those occurring on certain public properties, such as streets adjacent to the institution; and failed to identify all noncampus locations subject to reporting. Although each campus is unique, it is important that institutions consistently apply the criteria established by Education to accurately classify reportable crimes.

To improve the accuracy and completeness of their data Berkeley, Long Beach, Stanford, UCLA, and USC should establish procedures to accurately identify all campus, noncampus, and public property locations and report all associated crimes.

University of California—Berkeley's Action: Corrective action taken.

Berkeley states that as described in its response to the audit, it has already complied with this recommendation by using the Education handbook definition to compile statistics for two of the three years reported in its 2006 annual report.

California State University—Long Beach’s Action: Corrective action taken.

Long Beach states that it has altered its definition of reportable locations to match that of the Education handbook in its 2006 annual report.

Leland Stanford Junior University’s Action: Partial corrective action taken.

Stanford indicated that it would contact Education for guidance on the proper designation of certain properties, but did not indicate it had yet done so in its one-year response. Further, Stanford will include the Stanford Hospital and the Stanford Linear Accelerator Center as campus locations; and will include the Stanford Sierra Camp and Boathouse as noncampus locations. Finally, its Clery coordinator received a list of Stanford properties to determine if all campus and noncampus locations have been properly identified.

University of California—Los Angeles’ Action: Corrective action taken.

UCLA indicates that it now obtains a complete list of property from its Space Management Division annually, and a complete list of Greek housing from the fraternity and sorority relations staff. Further, it has reviewed its property and redrawn the campus boundaries for the purpose of identifying reportable locations. It also stated that the crime analyst ensures all locations are properly identified and associated crimes are accurately reported.

University of Southern California’s Action: Partial corrective action taken.

USC indicates that it has spent time to educate staff and review local police reports to improve reporting accuracy of the crimes reported by local police. It indicates that it also expanded its review process to appropriately classify new properties and those whose use changes. USC did not address our concerns regarding the correction of any incorrect property classifications where the use of the property has not changed.

Finding #5: The statistics institutions report to Education do not always match the statistics in their annual security reports.

In addition to disclosing crime statistics in their annual reports, institutions must submit the information to Education, using a form on Education’s Web site. Although we would expect these statistics to mirror one another, five institutions had discrepancies between the number of crimes published in their annual reports and those they submitted to Education. Among the causes of the discrepancies were institutions’ errors when completing Education’s online form, errors in the institutions’ annual reports, the discovery of misplaced information, and corrections institutions made after obtaining additional information. Errors made in reporting to Education and when preparing annual reports distort the actual levels of crime experienced by the institutions and result in unreliable resources for current and prospective students.

To improve the accuracy and completeness of their data, we recommended that Berkeley, Long Beach, Stanford, UCLA, and USC establish procedures to minimize data entry errors in their annual reports and in their annual submissions to Education.

University of California—Berkeley’s Action: Corrective action taken.

Berkeley has created a checklist to ensure that all data submitted by campus security authorities is correctly included in both its annual report and the data it submits to Education.

California State University—Long Beach’s Action: Corrective action taken.

Long Beach states that it has established written procedures to minimize data entry errors and has assigned responsibility for these tasks to a single position. It also indicates that it reviewed randomly selected items to ensure accuracy and had the reported statistics reviewed by no less than two personnel.

Leland Stanford Junior University's Action: Corrective action taken.

Stanford states that its Clery coordinator and records supervisor cross check data entries prior to the submission of statistics.

University of California—Los Angeles' Action: Corrective action taken.

UCLA states that by addressing and correcting data integrity issues the concerns regarding the statistics reported to Education have been corrected. In addition, both the crime analyst and information systems manager review all reported Clery statistics for data entry errors before they are finalized.

University of Southern California's Action: Corrective action taken.

USC indicates that it continues to review its statistics to minimize the potential for the duplicate reporting of crimes.

Finding #6: Some Institutions did not comply with the Clery Act requirements to disclose campus security policies.

The Clery Act requires that each institution disclose its current campus security policies. While all six institutions we reviewed made good-faith efforts to fully disclose these policies, two institutions did not fully comply in their disclosures. Although one institution disclosed information for all seven of the categories we reviewed, its sexual assault information did not include all the components required by the Clery Act. Complying with the Clery Act provides students and employees at these institutions with important information concerning their safety. In addition, California Education Code, Section 67382(c), suggests that institutions establish and publicize a policy that allows victims or witnesses to report crimes to the institutions' police agencies or to a specified campus security authority on a voluntary, confidential, or anonymous basis, and federal regulations require institutions offering confidential or anonymous reporting to disclose its availability in their annual reports. Unless institutions establish and inform students and staff of the availability of an anonymous reporting system, they may not have a clear picture of the degree of sexual violence occurring on their campus and surrounding communities.

To ensure compliance with the Clery Act, USC should enhance the disclosures regarding sexual assaults in its annual report to fully meet statutory requirements. Long Beach should establish procedures to ensure adequate disclosure of the availability of anonymous and confidential reporting to its campus community.

California State University—Long Beach's Action: Corrective action taken.

Long Beach states that it has developed a procedure to ensure adequate disclosure of the availability of anonymous reporting.

University of Southern California's Action: Corrective action taken.

USC stated that it amended its sexual assault policy contained in its annual security report to meet statutory requirements.

Finding #7: Some institutions have not established all the policies or procedures described by their annual reports.

A major component of Clery Act compliance is the disclosure of policy statements in the annual report. The Clery Act outlines numerous campus security policies that institutions must disclose, and the Education handbook provides guidance on the minimum requirements for specific information that the report must include. However, the policies and procedures described in the annual report must also accurately reflect the institution's unique security policies, procedures, and practices, and if the institution

does not have a particular policy or procedure, it must disclose that fact. Although the institutions we reviewed generally disclosed the information required by the Clery Act in their annual reports, most campuses were unable to provide us with the policies and procedures to support some of the disclosures they had made in those reports. In addition, the Education handbook states that to keep the campus community informed about safety and security issues, an institution must alert the campus community of reportable crimes considered an ongoing threat to students and employees in a manner that is timely and will aid in the prevention of similar crimes. Because of its potential to prevent crimes, each institution is required to have a policy specifying how it will issue these warnings. Because the Clery Act does not define timely, we expected institutions to have established their own definitions. However, two institutions had not established guidelines or time frames for reporting incidents to the campus community.

To ensure compliance with the Clery Act, we recommended that American River, Long Beach, Stanford, and USC establish comprehensive departmental policies that support disclosures made in their annual reports, and establish a policy to define timely warnings and establish procedures to ensure that they provide timely warnings when threats to campus safety occur.

American River College's Action: Corrective action taken.

American River updated its general orders, and included policies and procedures supporting required disclosures.

California State University—Long Beach's Action: Corrective action taken.

Long Beach states that it has developed policies and procedures that support the disclosures made in the annual report and has integrated them into the campus police rules and regulations manual, including a policy to define timely warnings.

Leland Stanford Junior University's Action: Partial corrective action taken.

Stanford states that it refined its written policy regarding timely warnings, and formed a task force to review, improve, and formalize its existing policies and procedures.

University of Southern California's Action: Partial corrective action taken.

USC states that it is updating its policy manual and expects to complete this process in 2009. In addition, USC states that it has developed a new timely warning policy and has amended its internal timely warning procedures.

Finding #8: One institution did not notify all current and prospective students and employees of the availability of its annual report.

Federal regulations require institutions to distribute their annual reports to all enrolled students and current employees by October 1 of each year through appropriate publications or mailings. In addition, institutions must notify prospective students and employees of the availability of their annual reports. American River did not distribute its annual report or satisfactorily notify students and employees of its availability during the period we audited. The annual report is only effective in educating students and staff about crime on campus and on the institution's security policies and procedures when students and staff are aware of its availability.

To ensure compliance with the Clery Act, American River should establish procedures to ensure that the campus community is informed of the availability of the annual report.

American River College's Action: Corrective action taken.

American River indicates that it now uses a variety of documents to notify students, staff, and faculty of the availability of its annual report.

Finding #9: The commission does not ensure a link exists to institutions' crime statistics.

State law requires the commission to provide a link to the Web site of each California institution containing crime statistics information. To fulfill this requirement, the commission provides links on its Web site to connect users to the selected institution's summary information on Education's Web site. The commission believes that this ensures uniform reporting of crime statistics, provides interested persons with a common reporting format for comparison purposes, reduces the reporting burden on institutions, and makes the best use of the commission's scarce resources. However, the commission was unaware that five institutions listed on its Web site had not submitted crime statistics to Education's Web site. Although the commission has procedures in place to verify that it includes a valid link to Education's summary information for each institution, it does not ensure that the summary page contains a link to a valid crime statistics report. The commission stated that in the future it will identify institutions whose pages on Education's Web site do not contain the required crime statistics information and will determine each institution's status.

To ensure that its Web site contains a link to all institutions' crime statistics, the commission should continue with its plan to test the validity of its links.

California Postsecondary Education Commission's Action: Corrective action taken.

The commission indicates that it has developed a program to accomplish this task, and conducts verification checks monthly.

Home-to-School Transportation Program

The Funding Formula Should Be Modified to Be More Equitable

REPORT NUMBER 2006-109, MARCH 2007

California Department of Education's response as of February 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the California Department of Education's (Education) disbursement of Home-to-School Transportation (Home-to-School) program funds to identify any inequities. Specifically, we were asked to review the funding formula that Education uses to determine Home-to-School program payments to school districts. The audit committee also asked us to determine how the program is funded and what roles Education and school districts have in determining the funding levels. In addition, we were asked to compare data related to the number and percentage of students receiving transportation services, the amount paid for the Home-to-School program in total and per student, the actual cost of transporting students in total and per student, and the excess cost over Home-to-School program payments by school district and region for both regular and special education students to determine if and why variances exist. Further, the audit committee asked that we determine how school districts fund the difference between what is paid to them by Education and their actual cost, and evaluate, to the extent possible, whether this practice affects other programs. Additionally, the audit committee asked us to determine, to the extent possible, whether any correlations exist between higher transportation costs and staffing levels.

Finding: The prescribed funding formula does not allow some school districts to receive transportation funding.

Home-to-School program funding is contingent upon receiving funds for this program in the immediately preceding fiscal year. Consequently, some school districts and county offices of education (school districts) are not eligible to receive these funds. Current laws require that Education allocate Home-to-School program funds to each school district based on the lesser of its prior year's allocation or approved cost of providing transportation services, increased by the amount specified in the budget act. School districts that did not previously receive Home-to-School program allocations for special education transportation, regular education transportation, or both, are not eligible to receive these allocations under the current laws. Furthermore, some school districts have experienced dramatic increases in student population over the years. Although the funding method provides for some adjustments for the increase in statewide average daily attendance, the allocations have not always increased at the same rate as the increase in student population at individual school districts.

To determine the fiscal impact on school districts that do not receive the Home-to-School program funds, we recommended that Education identify all school districts that provide transportation services to their students but are not eligible to receive Home-to-School program

Audit Highlights . . .

Our review of the Home-to-School Transportation (Home-to-School) program administered by the California Department of Education found that:

- » *The current legally prescribed funding mechanism prevents some school districts from receiving Home-to-School program funds because of the basis of allocation.*
- » *Although the annual budget act increases the Home-to-School program funds to account for the increases in the statewide average daily attendance, these increases are less than the student population growth some school districts have experienced over the years.*
- » *Urban school districts received less overall Home-to-School program payments per student transported than rural school districts (\$559 versus \$609) and paid for more overall costs per student transported from non-Home-to-School program funds (\$828 versus \$299).*
- » *While all school districts typically incurred higher costs to transport a special education student, such costs were higher in rural school districts (\$5,315) than in urban school districts (\$4,728).*
- » *Staffing levels and student test scores bear no relationship to the amount of transportation expenditures the school districts paid per student from non-Home-to-School program funds during fiscal year 2004–05.*

funds for regular education transportation, special education transportation, or both. In addition, we recommended that Education determine the actual costs these school districts incur and the funding sources they use to pay them. Further, we recommended that Education seek legislation to revise the current laws to ensure that all school districts that provide transportation services to regular education, special education, or both, are eligible for funding. To ensure that school districts are funded equitably for the Home-to-School program, we also recommended that Education seek legislation to revise the law to ensure that funding is flexible enough to account for changes that affect school districts' transportation programs, such as large increases in enrollment.

Education's Action: None.



Education noted that it does not have the resources to identify all school districts that provide transportation services to their students but are not eligible to receive Home-to-School program funds for regular education transportation, special education transportation, or both; and determine the actual costs these school districts incur and the funding sources they use to pay them. It further noted that it submitted a Budget Change Proposal for the fiscal year 2008–09 budget for a new position to, among other things, develop a pupil transportation funding reform proposal. However, Education noted that this proposal was not included in the fiscal year 2008–09 Governor's Budget.

Education was silent regarding any efforts it had taken to seek legislation to revise the law to ensure that all school districts that provide transportation services are eligible for funding and that funding is flexible enough to account for changes that affect school districts' transportation programs.

California State Polytechnic University, Pomona

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

INVESTIGATION I2007-0671 (REPORT I2007-2), SEPTEMBER 2007

California State Polytechnic University, Pomona's response as of August 2008

We investigated and substantiated an allegation that an employee with the California State Polytechnic University, Pomona (Pomona), inappropriately used university computers to view pornographic Web sites.

Finding: The employee misused state resources to engage in improper activities.

We asked Pomona to assist us in the investigation, and we substantiated the allegation. Pomona found that the official repeatedly used university computers to view Web sites containing pornographic material. State laws prohibit employees from using public resources, such as time and equipment, for personal purposes. In addition, these laws require employees to devote their full time and attention to their duties, and prohibit individuals employed by the State from using a state-issued computer to access, view, download, or otherwise obtain obscene matter. Specifically, Pomona found that the official viewed approximately 1,400 pornographic images on two university computers during several weeks in 2006 and also from February to May 2007. Pomona was unable to review the official's complete Internet usage because the settings on the official's main computer only allowed for a two-month retention period of Internet activity. When interviewed, the official admitted to viewing pornographic Web sites regularly using university computers.

Pomona's Action: Partial corrective action taken.

In January 2008 Pomona stated that its academic senate approved an interim Appropriate Use Policy, which states that administrators, faculty, and staff must not use computers for personal purposes. Pomona reported that to become official, the interim policy must go through a meet-and-confer process with the unions for staff and faculty.

In August 2008 Pomona reported that it met with the two employee unions in July 2008 to start the meet-and-confer process. Pomona stated that the unions requested changes to Pomona's interim policy and that all parties must agree to the changes before the policy becomes official. We are concerned about the length of time Pomona has taken to institute a policy in response to an official accessing pornographic Web sites because one year after we issued our report, Pomona had not yet finalized its policy on the appropriate use of university equipment.

Investigative Highlight . . .

An employee at the California State Polytechnic University, Pomona, admitted, when interviewed, to viewing pornographic Web sites regularly using university computers.



California State University

It Needs to Strengthen Its Oversight and Establish Stricter Policies for Compensating Current and Former Employees

REPORT NUMBER 2007-102.1, NOVEMBER 2007

California State University's response as of November 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the compensation practices of the California State University (university).¹ Specifically, the audit committee asked us to identify systemwide compensation by type and funding source, to the extent data are centrally maintained and reasonably consistent among campuses. The audit committee also asked us, subject to the same limitations, to categorize by type and funding source the compensation of highly paid individuals receiving funds from state appropriations and student tuition and fees. In addition, for the most highly paid individuals, the audit committee asked us to identify any additional compensation or employment inducements not appearing in the university's centrally maintained records, such as those recorded in any employment agreements with the university. Further, the audit committee asked us to review any postemployment compensation packages and identify the terms and conditions of transitional special assignments for highly paid individuals, including top executives and campus presidents, who left the university in the last five years. Finally, the audit committee asked us to determine the extent to which the university's compensation programs and special assignments are disclosed to the board of trustees (board) and to the public, including the types of programs that exist, the size and cost of each, and the benefits that participants receive. To the extent that this information is available and is not publicly disclosed, the audit committee asked us to include these items in our report.

Finding #1: The university has not developed a central system sufficient for monitoring compliance with its compensation policies.

The chancellor's office establishes systemwide compensation policies but does not have a system in place that allows it to adequately monitor adherence to those policies and to measure their impact on university finances. Specifically, the chancellor's office does not maintain systemwide compensation data by type and funding source, either by individual or in total. The lack of this data impairs the ability of the chancellor's office to provide effective oversight of the university's compensation programs. The executive vice chancellor and chief financial officer (executive vice chancellor) indicated that it was never the intent of the chancellor's office to have detailed systems in place to monitor employee payments and to ensure that payments are consistent with policy, as it believes that is a campus responsibility. Accordingly, the financial tools available to the chancellor's office for payroll purposes reflect its view that campuses are delegated the authority and responsibility to monitor compliance with university

¹ The audit committee also requested that we review the university's hiring practices and employment discrimination lawsuits. The results of our review of these areas were included in a separate report (2007-102.2), which we issued in December 2007.

Audit Highlights . . .

Our review of the California State University's (university) compensation practices revealed the following:

- » *The university has not developed a central system enabling it to adequately monitor adherence to its compensation policies or measure their impact on university finances.*
- » *Average executive compensation increased by 25.1 percent from July 1, 2002, through June 30, 2007, with salary increases contributing the most to the growth.*
- » *The board of trustees (board) has justified increasing executive salaries on the basis that its executives' cash compensation, excluding benefits and perquisites, lags those of comparable institutions, but concerns have been raised about the methodology used.*
- » *The university has three executive transition programs that provide postemployment compensation packages to departing executives, in addition to the standard retirement benefits available to eligible executives.*
- » *Some Management Personnel Plan employees received questionable compensation after they were no longer providing services to the university or while they were transitioning to faculty positions.*
- » *The discretionary nature of the university's relocation policy can result in questionable reimbursements of costs for moving household goods and closing costs associated with selling and purchasing residences.*

policy. The executive vice chancellor cited the standing orders of the board and the board's statement of general principles as the general policy basis for this delegation. Although we recognize that campuses have primary responsibility for implementing compensation policies, it is important for the chancellor's office to have sufficient data to ensure that the campuses appropriately carry out their responsibilities.

To provide effective oversight of its systemwide compensation policies, the university needs accurate, detailed, and timely compensation data. The university should create a centralized information structure to catalog university compensation by individual, payment type, and funding source. The chancellor's office should then use the data to monitor the campuses' implementation of systemwide policies and to measure the impact of systemwide policies on university finances.

University's Action: Partial corrective action taken.

The university reports that the board continues to believe that it is appropriate to delegate authority to campus presidents to monitor employee pay transactions. The board does not believe that it is necessary for the chancellor's office to monitor this information. However, in order to improve transparency, the chancellor will review presidential recommendations for vice presidential compensation, including salary, salary increases, bonuses, and supplemental compensation, from all fund sources, upon initial appointment and in subsequent years, and will provide an annual report to the board on such compensation each fall. The university also reports that in April 2008 it provided training to almost 600 employees who enter salary and payroll data at all 23 campuses on the coding of salary payments. In addition, the university created a business process model to provide guidance to campuses on required steps when entering data, and enhanced its personnel/payroll transaction form to reduce the possibility of coding errors. The university states it is in the process of identifying any employees who were required to attend the training, but did not, and will ensure that any such individuals receive the training. The university states that once this process is complete, its office of the university auditor will review the new business process model and the changes to the personnel/payroll transaction form to determine their effectiveness. Finally, the office of the university auditor will also conduct periodic audits to ensure the proper coding of payments. However, although such steps may be beneficial, they do not satisfy the need for centralized oversight of the university's compliance with its systemwide compensation policies.

Finding #2: The board has continually justified increasing executive salaries on the basis that its executives' cash compensation lags that of comparable institutions.

Average executive compensation increased by 25.1 percent from July 1, 2002, through June 30, 2007. Because this increase was greater than that of other employee classifications, we examined the growth in the various components that make up executive compensation—salaries, housing allowances, and automobile allowances—over the five-year period. We found that salary increases contributed the most to this growth, with the board approving salary increases on three separate occasions. The salary increases for executives ranged from an average of 1.68 percent to 13.7 percent. The board has continually justified increasing executive salaries on the basis that its executives' cash, or salary, compensation lags behind that of comparable institutions. However, as early as October 2004, the California Postsecondary Education Commission (commission), the entity that was involved with executive compensation studies until that time, raised concerns that the methodology used in making such comparisons did not present a complete picture of the value of individual compensation packages because it did not consider benefits and perquisites provided to executives, which can be substantial. Despite these concerns and the absence of further commission involvement in surveys of executive compensation, the university proceeded to use a consulting firm to perform surveys of the comparison institutions using the questioned methodology. Further, documents indicate that the board approved executive salary increases in October 2005 and January 2007 based only on the lag in cash compensation.

The commission and the Legislative Analyst's Office (legislative analyst) expressed further concerns in 2007 about the existing methodology used in these types of comparisons. Nevertheless, in September 2007 the board granted its executives another raise averaging 11.8 percent. Further, the chancellor recommended that the board adopt a new formal executive compensation policy and

that the board continue to have a salary target focused on the average cash compensation for similar positions at comparable institutions. In response to these recommendations, the board adopted a new executive compensation policy and resolved that it aims to attain parity for its executives and faculty by fiscal year 2010–11.

We asked the chancellor's office why the university continued to justify increases in compensation for its executives based on a methodology that has been questioned by the commission and the legislative analyst. The chancellor's office responded that the university did not believe it appropriate to deviate from a methodology that was agreed upon years ago by the various interested parties, including the commission and the legislative analyst. However, as these are now the same parties that are raising concerns, we believe it is time for the university to work with the interested parties to develop a more appropriate methodology that considers total compensation.

We recommended that the board consider total compensation received by comparable institutions, rather than just cash compensation, when deciding on future salary increases for executives, faculty, and other employees. The university should work with interested parties, such as the commission and the legislative analyst, to develop a methodology for comparing itself to other institutions that considers total compensation. If the university believes it needs a statutory change to facilitate its efforts, it should seek it.

University's Action: Partial corrective action taken.

The university agrees that total compensation must reflect salary and the range of benefits available to different employee categories in order to make accurate comparisons to the marketplace. In addition, the university reports that it has initiated conversations with the legislative analyst, the commission, the Department of Finance, and legislative staff regarding the methodology and comparison institutions to be used for calculating compensation comparisons. The university also states that, working with an outside consultant, it will produce an executive and faculty total compensation report that will be presented to the board in the fall of 2009. Finally, the university will produce this report every five years, and more frequently if necessary, and will expand the report to include all employee groups.

Finding #3: The university has generous postemployment compensation packages for departing executives.

The university typically offers its departing executives a transition program that often provides a generous postemployment compensation package. This program is in addition to the standard retirement benefits the university provides to eligible executives, including retirement income, medical and dental coverage, and voluntary retirement savings plans. Although the original transition program has been overhauled a few times, leaving the university with three transition programs currently in use, each departing executive is eligible for the program that was in place at his or her time of appointment. The terms of the transition agreement offered to a departing executive vary with the transition program the executive is eligible for but can include one year of paid leave, lifetime tenure as a trustee professor at a campus, or an alternative agreement negotiated by the chancellor.

In November 2006, after media criticism of existing postemployment compensation packages, the board passed a resolution requiring the chancellor to provide every board member with a copy of each final transition agreement and to submit an annual report summarizing all existing transition agreements. However, the annual report contains no information on the status of accomplishments or deliverables that former executives may have agreed to provide the university as part of their transition agreements, and disclosure does not occur until after the chancellor has reached a final agreement with a departing executive. Although the board has decided not to participate in negotiating transition agreements, it is important that the board continue to monitor the chancellor's administration of the executive transition program to ensure that the agreements departing employees receive are prudent and that intended cost savings are achieved for the university.

We recommended that the board continue to monitor the executive transition programs to ensure that the chancellor administers them prudently and that intended cost savings are achieved for the university. In addition, the board should require the chancellor to include in the transition agreements clear expectations of specific duties to be performed, as well as procedures for the former executives to report on their accomplishments and status of deliverables. Further, the board should require the chancellor to include information in his annual report on the status of accomplishments and deliverables associated with transition agreements.

University's Action: Partial corrective action taken.

The university reports that the chancellor already has begun to include in transition agreements clear expectations regarding specific duties to be performed by executives. In addition, in January 2008, the board adopted a resolution requiring the chancellor to report on progress and deliverables associated with transition agreements in his annual update on executive transitions. In a September 2008 board meeting, the chancellor provided the board a report on executives participating in transition programs. We reviewed this report and noted that there is only one former executive participating in an active transition program. Although the report indicated that the former executive is serving as a trustee professor at the university's Los Angeles campus, it did not include any information on the status of this individual's accomplishments or deliverables.

Finding #4: The university paid questionable compensation to management personnel no longer performing services for the university.

The paid leaves of absence the university provides as part of transition programs are intended only for departing executives. However, the university operates under a very broad policy for granting paid leaves of absence for Management Personnel Plan employees (management personnel). Title 5, Section 42727, of the California Code of Regulations, which addresses professional development, specifies that management personnel may participate in programs and activities that develop, update, or improve their management or supervisory skills. The programs and activities may include "professional leaves, administrative exchanges, academic coursework, and seminars." Management personnel may participate in such programs and activities only after the chancellor or campus president grants approval and only to the extent that funds are available. The regulations do not sufficiently define the criteria that must be met before a paid leave will be granted, and it does not establish time restrictions for a paid leave.

Our review confirms the need for the university to strengthen its regulations and policies in this area. In reviewing a sample of personnel files at the chancellor's office and various campuses, we found instances in which management personnel received questionable compensation after they were no longer providing services to the university or while they were transitioning to faculty positions. For example, we found that one individual, who received compensation totaling \$102,000 during a seven-year leave on the premise that he was gaining experience that would benefit the university on his return, never returned to university employment. We also noted that one individual was granted a future leave of absence with pay to transition from an administrative position to a faculty position.

We recommended that the university work through the regulatory process to develop stronger regulations governing paid leaves of absence for management personnel. The improved regulations should include specific eligibility criteria, time restrictions, and provisions designed to protect the university from financial loss if an employee fails to render service to the university following a leave. Further, the board should establish a policy defining the extent to which it wants to be informed of such leaves of absence for management personnel.

University's Action: Partial corrective action taken.

At a September 2008 meeting, the board approved a resolution to add Section 42729 to Title 5 of the California Code of Regulations that would govern paid leaves of absences for management personnel. In October 2008 this new regulation became operative and established eligibility criteria and time restrictions for such leaves of absence. However, this new regulation does not include any provisions to protect the university from financial loss in the event an employee fails to render service to the university following a leave. Also, in its periodic responses to our report, the university did not address our recommendation that the board establish a policy defining the extent to which it wants to be informed of leaves of absence for management personnel.

Finding #5: The university exercises considerable discretion in paying relocation costs for new employees.

The university has established a broad policy for paying costs related to moving and relocation (collectively referred to here as relocation) for its employees. The policy provides that incoming employees may receive reimbursement for actual, necessary, and reasonable expenses but includes few monetary limits for reimbursable expenses. Further, although the policy identifies the types of expenses that can be reimbursed, it contains clauses permitting the chancellor or campus presidents to grant exceptions. The chancellor determines the amounts of relocation reimbursements for executives, campus presidents, and management personnel in the chancellor's office, and the campus presidents determine the amounts for management personnel and faculty at their respective campuses. Neither the chancellor nor the campus presidents are required to obtain the approval of the board for relocation reimbursements, and they typically do not disclose these payments to the board. The discretionary nature of the university's policy can result in questionable reimbursements for costs, such as those for moving household goods and closing costs associated with selling and purchasing residences. These costs can be considerable. For example, we noted that the university reimbursed one individual for \$65,000 in closing costs and \$19,000 in moving expenses.

We recommended that the university strengthen its policy governing the reimbursement of relocation expenses. For example, the policy should include comprehensive monetary thresholds above which board approval is required. In addition, the policy should prohibit reimbursements for any tax liabilities resulting from relocation payments. Finally, the board should require the chancellor to disclose the amounts of relocation reimbursements to be offered to incoming executives.

University's Action: Partial corrective action taken.

The university's initial response to our report commented that the board would consider means of strengthening the controls related to the reimbursement of relocation expenses and that it would review the amount of discretion given to system executives and determine the extent to which the board wishes to review or approve any such expenses. However, it does not appear that the board has taken any action to strengthen the university's policy governing the reimbursement of relocation expenses. Rather, the board has simply required the chancellor to disclose the amounts of any such reimbursements offered to incoming executives. For example, at a July 2008 board meeting, the chancellor reported that the university would be reimbursing the new president of the San Jose campus up to \$18,775 for the costs of moving his household goods and property from his prior residence. In addition, the chancellor disclosed that the university would reimburse the new president up to \$66,577 for brokerage commissions, escrow fees, prepayment penalties, taxes, and other expenses associated with selling his prior residence. These relocation reimbursements are in addition to the new president's starting annual salary of \$353,000, university-provided housing, a university-provided vehicle or a \$1,000 monthly vehicle allowance, and other standard benefits that the university provides to its executives.

At a September 2008 board meeting, the chancellor reported that he had agreed that the university would reimburse its recently appointed vice chancellor of administration and finance up to \$39,758 for the costs of relocating his household goods and property from his prior residence.

In addition, the chancellor disclosed that the university would reimburse the new vice chancellor up to \$67,500 for brokerage commissions, escrow fees, prepayment penalties, recording fees, taxes, and other expenses associated with selling his prior residence. In this case, the chancellor also reported that he had agreed to provide the new vice chancellor with temporary housing for up to 60 to 90 days, at the chancellor's discretion. Again, these relocation reimbursements are in addition to the new vice chancellor's starting annual salary of \$310,000, a \$1,000 monthly vehicle allowance, and other standard benefits afforded to the university's executives.

Finding #6: The university's policy on dual employment is limited.

The university has established a dual-employment policy that allows its employees to have jobs outside the university system as long as no conflicts of interest exist. However, the policy does not require employees to obtain prior approval for outside employment, nor does it require them to disclose that they have such employment. Thus, the university is unable to adequately determine whether employees have outside employment in conflict with their university employment.

The university should work to strengthen its dual-employment policy by imposing disclosure and approval requirements for faculty and other employees, including management personnel. If the university believes it needs a statutory change to facilitate its efforts, it should seek it.

University's Action: Pending.



The university reports that it will continue to work through the collective bargaining process to strengthen the outside employment policy for faculty. The university states that it will adopt for executives and management personnel similar requirements to those adopted for faculty.

California State University

It Is Inconsistent in Considering Diversity When Hiring Professors, Management Personnel, Presidents, and System Executives

REPORT NUMBER 2007-102.2, DECEMBER 2007

California State University's response as of December 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the California State University's (university) practices for hiring to determine how it ensures that faculty and executives reflect the gender and ethnicity of the university they serve, the State, and the academic marketplace.¹ As part of our audit, we were asked to determine how the university develops hiring goals and how it monitors progress in meeting those goals. In addition, we were to gather and review the university's statistics on its hiring practices and results over the last five years and, to the extent possible, present the data collected by gender, ethnicity, position, and salary level.

Finding #1: Campuses are inconsistent in their approaches to considering diversity in their hiring processes.

The chancellor's office and the board of trustees (board) of the university, who delegate the hiring authority of assistant, associate and full professors (professors) to the campuses, have not adopted systemwide guidance to aid in standardizing the hiring process. As a result, the five campuses we reviewed use different methods to consider gender and ethnicity in the hiring of professors. Although California's Proposition 209 specifically prohibits the university from giving preferences to women or minorities during the hiring process, these requirements coexist with federal affirmative action regulations and thus are not intended to limit employment opportunities for women or minorities.

During the position allocation phase of the hiring process for professors, the campuses we reviewed do little, if anything, in considering gender and ethnicity. For instance, just one of the five campuses we reviewed encourages departments to consider faculty diversity at this stage. We acknowledge that departments can choose to hire professors in a specialized field of study in which proportionately fewer women and minorities exist to meet reasonable academic needs. However, when flexibility exists, they should be open to the idea of recruiting new professors from those disciplines or areas of specialization that will not decrease the likelihood of hiring female or minority professors.

Further, the California Faculty Association recommends that search committees review their campuses' affirmative action plans so they are aware of underrepresentation and the actions that administrators have recommended to improve recruitment efforts to reach women

¹ The audit committee also requested that we review the university's compensation practices. The results of our review of those practices were the subject of a separate report (2007-102.1) issued November 6, 2007.

Audit Highlights . . .

Our review of California State University's (university) hiring processes and employment discrimination lawsuits revealed the following:

- » *The university has issued little systemwide guidance to the campuses regarding the hiring process.*
- » *Campuses are inconsistent in their consideration of gender and ethnicity when hiring assistant, associate, and full professors.*
- » *Campuses use differing levels of detail when estimating the percentage of qualified women and minorities available for employment, decreasing the university's ability to effectively compare data among campuses.*
- » *Campuses have hiring policies that vary in terms of the amount of guidance they provide search committees for Management Personnel Plan employees, and one campus has developed no policies for these positions that relate to nonacademic areas.*
- » *While the hiring process for presidents requires input from many stakeholders, the hiring of system executives is largely at the discretion of the chancellor in consultation with the board of trustees.*
- » *As of June 30, 2007, the university spent \$2.3 million on settlements resulting from employment discrimination lawsuits filed during the five-year period we reviewed, and \$5.3 million for outside counsel in defending itself against such lawsuits.*

and minorities. Nevertheless, the campuses we reviewed generally did not share information from the affirmative action plans with search committees. Additionally, although women and minority professors can provide search committees with different perspectives when evaluating candidates, the campuses we reviewed generally did not have written policies that address gender and ethnic representation on such committees. Further, the chancellor's office has not issued guidance on this matter. As a result, some campuses consider the gender and ethnic composition of search committees, while others forbid it.

Additionally, to analyze their employment processes in accordance with federal regulations, campuses distribute surveys to all job applicants to determine their gender and ethnicity. The University of California has issued guidelines that state that if women and minority applicants are not present in the applicant pool at about the rate of their estimated availability in the corresponding labor pool, campuses should review recruitment and outreach efforts and can consider reopening the search with expanded inclusive recruitment efforts. However, the chancellor's office has not issued guidance in this area. Not performing such comparisons increases the risk that departments are unaware of the need to perform more inclusive outreach.

Because applicants are not required to submit the surveys containing their gender and ethnicity, it is not unexpected that response rates can be low. During our review of the hiring processes at five campuses, we noted that one campus sent out a reminder e-mail to applicants requesting that they complete and submit the forms containing their gender and ethnicity, even if they decline to disclose their gender and ethnicity. The campus notes that while it does not typically send reminders to applicants, it does so when response rates are unreasonably low. This practice seems a promising measure to increase the low response rates cited by campuses as a reason why comparing applicant pool data with labor pool data often is not meaningful.

We recommended that the university issue systemwide guidance on the hiring process for professors to ensure it employs hiring practices that are consistent with laws and regulations and among campuses. This guidance should include the development of position descriptions that are as broad as possible, the use of affirmative action plans to familiarize search committees with estimated availability for women and minorities, the development of alternatives for including women and minorities on search committees, a requirement to compare the proportion of women and minorities in the total applicant pool to the proportion in the labor pool to help assess the success of their outreach efforts, and the distribution of reminders to applicants requesting them to submit information regarding their gender and ethnicity.

University's Action: Partial corrective action taken.

The university reported that in spring 2008 it formed a committee composed of campus and system managers to develop systemwide guidelines for hiring professors consistent with the provisions contained within the collective bargaining agreement between the university and the California Faculty Association. The university stated that subsequently, once the committee completed its work, campus faculty affairs managers, equal employment opportunity officers, and the system's office of the general counsel reviewed the systemwide guidelines. In December 2008 the university offered two training courses on the hiring process for professors, which included a discussion on campus affirmative action plans and Proposition 209, and stated that it distributed these guidelines to training participants at that time. Further, the university reported that it plans to distribute the guidelines officially to campuses in the near future. The systemwide guidelines include guidance to campuses on developing position descriptions as broadly as possible, ensuring search committees understand university policies on recruitment as they relate to equity and affirmative action, devising alternatives to create diverse search committees where possible, and establishing processes for monitoring the search process and applicant pool during the hiring process.

➔ The university did not address the portion of the recommendation relating to the distribution of reminders to applicants requesting them, when response rates are low, to submit information regarding their gender and ethnicity in its one-year response to our audit. However, in its original response to our audit report, the university stated that it would notify campus officials that they

may send reminders to applicants regarding the submission of their gender and ethnicity, but that such reminders should clearly explain the use of the data collected and the applicants' rights to decline to submit such information.

Finding #2: Campuses are inconsistent in how they conduct their availability analyses.

Because the chancellor's office does not provide campuses with a uniform method for determining availability, campuses have some latitude in deciding the factors they will consider. Availability is an estimate of the number of qualified women or minorities available for employment in a given job classification expressed as a percentage of all qualified persons available for employment in the comparable labor pool. Because, according to the university, campuses have different recruitment areas, specialties, and positions, the campuses each determine their own availability. However, our review of the availability analyses for various university campuses revealed that the reasonable recruitment area for professors is nationwide. Therefore, we believe that a uniform method of determining availability for professors in the reasonable recruitment area is possible, appropriate, and necessary.

We also noted differing levels of detail in campus availability analyses in their affirmative action plans. For instance, three of the five campuses we reviewed presented an aggregate analysis for professors campuswide rather than comparing the gender and ethnicity of their current professors in each department to those available in the labor pool. The differing levels of detail decrease the university's ability to effectively compare data among campuses.

We recommended that the university devise and implement a uniform method for calculating availability data to better enable it to identify and compare availability and goals systemwide and among campuses. Further, it should direct campuses to compare and report the gender and ethnicity of their current workforce to the labor pool by individual department to ensure that goals are meaningful and useful to those involved in the hiring process.

University's Action: Pending.

The university did not address this recommendation in its one-year response to our audit. However, in its original response to our audit report, the university asserted that it would establish a task force comprised of campus officials in order to identify a workable method for uniform calculating of availability data. The university also indicated that it would identify the appropriate levels for data comparison, stating that in some cases this may be at the department level, school, or other division level. Additionally, in its systemwide guidelines, the university included information pertaining to the formation of search committees, including the provision contained within the collective bargaining agreement between the university and the California Faculty Association that stipulates that campuses have departments elect faculty to serve on search committees.

Finding #3: The hiring process lacks consistent training.

Some campuses have more detailed procedures than others to maintain the integrity of the hiring process and to ensure that search committee members are aware of applicable laws and regulations. For instance, some campuses require search committee members to attend training regarding the hiring process while others do not. As a result, not all of the departments we reviewed were aware of campus hiring protocols. For example, although the collective bargaining agreement between the board and the California Faculty Association requires that search committees be elected and consist of tenured professors, some departments do not elect their search committee members. Further, this lack of guidance may have contributed to one campus developing a policy that requires the consideration of gender or ethnicity in hiring decisions. This policy is inconsistent with what other campuses are doing: the remaining four campuses we reviewed indicated that gender or ethnicity would never play a role in their hiring decisions because Proposition 209 prohibits preferences based on these factors.

We recommended that the university issue systemwide guidance that instructs campuses to require search committee members to receive training offered at the campus level regarding the hiring process, federal regulations, Proposition 209, and other relevant state and federal laws. Additionally, we recommended that the university take action to ensure that campuses have departments elect faculty to serve on search committees to help ensure that searches are conducted in accordance with the collective bargaining agreement and campus policies.

University's Action: Partial corrective action taken.

The university stated that it believes that campuses have primary responsibility for ensuring that search committee members and administrators with hiring authority are well informed about campus policies and practices regarding hiring. In the systemwide guidelines that it has developed and plans to officially distribute to campuses in the near future, the university emphasizes that campuses have a responsibility to provide training to individuals who will be involved with hiring professors and that it is especially important that members of search committees comply with established campus policies and obtain permission before deviating from published hiring processes. Additionally, to address the need for systemwide training, the university stated that in spring 2008, it developed a task force to, among other things, develop a training program to disseminate information to campuses on the appropriate use of affirmative action plans and availability data as well as Proposition 209 issues. Subsequently, in December 2008, the university offered two web-based training courses that it stated covered the use of affirmative action plans as well as strategies for inclusive outreach and guidelines for good practice in hiring professors. The university asserted that, as a long-term strategy, the chancellor's office has committed to developing a web-training module that could be used by campuses in conjunction with their own training, which it states it will develop and implement in 2009.

Additionally, in its systemwide guidelines, the university included information pertaining to the formation of search committees, including the provision contained within the collective bargaining agreement between the university and the California Faculty Association that stipulates that campuses have departments elect faculty to serve on search committees.

Finding #4: Campuses' hiring processes for management personnel vary and they are inconsistent in considering diversity in recruiting for these positions.

Similar to the hiring authority the university has delegated to campuses for professors, it has also delegated authority to the campuses to develop policies for hiring Management Personnel Plan employees (management personnel). Also, as with the hiring of professors, the university has not adopted systemwide guidance to aid in standardizing the hiring process for management personnel. Thus, it is not surprising that campuses we reviewed have developed hiring policies that vary in the amount of guidance they provide search committees on how to conduct the search process. For instance, only one of the five campuses we reviewed has developed policies that address each of the key steps in the hiring process for both academic and nonacademic management personnel, while some of the remaining campuses allow search committees for management personnel positions discretion in conducting the hiring process. In fact, one campus has not developed any formal written policies to govern the hiring of nonacademic positions.

Search committee members can be appointed or elected to serve depending on their position or campus and are generally responsible for conducting the search process for management personnel. Because these responsibilities are crucial to a hiring process that is fair and equitable, composition of the search committee is an important consideration. For instance, women and minorities can provide search committees with different perspectives when evaluating candidates. However, assessment of the gender and ethnic composition of search committees is not specifically required.

We have similar concerns regarding inconsistencies in campuses' approaches to considering gender and ethnicity at various stages in the hiring process for academic management personnel to those we express for hiring professors. Campuses we reviewed generally did not share information in their

affirmative action plans with search committees when planning the search process for academic management personnel in order to make progress in achieving equal employment opportunity for underrepresented groups. Further, although federal regulations require contractors, such as the university's 23 campuses, to perform in-depth analyses of their total employment processes to determine whether and where impediments to equal opportunity exist, most campuses we reviewed do not require an assessment of applicant pool data to evaluate their success in recruiting women and minorities. Moreover, because applicants are not required to submit the surveys containing their gender and ethnicity, response rates can be low, thus inhibiting the meaningfulness of comparing the diversity of the applicant pool to the estimated availability in the labor pool. As discussed in Finding 1, we noted a promising measure at one campus as it states that it sends reminders to applicants when response rates are unreasonably low requesting that they complete and submit the forms containing their gender and ethnicity.

We have some additional concerns about the hiring of nonacademic management personnel. The campuses we reviewed generally lack a requirement that search committees review information in campus affirmative action plans when planning the hiring process and performing an analysis of applicant pool data to assess their success in recruiting women and minorities for nonacademic management personnel positions. We also noted inconsistent hiring practices between academic and nonacademic management personnel positions at one campus. This inconsistency further highlights the need for the chancellor's office to issue systemwide guidance on the hiring process for all management personnel.

Finally, we have concerns about the manner in which the campuses conduct their availability analyses for these positions. The campuses we reviewed consider management personnel at the administrator IV level as one group for purposes of their availability analysis. Because they do not separate the analysis for management personnel based on the functions of the positions, the analysis is not as meaningful as it could be. For instance, campuses could present the analysis separately based on position duties, such as those having responsibility for academic affairs or finance, because these positions typically draw from separate labor pools. Devising a meaningful analysis may assist campuses in better planning their search and recruitment efforts for management personnel.

We recommended that the university issue systemwide guidance on the hiring process for management personnel and in developing this guidance it should direct campuses to develop hiring policies for management personnel that address the key steps in the hiring process. Further, this guidance should include the development of alternatives for including women and minorities on search committees, the use of affirmative action plans so search committees are aware of the underrepresentation of women and minorities, a requirement to compare the proportion of women and minorities in the total applicant pool to the proportion in the labor pool to help assess the success of their outreach efforts, and the distribution of reminders to applicants requesting them to submit information regarding their gender and ethnicity. Additionally, we recommended that the university advise campuses to compare and report the gender and ethnicity of their current workforce to the labor pool by separating management personnel positions into groups based on the function of their positions to ensure goals are meaningful and useful to those involved in the hiring process.

University's Action: Partial corrective action taken.

The university did not specifically address this recommendation in its one-year response to our audit, as it did not indicate whether it had issued systemwide guidance on the hiring process for management personnel or whether it had advised campuses on the manner in which to compare and report the gender and ethnicity of their current workforce. However, in its previous response to our audit report, the university asserted that it organized a task force of campus and system representatives in spring 2008 to work on guidelines to inform management personnel searches on best practices for inclusion of women and minorities on search committees, proper use of affirmative action goals and availability data, and broader advertising, as well as a training program for dissemination of this information. In its one-year response, the university stated that it developed systemwide web-based training covering the use of affirmative action plans,



strategies for inclusive outreach, and guidelines for good practice in the management personnel hiring process. In December 2008 the university offered this training in two web-based training courses. According to the university, as a long-term strategy, the chancellor's office is committed to developing a web-training module that could be used by campuses in conjunction with their own training, which it plans to develop and implement in 2009.

Finding #5: Policies for hiring system executives are minimal and the consideration of diversity when hiring presidents and system executives is limited.

The chancellor alone is responsible for the search process for system executives; the policy governing this hiring process gives the chancellor discretion on how to conduct the search. According to the university's chief of staff, the board's policy provides the chancellor with this responsibility because the board believes the chancellor should have the ability to select his or her executive team. The search process for system executives must include representation from the board and advice from one or more presidents, faculty, and students chosen at the chancellor's discretion. For the one system executive hired during our audit period, the chancellor appointed a search committee whose responsibilities included screening and selecting applicants. However, without establishing more complete policies to guide the recruitment process for system executives, the university cannot ensure that the process for each search is fair, equitable, and consistent.

Further, the university policies for hiring presidents and system executives do not require consideration of gender and ethnicity during the hiring process. For instance, although professor positions are generally advertised in a variety of sources, including the Women in Higher Education and Hispanic Outlook, these same publications are not routinely used when advertising for presidential and system executive positions. According to the university's chief of staff, advertising is just one aspect of recruiting and that, in the experience of the chancellor's office, the best means to attract women and minority applicants is through direct personal contact, including that made by the chancellor, the chief of staff, or a third party such as a campus president. Nevertheless, the university could enhance the effectiveness of its current recruitment efforts by having a more broad-based and consistent advertising requirement for presidential and system executive positions. Further, the university's policies that govern the formation of the search committees involved in the search and selection process for presidential positions do not address gender and ethnic representation on such committees.

We recommended that the university establish more complete policies to guide the recruitment process for system executives to ensure that the process for each search is fair, equitable, and consistent. Further, to ensure it is conducting inclusive and consistent advertising to obtain as diverse an applicant pool as possible, the university should require broad-based advertising, including publications primarily with women or minority audiences, for all presidential and system executive positions. Finally, to broaden the perspective of the committees involved in the search for presidential positions, the university should develop policies regarding the diversity of these committees and consider alternatives to increase their diversity.

University's Action: Partial corrective action taken.

- ➔ The university's board approved a revised policy and procedure for the recruitment and selection of system executives in March 2008; however, the university did not state in its one-year response that it required broad-based advertising for all presidential and system executive position searches. Instead, the university asserted that broad advertising is embedded into practice for recruitment of system executives and university presidents.
- ➔ In its one-year response, the university did not address the recommendation that it should develop policies regarding the diversity of search committees for presidential positions and consider alternatives to increase their diversity. However, in previous responses, the university stated that with respect to developing policies about the diversity of trustees serving on presidential search

committees, appointment to the board is not within the control of the university system. The university claims that restricting membership of trustees and others based on gender and ethnicity to serve on presidential search committees could be a violation of Proposition 209. However, because of the importance of this issue, we believe that the university should explore ways in which to develop policies in this area that are consistent with Proposition 209.

Affordability of College Textbooks

Textbook Prices Have Risen Significantly in the Last Four Years, but Some Strategies May Help to Control These Costs for Students

REPORT NUMBER 2007-116, AUGUST 2008

Responses from the University of California and the California State University as of October 2008, and the California Community Colleges as of December 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the affordability of college textbooks in California’s public universities and colleges. As part of our audit, we were to evaluate the textbook industry and its participants—including faculty, students, and others involved with the three public postsecondary educational systems in the State—to determine how the participants’ respective roles affect textbook prices. In addition, the audit committee asked that we survey a sample of publishers to ascertain as much as possible about the methods that publishers use to set prices and market textbooks, including any incentives offered and the publishers’ decisions about textbook packaging and the need for revisions. Further, we were asked to determine and evaluate how the three postsecondary educational systems identify, evaluate, select, and approve textbooks for courses on their campuses. The audit committee also asked us to identify and evaluate the success of the processes and practices that the University of California (UC), California State University (CSU), and the California Community Colleges (community colleges) use to keep the costs of textbooks affordable.

Finding #1: Publishers have increased the prices they charge retailers, and bookstores add their markup to those prices.

A publisher sells a textbook to a campus bookstore at an invoice price, and then the bookstore adds a markup to that invoice price, arriving at a retail price that will enable the bookstore to at least cover its operating costs. To identify which participant in this process—the publisher or the campus bookstore—is contributing more to the overall increase in the textbook prices students have to pay, we reviewed historical invoice prices and retail prices for a sample of three textbooks adopted by faculty at each of the nine campuses for use during academic years from 2004–05 through 2007–08. We found that the nine campus bookstores we reviewed generally apply a consistent percentage markup to the invoice price for each textbook they sell. Therefore, bookstores’ retail prices are increasing proportionately to the increases in the publishers’ invoice prices. Ultimately, then, the increase in the publishers’ invoice prices is driving the rise in the bookstores’ retail prices, which leads to increasing textbook costs for students.

The markups campus bookstores apply to publishers’ invoice prices for textbooks range from a low of 25 percent to a high of 43 percent at the nine campuses we reviewed. Campus bookstores generally use the proceeds resulting from these markups to cover their operating costs and, in some cases, to support campus activities and organizations.

Audit Highlights . . .

Our review of the affordability of college textbooks at the University of California (UC), California State University (CSU), and the California Community Colleges (community colleges) systems revealed the following:

- » *Increases in textbook prices have significantly outpaced median household income, which makes it more likely that some students will forgo or delay attending college because of the financial burden that postsecondary education imposes.*
- » *Students can somewhat offset rising textbook costs by purchasing used books or purchasing textbooks from third parties that advertise their textbooks with on-line retailers.*
- » *Several key players in the textbook industry believe the used textbook market drives up the cost of new textbooks and may play a role in how frequently publishers issue new editions.*
- » *Of 23 textbooks we reviewed, publishers released a new edition about every four years on average; however, many of the deans, department chairs, and faculty members that we interviewed stated that revisions to textbooks are minimal and are not always warranted.*
- » *Even though bookstore managers claim that timely textbook adoptions enable them to pay students more for used textbooks and allow them to procure more used books to sell in the next term, the majority of faculty submit textbook adoptions after the initial deadline.*

continued on next page . . .

- » *Campus bookstores have implemented several strategies to reduce students' textbook costs; however they have not consistently employed them.*
- » *The community colleges and CSU, with some participation from UC, have explored possible solutions for the rising costs of textbooks, including open educational resources and the Digital Marketplace, both of which offer means of content delivery that differ from that of traditional textbooks.*

Moreover, the markups that campus bookstores add to the publishers' invoice prices do not only apply to new books; they also apply to used textbooks the campus bookstores purchase from wholesalers or buyback from students at the end of an academic term. Generally, campus bookstores sell a used textbook at 75 percent of the new version's retail price, even though the price students receive at buyback is below that.

After the bookstores cover the operating costs with the proceeds resulting from their markups, they may contribute a portion of their revenues to campus functions, such as the operations of the associated students organization. For instance, in fiscal year 2006–07, the auxiliary that manages the bookstore and food services operation at one campus we reviewed made a contribution of \$100,000 to the university to support various student activities. However, in that same fiscal year the auxiliary's food services operation reported a \$600,000 loss, which the auxiliary covered using the \$1.6 million profit the campus bookstore earned over the same period. Although we recognize that these monetary contributions are important to some campus functions, such as student activities and dining services, it is difficult to assess whether students value these services enough to warrant the markup on textbooks. Given that some students may not want to fund these types of activities by paying higher textbook costs, it seems reasonable for campuses to solicit student feedback on whether they support using the revenues from bookstores to fund various student activities.

To increase awareness and transparency about the reasons campus bookstores add markups to publishers' invoice prices for textbooks, we recommended that UC, CSU, and the community colleges require campuses to reevaluate bookstores' pricing policies to ensure that markups are not higher than necessary to support bookstore operations. If the campuses determine that bookstore profits are needed to fund other campus activities, the campuses should seek input from students as necessary to determine whether such purposes are warranted and supported by the student body, particularly when higher textbook prices result. Further, campuses should direct bookstores to publicly disclose on an annual basis any amounts they use for purposes that do not relate to bookstore operations, such as contributions they make to campus organizations and activities.

UC's Action: None.

UC did not address these recommendations in its 60-day response to our audit report. However, UC acknowledged that it is still in the process of developing more specific action plans for implementing many of the recommendations, which it plans to include in its six-month response to our audit report.

CSU's Action: Pending.

According to CSU, it is in the process of determining the best methods to use to evaluate the competing factors that lead to textbook pricing. It asserts that campuses will evaluate the existing contracts they have with bookstores. Further, CSU states that it is exploring ways to seek input, beyond the elected student representatives, from the general student body when bookstore profits are used to fund other campus activities, and whether

such purposes, particularly if they result in higher textbook prices, are warranted. In addition, CSU reports that it is in the process of determining whether there is a more explicit mechanism, other than the annual disclosure of net income from bookstore operations contained in the campus auxiliaries' audited financial statements, for disclosure of bookstore contributions to other campus operations.

Community Colleges' Action: Pending.

According to the community colleges, it plans to initiate consultation with college chief executive officers, chief business officers, and bookstore managers to encourage them to implement this recommendation. The community colleges also states that it will initiate a conversation with the Association of College Business Officers on the contents of this recommendation and the best way for it to be implemented on local campuses. Furthermore, the community colleges indicated that it will recommend to colleges that transparency in bookstore pricing policies be addressed by local textbook taskforces that are already in existence or that were created in response to recommendations that were adopted in May 2008 by its board of governors.

Finding #2: Many faculty members do not understand how their decisions and priorities affect the textbook costs to students.

Nearly all the faculty members we interviewed about state laws encouraging them to participate in efforts to reduce textbook costs were unaware of them, and many did not understand how their textbook adoption decisions and priorities could affect students' textbook costs. For instance, state law encourages faculty to place their orders in a timely manner with their campus bookstores, and bookstore managers agree that prompt orders enhance their ability to provide students with opportunities for cost savings. However, according to the bookstores' records, most faculty members at the nine campuses in our review failed to meet the bookstores' submission deadlines for textbook adoptions. Specifically, campus bookstores received on average just 20 percent of the required textbook adoptions by the stores' deadlines, which typically fall in the middle of the preceding academic term. Only two of the nine campus bookstores reported receiving more than one quarter of the adoptions on time. Several bookstore managers said that in some cases instructors receive teaching assignments after textbook adoption due dates have passed. Although we acknowledge that these late assignments might contribute to the low submission rates previously noted, our finding that nearly half of the faculty members we spoke to were not aware of the importance of submitting their textbook choices in a timely manner suggests that lack of faculty awareness is likely a dominant factor.

Further, although state law encourages faculty to consider the least costly practices when selecting and assigning textbooks, many faculty members, department chairs, and deans we interviewed at nine campuses stated that cost is the last factor they consider or that they do not consider cost at all during the textbook adoption process. For instance, one professor listed 10 factors he considers more important than cost and cited only the availability of the textbooks as less important than cost. Many faculty members expressed similar priorities, explaining that they choose textbooks by considering factors like quality, readability, and relevance of content rather than cost. Although we acknowledge the importance of providing students with a quality education, faculty's failure to consider less costly textbooks that do not compromise quality may play a role in increasing students' textbook costs.

Additionally, some faculty members we interviewed did not know that bundled textbooks frequently have no resale value. Bookstore managers at the campuses we reviewed stated that they accepted few or no bundled textbooks or their components during buyback at the end of the academic term. Although some bookstore managers stated they sometimes purchase bundled items from students, they explained that usually publishers bundle textbooks with items that cannot be reused, such as CDs with expiring access codes or workbooks with removable pages. However, according to bookstore managers, even a bundle consisting of several separate textbooks may have no buyback value because the publisher has changed the components of the bundle in a revised edition that faculty adopt for the next academic term. Thus, bundled textbooks prevent buyback and limit the used textbook market, depriving students of short-term cost savings they might otherwise realize if faculty had not required them to purchase a textbook bundled with other items.

We recommended that UC, CSU, and the community colleges issue systemwide guidance on the textbook adoption process to ensure that faculty members are aware of factors affecting textbook costs. This guidance should direct campuses to communicate the provisions contained within recent state laws regarding textbook affordability; to advise faculty to submit their textbook adoption information to the bookstores by the due dates; to encourage faculty to consider price in the textbook adoption process and, without compromising the quality of the education students receive or the academic freedom of faculty, to consider adopting less costly textbooks whenever possible; and to instruct faculty to consider adopting textbooks that are not bundled with supplementary products, unless all the components are required for the course.

UC's Action: None.

UC did not specifically address this recommendation in its 60-day response to our audit report. However, UC acknowledged that it is still in the process of developing more specific action plans for implementing many of the recommendations, which it plans to include in its six-month response to our audit report.

CSU's Action: Corrective action taken.

In October 2008 CSU's executive vice chancellor/chief academic officer distributed an official "coded" memorandum to campus presidents requesting that they distribute a message to all faculty regarding our recommendations and that they renew their message to all faculty at appropriate times in order to remind them each academic term to take actions that may result in lower costs to students for textbooks and learning materials. CSU included a "draft text of a message to faculty regarding textbook affordability" for presidents to use at their discretion in communicating the recommendations in our report that relate to ensuring faculty members are aware of factors affecting textbook costs.

Community Colleges' Action: Pending.

According to the community colleges, it developed recommendations to colleges on textbook affordability in a report that it presented to its board of governors in May 2008 that address several of the bureau's recommendations. It indicated that one of the primary recommendations in its report was for colleges to create local textbook affordability taskforces that would include academic senates, faculty, and other stakeholders to address these issues. According to the community colleges, campuses began working on implementing the recommendations in its report at the start of the 2008–09 academic year. Further, the community colleges indicated that management and staff of its system office have made several presentations at statewide conferences of various community college stakeholders on textbook affordability between March and November 2008 that address the bureau's recommendations. It plans to have staff continue to make presentations at statewide conferences in the coming year whenever the opportunity presents itself. In addition, the community colleges stated that its system office is in the process of developing an on-line archive and Web site of research, policy, legislation, links, and other useful information to assist local college textbook affordability taskforces in implementing our recommendations. Once the Web site is complete, the community colleges plans to email an announcement of its contents to the distribution lists of all major community colleges constituent groups, including faculty. The community colleges indicate that it has begun the planning phase of this Web site and anticipates a completion date of February 2009.

Finding #3: Campus bookstores use inconsistent methods to reduce textbook costs for students.

Although a single campus bookstore might implement several strategies to reduce students' textbook costs, the bookstores across the three postsecondary educational systems we reviewed are inconsistent in the types of strategies they use. For instance, some campus bookstores guarantee they will buy back certain textbooks at the end of an academic term for 50 percent of the books' retail prices—even if faculty do not readopt the books or the publishers issue new editions. Other campus bookstores do

not offer such guarantees. Likewise, some but not all campus bookstores have developed incentives that encourage faculty to submit their textbook choices on time and thus increase the likelihood that the bookstores can procure used textbooks and pay higher amounts to students during buyback. By implementing consistent strategies that are equally effective, campus bookstores could provide greater opportunities for all students across the three systems to realize similar cost savings.

We recommended that UC, CSU, and the community colleges issue guidance directing campuses to advise their bookstores to evaluate the feasibility of implementing cost-saving strategies, such as low-price guarantees and guaranteed buyback on certain titles, to the extent they have not already done so.

UC's Action: Pending.

UC did not specifically address this recommendation in its 60-day response to our audit report; however, it did acknowledge that it has shared the audit report widely and is encouraging all campuses to consider one campus bookstore's practice that has resulted in a higher proportion of faculty meeting the textbook adoption due dates, and other notable practices mentioned in the report because of their success. Further, UC stated that several of the bookstore managers have reported their individual efforts to address the objectives of the recommendations, as well as their efforts to share their practices with their colleagues. Finally, UC asserted that it is still in the process of developing more specific action plans for implementing many of the recommendations, which it plans to include in its six-month response to our audit report.

CSU's Action: Pending.

Although CSU did not specifically address this recommendation in its 60-day response, it reported that organizational conversations have commenced with campus bookstores to evaluate alternative ideas that could reduce textbook costs, including buyback, rental, or exchange programs.

Community Colleges' Action: Pending.

The community colleges addressed this recommendation in its response to finding number 2.

Finding #4: Some campuses have developed initiatives to reduce students' textbook costs.

All the campuses we reviewed enable faculty to place copies of required textbooks on reserve at the library, and some have implemented strategies specifically intended to reduce the cost of textbooks for students. For instance, we found that one of the nine campuses in our review operates a textbook loan program for low-income students and three other campuses operate student book exchanges. Although few colleges have implemented textbook loan and rental programs, these are strategies that could make textbooks more affordable for students. For example, the director of one campus bookstore, who also oversees that campus's rental program, indicated that students typically pay from 25 percent to 45 percent of the new retail price to rent a textbook. Further, as the administrator of student activities, the associate dean at another campus indicated that to his knowledge he oversees the only book loan program in the three systems. He indicated that students may borrow up to three textbooks at no charge for an entire academic term. However, textbook rental and loan programs typically require initial startup costs and may demand ongoing funding to continue operating, which might explain the low participation rates among colleges in these programs.

Student book exchanges may also offer opportunities for students to reduce their textbook costs. Three campuses we reviewed reported hosting student book exchanges, operated by the associated students organization on each campus. One of the three campuses offered unique support to the program through the cooperation of the campus bookstore. According to the associated students' business manager at this campus, the bookstore gives the book exchange access to its entire textbook-ordering database, which includes information on adopted textbooks and new and

used textbook prices. Students at all three-book exchanges are able to set their prices. However, faculty's decisions to adopt a different textbook, or the publishers' decisions to release new editions, play a role in the success of student book exchanges.

We recommended that UC, CSU, and the community colleges issue guidance directing campuses to evaluate the feasibility of implementing book rental programs or student book exchange programs to the extent they have not already done so.

UC's Action: None.

UC did not specifically address this recommendation in its 60-day response to our audit report. However, UC acknowledged that it is still in the process of developing more specific action plans for implementing many of the recommendations, which it plans to include in its six-month response to our audit report.

CSU's Action: Pending.

Although CSU did not specifically address this recommendation in its 60-day response, it reported that organizational conversations have commenced with campus bookstores to evaluate alternative ideas that could reduce textbook costs, including buyback, rental, or exchange programs.

Community Colleges' Action: Pending.

The community colleges addressed this recommendation in its response to finding number 2.

Finding #5: Open educational resources could provide long-term cost savings to students.

The community colleges have recently explored various avenues for reducing textbook costs for students and increasing faculty's awareness of their role in textbook pricing. During the fall of 2007 and spring of 2008 academic terms, the system office of the community colleges convened two textbook summits to identify strategies that campuses could implement to reduce textbook costs. In early May 2008, as a result of the summit meetings, participants compiled a list of 11 recommendations for consideration by the board of governors—the entity that sets policy and provides guidance for the community college system of 72 districts and 110 colleges. In May 2008 the board of governors approved the nine short-term and two medium- to long-term recommendations.

One long-term recommendation was to “promote awareness, development, and adoption of free, open educational resources in the community colleges as alternatives to high-cost textbooks and learning materials.” To produce a traditional textbook, publishers must pay various costs such as author royalties, production, and development costs and, according to several publishers, these costs affect the final price of the textbook. Open educational resources can provide content similar to that of a traditional textbook in a paperless, on-line format. The William and Flora Hewlett Foundation, which is active in promoting open educational resources, defines them as teaching, learning, and research resources that reside in the public domain or have been released under intellectual property licenses that permit their free use or repurposing by others. Open educational resources include full courses; course materials; modules; textbooks; streaming videos; tests; software; and any other books, materials, or techniques used to support access to knowledge. According to one professor at a community college who uses open educational resources in her classroom and participated in the summit meetings, these resources offer an alternative approach to content delivery, as well as the potential for improved student learning and long-term cost savings to students.

Although open educational resources have received some faculty support, many faculty members are concerned that the content of this learning material may not be as credible as a traditional textbook, which typically undergoes a peer review process. Further, participants in the community college summit discussed potential issues about the compatibility of open educational resources and the requirements of the articulation process. According to the president of the academic senate for community colleges, UC and CSU will not accept transfer credits for certain Web and online classes. However, he stated that

the system office of the community colleges, the UC office of the president, and the CSU chancellor's office continue to refine articulation issues. Thus, as open educational resources is being developed as a possible long-term cost-saving strategy for students, the three systems need to clarify its impact on articulation requirements.

We recommended that the system offices of UC, CSU, and the community colleges continue taking steps to promote awareness, development, and adoption of open educational resources as alternatives to traditional textbooks. Further, to ensure that courses taught by faculty who mainly use these alternative instructional materials meet the articulation requirements for transfer to the UC and CSU systems, faculty and the system offices should collaborate to develop acceptable standards and policies related to content, currency, and quality of open educational resources.

UC's Action: Pending.

Although UC did not specifically address this recommendation in its 60-day response, it did state that it is partnering with the community colleges in the Hewlett-funded Open Textbook Project (project). According to UC, this effort aims to create free or low-cost, high-quality textbooks for community college students. Further, UC reported that its Strategic Publishing and Broadcast Services, which creates on-line courses targeted to the one million California students with limited access to college prep materials, is publishing an on-line course component for the project's first open textbook, a popular work co-authored by two community college mathematicians. UC stated that these on-line courses are all openly available on the Internet. UC acknowledged that it is still in the process of developing more specific action plans for implementing many of the recommendations, which it plans to include in its six-month response to our audit report.

CSU's Action: Pending.

CSU reported that it is continuing conversations with the community colleges regarding smooth articulation for those courses that use open educational resources. Further, CSU asserts that it has been a leader in open educational resources since 1997 with the development of the Multimedia Educational Resource for Learning Online Teaching (MERLOT). MERLOT is a digital library that contains over 20,000 free on-line learning materials across a wide range of academic disciplines. CSU stated that it recently partnered with the Public Interest Research Group to create and support a digital library service for people creating and searching for open educational resources. Further, CSU states that its Academic Technology Services division is delivering a program throughout the system to educate faculty on how best to utilize open educational resources to support use of both the open textbook collection as well as all other free instructional content. CSU reported that this program will include, among other things, workshops on the MERLOT digital library, an incentive program for faculty members to encourage their promotion and training of free MERLOT resources and the electronic core collection of CSU libraries—which is free for campus use due to systemwide licensing of these library resources. Further, CSU asserts that it will monitor campus bookstore pilots of digital textbooks to enable systemwide communication of pilot results.

Community Colleges' Action: Partial corrective action taken.

The community colleges stated that it plans to collaborate with the UC Office of the President, CSU Chancellor's Office, and with faculty on issues related to articulation and open educational resources through several existing mechanisms. Furthermore, the community colleges indicated it will continue to promote awareness, development, and adoption of open educational resources through the actions recommended by the community colleges board of governors in its May 2008 meeting. It also stated that its system office will support legislation and faculty development related to open educational resources, as well as the continued efforts of organizations like Community College Consortium for Open Educational Resources, and others to discover, create, and deploy these resources. Finally, the community colleges pointed out that AB 2261, which was chaptered in September 2008 and will go into effect January 1, 2009, authorizes the board of governors to establish a pilot program to provide faculty and staff from community college districts around the State with the information methods and instructional materials to establish open educational resources centers.

Finding #6: The CSU is in the process of developing the Digital Marketplace.

In addition to open educational resources, the Digital Marketplace—a one-stop, Web-based service for selecting, contributing, sharing, approving, procuring, and distributing no-cost and cost-based academic technology products and services—is another long-term strategy in the beginning stages of development by CSU. To provide a clearer definition of what this program will entail, the senior director of academic technology services for CSU (senior director) stated that the Digital Marketplace will be a centrally maintained system administered by individual campuses containing free content, such as open educational resources, as well as fee-based content, such as single chapters in digital format, for faculty to access and adopt as the educational materials they will use in their courses. Using this system or Web site, faculty will be able to select both free and fee-based digitized content for their courses, and students will no longer be required to purchase printed textbooks. Students also will be able to log on to the Web site to purchase the fee-based content and obtain the free materials at their own discretion. The senior director anticipates that each campus will be able to customize their Digital Marketplace services to meet their individual needs. Thus, it will allow publishers to provide educational content directly to students, bypassing the campus bookstore as a textbook retailer and eliminating the bookstore's markup on textbooks.

However, according to the senior director, despite its efforts to involve a broad base of CSU participants, the chancellor's office understands that faculty have diverse opinions of technology. Thus, one of the challenges confronting the Digital Marketplace is faculty resistance to digital teaching resources. Beyond faculty usage, the senior director described how the success of the Digital Marketplace partly depends on its reception by current and future college students. However, current college students have indicated that they prefer to read printed material, and the few copies of digital textbooks available at campus bookstores do not sell well. Thus, resistance from students as well as faculty may pose continuing obstacles for the implementation of the Digital Marketplace.

We recommended CSU to continue its efforts to develop, implement, and promote awareness of the Digital Marketplace, and while doing so, to monitor any resistance from students and faculty to ensure that the digital education content aligns with their needs and preferences.

CSU's Action: Pending.

CSU acknowledged that it will continue its efforts regarding the Digital Marketplace and make necessary modifications to respond to the needs and preferences of students and faculty. In its 60-day response, CSU stated that it is developing and testing a prototype of the Digital Marketplace. Specifically, it reported that the office of the chancellor has partnered with CSU San Bernardino in the testing of the prototype with a focus on faculty in academic year 2008–09. Further, CSU asserts that the Long Beach Center for Usability in Design and Accessibility will be testing the Digital Marketplace prototype with students in academic year 2008–09.

California Department of Education

Although It Generally Provides Appropriate Oversight of the Special Education Hearings and Mediations Process, a Few Areas Could Be Improved

REPORT NUMBER 2008-109, DECEMBER 2008

The California Department of Education's and Department of General Services' Office of Administrative Hearings' response as of December 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine how the Department of General Services' Office of Administrative Hearings (Administrative Hearings) has conducted its operations since it began administering the special education hearings and mediations process. Specifically, the audit committee requested that we review and evaluate applicable laws, rules, and regulations specific to special education hearings and mediations and determine the roles and responsibilities of both the California Department of Education (Education) and Administrative Hearings, including any oversight responsibilities Education has related to Administrative Hearings' performance under the interagency agreement. The audit committee also requested that we make recommendations related to the future provision of special education mediation and adjudication functions, as appropriate.

Finding #1: Education needs to continue to work with Administrative Hearings to ensure that it reports all required information in its quarterly reports and its database contains accurate and complete information.

Our review of one of Administrative Hearings' quarterly reports for each fiscal year between 2005–06 and 2007–08 found that it had not consistently included in these reports 10 items that the interagency agreement requires. By not ensuring that Administrative Hearings is consistently including all required information in its quarterly reports, Education is unable to review the information as part of its oversight activities, and it is not ensuring that Administrative Hearings complies with the reporting requirements of its interagency agreement and state law.

According to Education, it was aware that Administrative Hearings was not including all the required information in its quarterly reports, and we found some evidence that staff from Education and Administrative Hearings discussed this issue during monthly meetings involving both agencies. In September 2008 the presiding administrative judge for Administrative Hearings indicated that Administrative Hearings has modified the database to include the missing information, beginning with the first quarterly report for fiscal year 2008–09. However, when we later reviewed its first quarterly report, we found that Administrative Hearings was still missing one of the 10 items. It was not until we informed Administrative Hearings that the quarterly report was still missing one item that it amended the quarterly report to include all the required items on November 13, 2008.

Audit Highlights . . .

Our review of the California Department of Education's (Education) oversight of the special education hearings and mediations process revealed that:

- » *The average cost per case closed has increased by 14 percent since the Office of Administrative Hearings (Administrative Hearings) took over the hearings and mediations process.*
- » *The average time the University of the Pacific's McGeorge School of Law took to close cases was 185 days, whereas, Administrative Hearings took an average of 118 days.*
- » *Neither Education nor any other entity tracks the total number and cost of appealed hearing decisions.*
- » *Education could improve its oversight to ensure Administrative Hearings is meeting established standards called for in its interagency agreement.*
- » *Administrative Hearings did not consistently include 10 items, required by the interagency agreement, in its quarterly reports to Education—seven of these items are also required by state law and five of these items must be reported annually to the federal government.*
- » *Administrative Hearings was unable to provide documentation demonstrating that its administrative law judges receive all the training required by state law and the interagency agreement.*
- » *Administrative Hearings has not always issued hearing decisions within the legally required time frame, which could potentially lead to sanctions by the federal government.*

Additionally, our review of Administrative Hearings' new database—Practice Manager—found that the data were inaccurate or missing in certain fields. Specifically, we reviewed a sample of 29 closed cases and found that the reason-for-closure field was inaccurate for one case and missing for another. Additionally, for three cases, one of the following fields were inaccurate: closed within the legally required time frame, case closed date, and case opened date. According to Administrative Hearings, it uses these fields to compile certain data that it includes in the quarterly reports it submits to Education.

To ensure that Administrative Hearings complies with state and federal laws, as well as with the specifications in its interagency agreement, we recommended that Education, in its oversight role, continue to work with Administrative Hearings to ensure that it reports all the required information in its quarterly reports and that its database contains accurate and complete information.

Education's Action: Partial corrective action taken.

According to Education, it has been working with Administrative Hearings to ensure that the required information is included in the quarterly reports. Education also indicated that it is exploring options that will further strengthen existing monitoring procedures to ensure that all information, as required in the interagency agreement with Administrative Hearings, is accurate and included in the quarterly reports. For example, it stated that it plans to develop a monitoring checklist to ensure that all required information is received timely from Administrative Hearings. Finally, to further ensure the accuracy of the Administrative Hearings' database, Education plans to review and inspect, on a sample basis, books, documents, papers, and records supporting required information that is contained in Administrative Hearings' quarterly reports.

Finding #2: Education has not verified that the administrative law judges (administrative judges) are receiving the appropriate training.

Education has not taken steps to verify that Administrative Hearings is ensuring that its administrative judges receive all the training required by state law and the interagency agreement. Administrative Hearings has reported to Education that its administrative judges have participated in the required training. However, when we selected 15 administrative judges and attempted to verify that they had taken two classes listed in Administrative Hearings' report, we found that Administrative Hearings could not always demonstrate that all 15 had, in fact, taken the two courses.

To ensure that Administrative Hearings complies with state and federal laws, as well as with the specifications in its interagency agreement, we recommended that Education, in its oversight role, require Administrative Hearings to maintain sufficient documentation showing that its administrative judges have received the required training and review these records periodically to ensure that Administrative Hearings complies with the training requirements.

Education's Action: Pending.

Education entered into a new interagency agreement with Administrative Hearings effective June 26, 2008, for the period of July 1, 2008, through June 30, 2011, and it requires Administrative Hearings to provide Education with quarterly training logs for each administrative judge and mediator covering training taken during the previous quarter. To ensure accuracy of training data, Education stated that it plans to conduct periodic reviews of documentation supporting the quarterly logs for a sample selection of administrative judges and mediators. It also stated that its review of documentation will include training certificates or similar documentation from the training entity or instructor delineating the course description, date and hours of training, and attendee names.

Finding #3: Administrative Hearings has not always issued hearing decisions within the legally required time frame.

Our audit revealed that Administrative Hearings has not always issued hearing decisions within the legally required time frame. For example, Administrative Hearings reported that it issued only 29 percent and 57 percent of its decisions on time in the third and fourth quarters of fiscal year 2005–06, respectively, and it issued on time decisions 72 percent of the time in the first quarter of fiscal year 2006–07. The types of noncompliance related to timeliness of decisions could potentially lead to sanctions by the federal government and affect special education funding for the State. For its part, Education has been raising this issue with Administrative Hearings in letters requesting corrective action plans and during monthly meetings between staff of Education and Administrative Hearings. Administrative Hearings has reported measurable improvements, including that since the second quarter of fiscal year 2006–07 it had only about one late case in each quarter. However, despite this improvement, it needs to issue 100 percent of its hearing decisions on time to ensure that it complies with relevant laws and regulations.

To ensure that Administrative Hearings complies with state and federal laws, as well as with the specifications in its interagency agreement, we recommended that Education, in its oversight role, continue to monitor Administrative Hearings to ensure that it consistently issues hearing decisions within the time frame established in federal regulations and state law so that Education is not exposed to possible federal sanctions.

Education's Action: Pending.

Education stated that it concurs with the bureau that Administrative Hearings should issue 100 percent of its hearing decisions on time. It indicated that it will continue to monitor Administrative Hearings to ensure that all hearing decisions are issued within the required time frames established by federal regulations and state law.

County Poll Workers

The Office of the Secretary of State Has Developed Statewide Guidelines, but County Training Programs Need Some Improvement

REPORT NUMBER 2008-106, SEPTEMBER 2008

Office of the Secretary of State and five county registrar offices' responses as of November 2008 (three counties did not provide a 60-day response)

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct an audit of the county registrars' training of poll workers. Specifically, the audit committee requested that we determine the role of the Office of the Secretary of State (office) in providing guidelines or standards to county registrars' offices, including those for the training of poll workers, and whether those guidelines meet the requirements set in law and regulations, are periodically updated, and adhered to by the counties. In addition, the audit committee requested that, for a sample of counties, we identify the methods, format, amount, timing, and frequency of training provided to poll workers, and whether the training complies with the guidelines provided by the office, is assessed for effectiveness, and are adequately updated. Further we were asked to determine how each county trains poll workers to handle complaints, the actions each county takes when receiving complaints, and how each county determines the number of poll workers to assign to each polling place.

Finding #1: The office has provided guidelines for training county poll workers, but lacks a directive to monitor their use by the counties or update the guidelines.

In 2003 the Legislature enacted a law that required the office to establish a task force to recommend uniform guidelines for training poll workers. The guidelines were to include certain topics, such as voters' rights and polling place operations. In 2006, as required by state law, the office published the *Poll Worker Training Guidelines 2006* (training guidelines), which reflects the work of the task force. The document was not intended to take the place of training materials or resources for poll workers; rather, it was to establish a minimum set of requirements that training sessions and materials developed by the counties must meet and to set a standard against which county programs for poll workers should be measured.

The law does not require the training guidelines to be updated, and the office has not done so since issuing them in 2006. Nevertheless, senior management at the office have expressed a desire to update the training guidelines and have acknowledged that to do so, the office would need to convene a task force similar to the one used to develop the original training guidelines.

One subject not covered in the training guidelines is the rights of voters who registered to vote without declaring a political party affiliation (decline-to-state voters). The office's senior management stated that in the February 2008 presidential primary election, many

Audit Highlights . . .

Our review of county elections officials' training of poll workers revealed the following:

- » *In 2006 the Office of the Secretary of State (office) adopted poll worker training guidelines (training guidelines), as required by law.*
- » *The law does not require the training guidelines to be updated and the office has not done so since issuing the training guidelines in 2006.*
- » *The office's senior management asserts that although the law does not direct the office to monitor counties' compliance with the training guidelines, the office does conduct some observations of counties' elections and shares the results of its findings with the counties it observes.*
- » *The eight counties we reviewed substantially complied with the content of the training guidelines when training their inspectors, but some counties appeared to only partially train poll workers in certain areas.*
- » *Some counties employed noteworthy practices targeted toward providing poll workers with added opportunities to practice what they have learned.*
- » *Not all counties required inspectors to attend training or were able to demonstrate they trained all inspectors prior to the February 2008 election.*

continued on next page . . .

- » *None of the counties could clearly demonstrate how the information collected from the February 2008 election was summarized and used to update their training for the June 2008 election.*
- » *Many of the counties were not able to provide reliable data that described how they resolved voter and poll worker complaints.*

decline-to-state voters were confused about which political parties' candidates they could cast ballots for because only two of California's six qualified political parties had authorized this type of voter to cast ballots in their primaries. In addition, some news agencies reported that poll workers gave unclear instructions to decline-to-state voters and that poll workers were unsure as to how much information they could volunteer to these voters. The office has taken steps to eliminate voter and poll worker confusion, such as emphasizing the rights of decline-to-state voters in its June 2008 Voter Information Guide. In addition to its guidelines, the office has communicated training information through periodic memorandums (memos) to county elections officials, as well as through trainings and informational seminars conducted by the California Association of Clerks and Election Officials (CACEO), an association of county elections officials. The office uses the memos as a means of communicating with county elections officials about election-related topics. Of the more than 650 memos the office issued between April 2006 and April 2008, we found that 11 seemed to have implications for poll worker training.

Although not required to do so, the office performs limited monitoring of the poll worker training conducted by counties. The office's senior management noted that although the law establishes the secretary of state as the chief elections officer it does not direct the office to track whether counties conform to the office's guidelines when training poll workers or to develop regulations or policies surrounding poll worker training. However, the office does perform some monitoring of counties' administration of elections through its Election Day Observation Program (observation program). Created in 2003, the observation program began as a poll monitoring program that focused on preventing issues such as long lines at polling places and the intimidation of voters. Subsequent election reviews have focused on how well counties were complying with federal election requirements. During the February 2008 primary election, the office staff visited 31 counties and afterward shared their observations with each county to help them identify ways to strengthen their respective poll worker training. The office performed a similar review in June 2008, and the office's senior management stated that they plan to perform a review in November 2008 but are uncertain about the 2010 election cycle. According to the deputy director of operations, whether the observation program will continue in 2010 is dependent upon available resources and whether changes in the law require changes in polling place operations that dictate a need to observe how the counties are implementing those changes. Many of the eight counties we reviewed look to other sources of information, rather than the office when updating their training programs. Three of the eight counties we visited told us they do not believe they are required to follow the training guidelines. One county told us that it seldom reviews the training guidelines for current elections because the guidelines have not been updated. Seven of the eight mentioned using the CACEO or the United States Election Assistance Commission (commission) for information to update their poll worker training programs. The Election Administration Research Center (center) at the University of California, Berkeley, is another organization that provides tools to counties for improving their training programs. The center released two reports summarizing its findings from surveys of poll workers that the center administered during the 2006 election cycle.

We recommended that the Legislature consider amending the Elections Code to explicitly direct the office to periodically update its poll worker training guidelines and to monitor county adherence to these standards. In the interim, the office should continue with its plans to update its training guidelines and incorporate new guidance on the proper handling of decline-to-state voters. Finally, to the extent feasible, the office should continue its efforts to monitor county adherence to its guidelines through its observation program.

Legislative Action: Unknown.

There does not appear to be any pending legislation that would require the office to periodically update its poll worker training guidelines.

Office's Action: Partial corrective action taken.

The office reports that it will update its poll worker training guidelines in 2009 and has advised county election officials that it will form a committee in the coming months to revise and expand the guidelines to address additional topics, including decline-to-state voters. In addition, the office stated that it had conducted an observation of selected counties for the November 4, 2008, general election. According to the office, it observed the counties in which it had noted deficiencies during the June 2008 statewide direct primary election. The office reported to us that the counties it observed appeared to have corrected all of the deficiencies that were identified during previous observations and no new issues were noted.

Finding #2: County elections officials generally followed the poll worker training guidelines issued by the office and instructed poll workers on the voting options of decline-to-state voters for the June 2008 election.

The eight counties we reviewed substantially complied with the content of the office's training guidelines when training poll workers, which consist of the inspectors who supervise polling places and the clerks who staff them. However, some counties appeared to only partially train poll workers in certain areas. For example, Fresno County partially trained its inspectors on voters' rights to replace spoiled ballots, but did not train them on voters' rights to report illegal or fraudulent activity. Further, three counties in our sample only partially trained poll workers on cultural competency. Specifically, these three counties trained poll workers to display multilingual materials, but not on how to be respectful of diverse cultures. Additionally, some counties did not use suggested training methods, such as role playing for processing voters' ballots and hands-on training for teaching workers to operate voting machines. However, after encountering problems in the February 2008 primary election with ensuring the rights of decline-to-state voters, the eight counties whose training we observed all discussed the voting options available to these voters prior to the June 2008 election.

To ensure that poll worker training programs conform with the office's guidelines, we recommended that county elections officials review the content of their programs, ensuring their training fully covers topics such as voter complaint procedures, preventing voter intimidation, and issues pertaining to a culturally diverse electorate.

Alameda County's Action: Corrective action taken.

At the time of the audit, Alameda County could not demonstrate that it instructed poll workers to be polite to voters and respectful of diverse cultures. In addition, the audit found that Alameda County didn't employ certain training methods called for under the office's guidelines, such as using role-playing scenarios and asking questions of the audience to reinforce key points.

In its 60-day update to the audit, Alameda County provided evidence that it modified its training presentation to stress the importance of poll workers being polite and respectful to all cultures. In addition, the county indicated that its training sessions for the November 2008 election were interactive and included role-playing scenarios.

Fresno County's Action: Corrective action taken.

At the time of the audit, Fresno County could not demonstrate that it had trained poll workers on voters' rights to report illegal/fraudulent activity, prohibiting the intimidation of voters at the polls, and being polite and respectful of diverse cultures. In addition, the county could not demonstrate that it provided hands-on training on the use of voting equipment or used role-playing scenarios during training.

In its 60-day response to the audit, Fresno County stated that for the November 4, 2008, election it implemented the three training topics we reported were missing from its poll worker training program: voters' rights to report illegal or fraudulent activity, prohibiting the intimidation of voters, and being polite to voters and respectful of diverse cultures.

Kings County's Action: Corrective action taken.

At the time of the audit, Kings County's training program did not train poll workers on being polite and respectful to all cultures. In addition, the county did not offer hands-on practice with voting equipment and did not use role-playing exercises during the training class we observed.

In its 60-day response to the audit, Kings County provided an update on its efforts to implement the audit report's recommendations that included an expanded training presentation on voters' rights, treating voters politely, and respecting cultural diversity.

Los Angeles County's Action: Corrective action taken.

At the time of the audit, Los Angeles County's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Los Angeles County did not provide a 60-day update on its efforts to implement this recommendation, however, based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

Orange County's Action: Corrective action taken.

At the time of the audit, Orange County's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Although Orange County provided a 60-day update on its efforts to implement some of the audit report's recommendations, it did not address this specific recommendation. Nevertheless, based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

San Diego County's Action: Pending.

At the time of the audit, San Diego County's training program did not provide poll workers with training on preventing voter intimidation at the polls.

San Diego County did not provide a 60-day update on its efforts to implement the audit report's recommendations. Further, its response to the audit report did not address this specific recommendation.

Santa Clara County's Action: Corrective action taken.

At the time of the audit, Santa Clara's training program complied with the office's poll worker training guidelines. The audit report's Appendix and Table 2 provide more information on which aspects of poll worker training we reviewed during the audit.

Santa Clara County provided a 60-day update on its efforts to implement the audit report's recommendations, reaffirming that it complies with the office's training guidelines. Based on its performance during the audit, we believe the county requires no additional action regarding this specific recommendation.

Solano County's Action: Pending.

At the time of the audit, Solano County's training program did not train poll workers on voters' right to report illegal/fraudulent activity, prohibiting voter intimidation at the polls, and did not offer hands-on training on all of its voting equipment.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its response to the audit, the county disagreed with the report's findings and indicated that it receives very few complaints from voters. The county's response to the audit did not address the lack of hands-on training for some voting equipment.

Finding #3: Some counties exhibited noteworthy practices for training poll workers.

In our review of eight counties, we observed some noteworthy training practices. Most of these practices seemed targeted toward providing poll workers with additional opportunities to practice what they have learned while also being sensitive to their time commitments. For example, we found that some counties offered training at various times and locations and tailored the content to the experience level of the attendees to promote greater training attendance. Others offered on-line training or optional workshops with opportunities for more hands-on training just prior to the election.

Recognizing that these practices may improve poll workers' willingness to attend training and their ability to retain the lessons learned, we recommended that county elections officials consider implementing the following practices:

- Maximize the number of training sessions scheduled for poll workers while also offering the training at multiple locations with different start times to better accommodate poll workers' other time commitments. Also, providing condensed training tailored to experienced poll workers may entice greater attendance, while more extensive training can be reserved for new poll workers.
- Offer poll workers an opportunity to reinforce what they learned in class through the use of on-line supplemental training material. Such an on-line program might include practice quizzes on election day procedures, examples of the election materials to be used, and reference materials provided at training. County elections officials might also consider providing podcasts that emphasize critical aspects of poll worker training.
- Provide optional workshops giving poll workers additional opportunities to practice what they learned and to get hands on experience in the use of election day supplies and voting equipment. County elections officials might consider providing these workshops on the days immediately before an election to maximize poll worker confidence and retention of information.

Alameda County's Action: Partial corrective action taken.

Alameda County's 60-day update indicated that it was evaluating the feasibility of having separate training classes for more experienced workers and new poll workers. The county also indicated that it is considering providing on-line training. For the November 2008 election, Alameda County collected on-line surveys from poll workers who commented on the strengths and weaknesses of the county's training program. The county also reported that it offered poll workers the opportunity for individualized, refresher training for those wanting more exposure to classroom materials and voting machines.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county indicated that it provides an optional "Lab Day" when poll workers can go through the set up and use of the voting machines. However, as we state in the

report, the county did not offer hands-on training during the training class we observed. The county's initial response to the audit did not include any additional perspective on the other aspects of this recommendation.

Kings County's Action: Pending.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county did not address the report's recommendations.

Los Angeles County's Action: Pending.

Los Angeles County did not provide a 60-day update on its efforts to implement this recommendation. In its response to the audit, the county did not address this specific recommendation. Nevertheless, our audit report commented on the county's use of on-line training for some of its poll workers.

Orange County's Action: Corrective action taken.

Our audit report recognized Orange County's approach of having different training classes depending on the experience level of individual poll workers. In addition, the audit report recognized the county's use of on-line resources such as podcasts and optional workshops where poll workers can reinforce what they learned in class. In its 60-day update, the county reported that it has continued its prior practices and began training poll workers as early as six weeks before the November 2008 election.

San Diego County's Action: Corrective action taken.

In its 60-day update on its implementation of our recommendations, San Diego reported that it implemented on-line training for its poll workers for the February 5, 2008, Presidential Primary, and 20 percent of its poll workers used the on-line training for both the June 3, 2008, and November 4, 2008, elections. Moreover, our audit report recognized San Diego County's use of optional workshops where poll workers could practice with classroom material and voting machines, reinforcing what they had learned in class. According to San Diego for the February, June, and November 2008 elections, 821, 729, and 729 poll workers, respectively, used the workshops to practice their election-day lessons. Finally, San Diego reports it uses a three-week train-the-trainer program to prepare its trainers to teach poll workers.

Santa Clara County's Action: Pending.

Santa Clara County's 60-day update did not address this specific recommendation. In its initial response to the audit, Santa Clara County disagreed with many aspects of our audit report, however, its response did not address this specific recommendation.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. The county indicated that it would be able to provide an update sometime during the first quarter of 2009. In its initial response to the audit, the county expressed its disagreement with many aspects of our audit report, however, its response did not discuss this particular recommendation.

Finding #4: Not all poll workers are required to attend training, and most counties we visited could not provide reliable training data.

Although state law requires that polling place inspectors receive training prior to election day, six of the eight counties we reviewed were unable to provide reliable data to demonstrate that all of their inspectors had been trained before the February 2008 election. Specifically, many counties had difficulty providing us complete and accurate lists of inspectors that received training. As a result, we were unable to evaluate whether all inspectors were trained. Of the two counties that could provide reliable

data, one acknowledged that not all of its inspectors were trained, while the other county was able to provide evidence that all its inspectors received training. As a result, many counties in our sample cannot be certain that all these workers have the knowledge to efficiently administer elections.

We recommended that to better ensure that county elections officials provide knowledgeable inspectors to serve voters, counties should take steps to ensure that all inspectors receive training. Steps that counties might take to achieve this goal include:

- Compiling accurate lists of inspectors who have attended training while informing inspectors who did not go through training that they cannot serve as inspectors.
- Recruiting reserve poll workers who have gone through inspector training to be deployed, as necessary, to polling places where the assigned inspectors did not receive the required training.

Alameda County's Action: Corrective action taken.

In its 60-day update, Alameda County reported that it began using a new software program for the June and November elections. At the time of our audit, we had looked into attendance for the February election since it was the most recent. The county asserts that it now uses this new software to track poll workers by assignment and to record training class attendance. Our audit report recognized that Alameda County tries to recruit reservist poll workers.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county indicated that it strives to train all poll workers (inspectors and clerks) and maintained that it had provided us with a thorough record of those attending class. However, as we reported on page 35 of the audit report, the county did not have training records for the February election and its records for the June 2008 election were incomplete, with six of the 29 trained poll workers in our sample missing from the training lists provided. Fresno County's initial response to the audit did not discuss our recommendation regarding reservist poll workers.

Kings County's Action: Corrective action taken.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In addition, the county's initial response to the audit did not address this specific recommendation. However, our audit report noted that the county had accurate attendance lists and that all inspectors attended training. As a result, we believe the county requires no additional action regarding this specific recommendation.

Los Angeles County's Action: Corrective action taken.

In its 60-day update on its efforts to implement the audit report's recommendations, Los Angeles reported that it has implemented a process to contact precinct inspectors to remind them to attend training. In its initial response to the audit, the county acknowledged that some inspectors work when they do not attend training, explaining that there are various causes for this phenomenon. To address this issue in the past, the county indicated that it had increased the monetary incentive for attending training and focused on developing written and video materials to ensure that poll workers have reference information to run a polling place "from scratch" on election day. The county's initial response did not address our recommendation regarding the recruitment of reservist poll workers. Nevertheless, we acknowledged in the audit report that the county has a goal of recruiting 400 reservist poll workers. As a result, we believe the county requires no additional action regarding this specific recommendation. In addition, in the audit report we acknowledge that Los Angeles County had reliable data on poll worker training.

Orange County's Action: Pending.

During the audit, we did not attempt to assess the accuracy of Orange County's poll worker attendance data because internal documents indicated that this data was inaccurate. In its response to the audit, the county explained that it understood our decision, but maintained that a further review of training attendance would show that all inspectors attended training prior to the February 2008 election. In its 60-day update to the audit report, the county explained that it has not altered its process and indicated it is "completing [its] accounting of the attendance for poll worker training classes [for] election day and will provide proof of training in subsequent responses." The county's 60-day update indicates that it continues to recruit reservist poll workers, which we had originally acknowledged in the audit report.

San Diego County's Action: Corrective action taken.

San Diego County reported in its 60-day update on its efforts to implement the audit report's recommendations that all precinct, assistant, and touchscreen inspectors are required to attend training before each election. Training for clerks is optional. The county scans bar codes from training sign-in sheets and prints an attended training report to document the total number of poll workers who attend training. San Diego County reports that for the November 4, 2008 election, it trained 7,203 poll workers and 300 reserve poll workers in case some poll workers dropped out before or on election day.

Santa Clara County's Action: Pending.

In its 60-day update, Santa Clara County indicated that it would compile and summarize data to demonstrate that, at a minimum, all inspectors are trained before election day. The county's update indicated that it would begin doing this compilation for the November 4, 2008, election. Santa Clara's update did not discuss our recommendation pertaining to reservist poll workers. However, on page 46 of the audit report we discuss the county's practice of purposefully over-recruiting inspectors.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its initial response to the audit, the county maintains that all of its inspectors received training and explained they could not have received their polling place supplies had they not attended training. In our rebuttal comment, we noted that the receipts for supplies the county provided did not have dates and could not be matched with the dates the county provided the training. The county's response did not address our recommendation regarding reservist poll workers.

Finding #5: Counties we visited collect data on the effectiveness of poll worker training from various sources, but none could demonstrate how they identified changes needed in poll worker training.

The elections officials from the eight counties we visited told us they use a variety of sources for collecting information to identify needed improvements in their poll worker training programs. These sources included post-training feedback from poll workers, comments from instructors, postelection debriefing reports, analyses of voter complaints, and reviews of questions from poll workers on election day. Seven of the counties were able to provide at least some documentation of the information they collected. However, none could clearly demonstrate how the information collected from the February 2008 election was summarized and used to make changes in their training programs for the June 2008 election. At most, counties were able to provide postelection evaluation reports that described what needed to be changed in their training programs for poll workers, however, these reports did not link their conclusions from the data collected to the proposed changes to be made. As a result, we could not determine whether the counties in our sample effectively used the information they collected to improve their poll worker training.

Under state law, voters have the right to ask poll workers and elections officials questions and register complaints about election procedures and to receive an answer or be directed to an appropriate elections official for an answer. Although most of the counties we reviewed discussed procedures for handling voter complaints in their poll worker training, the emphasis the counties placed on handling complaints varied. In addition, although all eight counties told us they receive complaint calls from voters or poll workers on election day, most counties we visited were unable to provide information on how they resolved voter or poll worker complaints.

To better ensure that training programs for poll workers are effectively evaluated and needed improvements identified, we recommended that county elections officials consider taking steps to track voter complaints and poll worker questions that are received during an election, evaluate whether such comments suggest ways to improve their training programs, and implement those improvements.

Alameda County's Action: Corrective action taken.

In its 60-day update, Alameda County provided examples of voter complaint logs it has developed that will be used in conjunction with its automated data systems to develop a synopsis of the election and identify needed changes to its poll worker training programs. The county reports this recommendation was implemented in time for the November 2008 election. Similarly, the county provided us with an example of its poll worker questionnaire that asks poll workers to discuss whether they believe they were adequately trained for election day.

Fresno County's Action: Pending.

Fresno County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county did not address this specific recommendation. In the audit report, we noted that the county lacked summarized data on voter complaints and poll worker questions on election day.

Kings County's Action: Pending.

Kings County did not provide a 60-day update on its efforts to implement this recommendation. In its initial response to the audit, the county did not address this specific recommendation. In the audit report, we noted that the county lacked summarized data on voter complaints and poll worker questions on election day.

Los Angeles County's Action: Corrective action taken.

In its 60-day update on its efforts to implement this recommendation, Los Angeles reported that it has fully implemented its on-line survey of the effectiveness of its on-line poll worker training. In addition, for the November 4, 2008 election, the county reports it sought more formal feedback on the effectiveness of poll worker and precinct coordinator classes from the instructors who conduct the classes. Further, in the audit report we recognized that the county has summarized data on voter complaints and poll worker questions on election day. In its initial response to the audit, the county indicated that it is now using a new database that will address all of the areas critiqued by our report.

Orange County's Action: Pending.

In its 60-day response to the audit, Orange County indicates that it will use poll worker surveys (from training class and post-election surveys), as well as other sources to determine the need for enhancements to its poll worker training. In addition, the county indicates that it will consider looking into tracking voter questions and concerns.

San Diego County's Action: Pending.

San Diego County states that the audit report concluded that it was unable to provide documented evidence of summarized data on poll worker questions or concerns on election day. The county stated that it does collect data on poll worker questions or concerns, but uses it to send troubleshooters out to specific precincts to resolve issues rather than to evaluate its poll worker training.

Santa Clara County's Action: Pending.

Santa Clara County's 60-day update indicated that its staff will summarize voter complaints and poll workers questions and compile reports that will highlight potential best practices. The county's response indicated that this process would be in place in time for the November 2008 election.

Solano County's Action: Pending.

Solano County did not provide a 60-day update on its efforts to implement the audit report's recommendations. In its initial response to the audit, the county maintained that the Elections Code does not require the county to keep detailed logs of complaints, questions, or its responses and solutions. In our rebuttal comments on page 106 of the audit report (comment #15), we recognize that counties are not required to document voter complaints and poll worker questions. Nevertheless, as we state in the report, relying on the county's assertions of its practices without corroborating documentary evidence would not provide a sufficient basis for our analysis.

Nevertheless, the county's initial response indicated that it currently is implementing a system to track public calls that may result in summarized data on poll worker and voter concerns.

Grade Separation Program

An Unchanged Budget and Project Allocation Levels Established More Than 30 Years Ago May Discourage Local Agencies From Taking Advantage of the Program

REPORT NUMBER 2007-106, SEPTEMBER 2007

California Department of Transportation's response as of September 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) perform an audit of the funding and approval process required for state and local transportation agencies for grade separation projects. Specifically, the audit committee asked the bureau to assess the roles and responsibilities of the various agencies involved in the funding and approval of grade separation projects to determine if any duplication of effort or program exists. Further, the audit committee requested that the bureau determine whether the Grade Separation Program is being administered and operated in accordance with the appropriate statutes and regulations, and that it identify any obstacles that state and local agencies face in meeting the program's legislative goals.

We also were asked to identify the funding sources for the Grade Separation Program and to determine whether the program uses the sources available and whether funding levels are reasonable and consistent with other comparable programs. The audit committee asked that we identify any changes in statutes that would improve the program's administration or any alternative funding mechanisms that could facilitate meeting its legislative goals. In addition, we were asked to determine which local agencies have received state funding for grade separation projects and, to the extent possible, to review estimated and actual costs for the projects. We also were asked to review a sample of these projects to determine the reasons for any cost overruns, the efforts local agencies made in planning and funding the projects, best practices available to local agencies to improve projections and control costs, and whether all local agencies face similar issues with projecting and controlling costs.

Finding #1: Local agencies believe allocations are not sufficient to allow them to take advantage of the Grade Separation Program.

Once they have nominated a grade separation project to the Public Utilities Commission (Commission) and the project has been placed on the Commission's priority list, many local agencies we surveyed are not taking the additional steps to apply to the California Department of Transportation (Caltrans) for funding under the Grade Separation Program. Many of these agencies indicated that they are not applying for this funding because they are having difficulty securing the funds to cover their portion of the costs of grade separation projects. We found that the portion of project costs that local agencies are expected to pay has increased dramatically over the past 30 years. According to data provided by the Commission, the average cost of a grade separation project increased from \$2.5 million in 1974 to more than \$26 million currently, while the annual budget of \$15 million for the Grade Separation Program has remained unchanged since 1974. A report prepared by the Commission showed that \$165 million is needed

Audit Highlights . . .

Our review of the Grade Separation Program found that:

- » *Although the average cost of a grade separation project has increased from \$2.5 million in 1974 to a current average of just more than \$26 million, the annual funding of \$15 million available for the Grade Separation Program has not changed since 1974.*
- » *Local agencies say they are experiencing difficulties securing the funding necessary to pay for their share of grade separation projects; thus, some are not nominating new projects to be included on the Public Utilities Commission's (Commission) priority list and many are not applying for funds for the projects already on the priority list.*
- » *A report prepared by the Commission in March 2007 showed that \$165 million is needed to provide funding for the same number of grade separation projects that \$15 million provided in 1974.*
- » *Additional funding will be available for grade separation projects from a bond measure approved by California voters in November 2006, which will provide a one-time amount of \$250 million to improve railroad crossing safety.*
- » *The California Department of Transportation does not always comply with state regulations when allocating supplemental funds to projects for which the final costs exceed the preliminary cost estimates.*

to provide funding for the same number of grade separation projects as \$15 million provided in 1974. However, some local agencies have been able to secure funding from other sources to pay for their projects without using funds from the Grade Separation Program. A recently approved bond measure will provide additional funding for grade separation projects. In addition to the proceeds from the bond measure, the State Transportation Improvement Program can also fund various local transportation projects including grade separation projects.

We recommended that in light of local agencies' limited participation in the Grade Separation Program, the Legislature should reconsider its intent for the program and the extent to which it wishes to continue assisting local agencies with their grade separation projects. Among possible courses of action, the Legislature could discontinue the program after the proceeds from the bond measure approved in November 2006 have been allocated and require local agencies to compete with a broader range of projects for funding available to them through other programs such as the State Transportation Improvement Program. Alternatively, the Legislature could continue the program and increase the annual budget of \$15 million and allocation limits per project because it desires to continue providing a specific source of funding focused on grade separation projects.

Legislative Action: Legislation passed.

Assembly Bill 660, among other things, increased the maximum amount available to a single project that meets certain requirements. This bill was chaptered during the 2007-08 Legislative Session.

Finding #2: Caltrans does not always follow regulations when allocating supplemental funds, and some regulations are inconsistent with statutes.

We found that Caltrans does not always comply with state regulations when allocating supplemental funds to projects for which the final costs exceed the preliminary cost estimates. For example, four of the six applications we reviewed did not include one or more of the required certifications, and two were missing a statement explaining in detail why the original allocation was insufficient. Additionally, Caltrans' current regulations are inconsistent with statutes; thus, applicants may not be aware of changes in law and may either choose not to submit an application or submit inconsistent applications.

To ensure that it administers the Grade Separation Program in compliance with state regulations, we recommended that Caltrans follow state regulations when making supplemental allocations. Further, to be consistent with statute, it should seek to revise current regulations to conform to recent amendments to statute.

Caltrans' Action: Partial corrective action taken.

According to Caltrans, it has developed a checklist to verify that requests for supplemental allocations include all of the documentation required by the California Code of Regulations. It also indicated that its Legal Division submitted revised regulations for the Office of Administrative Law 2008, Rulemaking Calendar. The public hearing on the regulations will be held on September 8, 2008, and Caltrans anticipates adopting the revised regulations before the end of the calendar year.

The Carl Moyer Memorial Air Quality Standards Attainment Program

Improved Practices in Applicant Selection, Contracting, and Marketing Could Lead to More Cost-Effective Emission Reductions and Enhanced Operations

REPORT NUMBER 2006-115, JUNE 2007

State Air Resources Board and local air districts' responses as of June 2008

The Carl Moyer Memorial Air Quality Standards Attainment Program (Moyer Program) is an incentive program offered by the State Air Resources Board (state board) in conjunction with participating air pollution control districts and air quality management districts (collectively, local air districts). The Moyer Program provides funds to help private companies, public agencies, and individuals undertake projects to retrofit, repower, or replace existing engines to reduce pollution emissions beyond what is required by law or regulations. A local air district can fund a project that provides cost-effective emission reductions. Emission reductions are considered cost-effective when the cost to reduce one ton of emissions is at or below the cost ceiling imposed by the state board.

The Joint Legislative Audit Committee asked the Bureau of State Audits to review how the state board and key local air districts manage the Moyer Program. We limited our review to the four largest districts in terms of the Moyer Program funds they received—the Bay Area Air Quality Management District (Bay Area air district), Sacramento Metropolitan Air Quality Management District (Sacramento Metropolitan air district), San Joaquin Valley Unified Air Pollution Control District (San Joaquin Valley air district), and South Coast Air Quality Management District (South Coast air district). In addition to the findings and recommendations discussed below, we also examined the policies and procedures of the state board and the local air districts; the state board's use of liaisons to the local air districts and desk audits of reports from the local air districts to monitor their Moyer Programs; the high cancellation rate at one entity relative to others; the availability of Moyer Program funds to projects operating in multiple air districts; the project inspections local air districts conduct; monitoring of projects after they have been implemented; and the length of time it takes local air districts to move projects through the Moyer Program process. We found the following:

Finding #1: State law impedes maximum emission reductions.

California law impedes emission reductions by allowing the state board to set aside only 10 percent of Moyer Program funds for projects that operate in more than one local air district. A higher cap could lead to emission reductions with lower costs per ton. For example, if the cap for multidistrict projects were increased to 15 percent for funds appropriated in fiscal year 2004–05, the state board could have selected three additional projects with intended emission reductions costing an average of \$2,600 per ton. Shifting this funding would have reduced

Audit Highlights . . .

Our review of the Carl Moyer Memorial Air Quality Standards Attainment Program (Moyer Program) revealed the following:

- » *California law impedes emission reductions by allowing the State Air Resources Board (state board) to set aside only 10 percent of Moyer Program funds for projects that operate in more than one local air district.*
- » *The methodology the state board used to select projects for the multidistrict component undervalues the cost per ton of intended emission reductions.*
- » *For fiscal year 2003–04, 14 of the 16 projects the Bay Area Air Quality Management District designated as matching projects exceeded the Moyer Program's ceiling for cost per ton of intended emission reductions.*
- » *The South Coast Air Quality Management District did not spend \$24.1 million in Moyer Program funds within the required two years and the state board is monitoring the district to ensure these funds are spent by July 1, 2007.*
- » *We identified several best practices that, among other things, can help local air districts select projects with lower costs per ton of intended emission reductions.*

the money available to districts, thus preventing the four districts we visited from selecting 13 projects. However, the average cost of the intended emission reductions from those projects was nearly \$11,000 per ton, clearly not as good a value as the multidistrict projects.

We recommended the state board seek legislation to revise state law to increase the 10 percent maximum proportion it can allocate for multidistrict projects. If the state board opts not to seek this revision, the Legislature may wish to consider it.

Legislative Action: Legislation proposed.

Senate Bill 895 and Assembly Bill 2865 were both introduced to increase to 20 percent the maximum proportion the state board can allocate for multidistrict projects. Neither bill passed the Legislature during the 2007–08 session.

Finding #2: The methodology the state board uses to select projects has undervalued the cost-effectiveness of emission reductions.

Three of the six categories the state board uses to assign points when scoring applications for multidistrict projects are neither required nor encouraged by state law. Of the 100 possible points, these three categories accounted for 35 and 55 points, respectively, in the two fiscal years we reviewed. An applicant who received no points for any one of the three categories likely had limited ability to compete with other applicants under consideration. As a result, the state board selected some projects with higher costs per ton of intended emission reductions than it would have if the point values for the three optional categories were lower.

We recommended the state board, when evaluating applications for multidistrict projects, assign more points to scoring categories that help the state board achieve the lowest cost per ton of emission reductions.

State Board's Action: Corrective action taken.

According to the state board, it increased the weight of the cost per ton of emission reductions for its 2008 projects from 45 percent to 70 percent.

Finding #3: Some projects the Bay Area air district funded for matching purposes do not meet the Moyer Program requirements for cost-effective emission reductions.

State law requires local air districts to provide their own funds to match Moyer Program funds provided by the state board. Further, projects funded with these matching funds must meet all Moyer Program criteria. Our review revealed that projects funded by one local air district did not meet the Moyer Program requirements for cost per ton of intended emission reductions. As allowed by state law, the Bay Area air district designated 16 projects funded by other programs it administered as matching projects for the Moyer Program for fiscal year 2003–04. However, 14 of the 16 projects it identified exceeded the state board's cost ceiling of \$13,600 per ton. The Bay Area air district knew the costs per ton for the projects it selected for matching exceeded the cost ceiling. Instead of selecting other eligible projects, the district attempted to make the 14 projects qualify as match under the Moyer Program by counting only a portion of the projects' total costs when it calculated the projects' costs per ton. Specifically, the district counted as the matching fund portion for the Moyer Program only \$740,000 of the \$2.5 million it awarded to these 14 projects. This approach is contrary to state law and Moyer Program guidelines because the district did not include all funds under its budgetary control when it calculated the costs per ton of intended emission reductions.

We recommended that local air districts include all funds under their budgetary authority as part of the calculations when determining the cost per ton of a project's intended emission reductions. Further, districts should develop and implement policies and procedures that enable them to meet the requirements in the Moyer Program guidelines regarding matching funds.

Bay Area Air District's Action: Partial corrective action taken.

The Bay Area air district stated that most work to recalculate the cost per ton of emission reductions for Moyer projects has been completed. It also stated that the rest of this work will be completed in 2008 and that these recalculations will allow the district to reallocate matching funds if necessary. The air district also has updated its policies and procedures manual for the Moyer Program, which includes a discussion of sources of matching funds.

Finding #4: Unspent Moyer Program funds remained at local air districts after availability had expired.

State law requires that local air districts expend Moyer Program funds allocated by the state board by June 30 of the second year following the allocation; otherwise, the unexpended funds revert to the state board. As of December 2006 the South Coast air district had \$24.1 million in Moyer Program funds it had not spent within the two-year time frame established by law. Unspent Moyer Program allocations are a strong indicator that intended emission reductions likely are not occurring. When allocating its fiscal year 2004–05 Moyer Program funds, the South Coast air district selected projects intended to reduce 1 ton of emissions for every \$4,256 it spent, on average. Had the South Coast air district spent the \$24.1 million on similarly cost-effective projects by the statutory deadline of June 30, 2006, 5,600 tons of pollutants would have been removed.

The South Coast air district interprets the word “expended,” as it appears in state law, to mean obligated. Under that interpretation, as long as a local air district had obligated a specific amount of Moyer Program funds to pay for a project that will be completed in the future, unspent funds would not revert to the state board. However, both the state board and the Department of Finance (Finance) have criticized the South Coast air district for its lack of spending in audit reports issued in October 2006 and April 2007, respectively. It is clear that, within the context of their reports, both the state board and Finance expected the district to spend Moyer Program funds within the two-year availability period, not merely obligate them for projects.

The state board is withholding future Moyer Program allocations to the South Coast air district until it spends its expired funds. The state board noted that it has the district's assurance that it will fully expend all applicable Moyer Program funds by July 1, 2007. The state board is monitoring the district to ensure that this happens.

We recommended that the South Coast air district ensure that it spends by July 1, 2007, all remaining Moyer Program funds that are beyond the two-year availability period.

Also, to help ensure that the South Coast air district spends the allocations, the state board should continue monitoring the district's efforts and take appropriate action should its efforts falter. If the South Coast air district does not spend the funds by July 1, 2007, the state board should initiate appropriate administrative action, up to or including recovering all remaining unspent funds.

State Board's and South Coast Air District's Actions: Corrective action taken.

The state board determined that the South Coast air district had met its expenditure requirements for the unspent funds. Further, the state board reported that it continues to monitor the South Coast air district's expenditures through quarterly progress reports; the April 2008 progress report shows that the district is on track with the timely expenditure of funds. In addition, the state board stated that it updated the Moyer Program guidelines regarding consequences for local air districts

should they fail to meet the two-year expenditure requirement. The guidelines explicitly require air districts that fail to meet the expenditure deadline to either return unspent funds within 60 days or have the funds deducted from their next allocation.

Finding #5: Infrequent on-site audits are a concern.

The state board may not be performing on-site audits of local air districts with sufficient frequency. It conducted four on-site audits in 2006 and plans to complete four more in 2007. If it maintains the rate of four audits per year, the state board will audit districts participating in the Moyer Program, on average, once every seven years. Audits released in 2006 demonstrate that some local air districts improperly administer the Moyer Program. More frequent audits would address identified problems earlier.

The state board is updating the procedures it uses to conduct on-site audits of local air districts, according to a program manager. These changes are based on findings from a 2006 review by Finance of the Moyer Program guidelines as well as feedback from the audited districts and from the state board's audit staff about the on-site audits it had already completed. In its report in December 2006, Finance made eight observations with recommendations for ways the state board could improve the Moyer Program guidelines and procedures, including a recommendation that the state board adopt a systematic, risk-based approach to selecting local air districts to audit. Finance also recommended 12 revisions to the guidelines to make the language clearer, define terms, and provide more detail.

We recommended that, to ensure that it monitors local air districts' implementation of the Moyer Program effectively, the state board continue to implement its planned changes to audit procedures and address the recommendations in Finance's 2006 audit report, including the development of a risk-based approach to selecting districts to audit. As part of this effort, the state board should consider how frequently it will audit districts.

State Board's Action: Corrective action taken.

According to the state board, it has taken several steps to improve its evaluation and audit procedures for local air districts. It has created and fully staffed a new oversight section; updated its procedures for auditing the Moyer Program, in part to incorporate Finance's recommendations; and released plans to audit seven air districts in 2008. To select the air districts to be audited, the state board stated that it used a risk-based methodology developed in cooperation with Finance. The state board plans to audit at least 10 percent of the annual program funds each year, and audit large air districts at least once every four years, medium air districts at least once every six years, and small air districts at least once every eight years.

Finding #6: Although local air districts market the Moyer Program in various ways, they could do more to evaluate the results of their efforts.

Local air districts use various methods to market the Moyer Program, such as brochures, mailing lists, Web pages, and workshops, but they do not adequately evaluate their efforts to determine whether they are reaching the business sectors that might be able to provide more cost-effective emission reductions. The districts rely primarily on one measure—whether they receive enough applications to distribute all Moyer Program funds—to evaluate their marketing efforts. Thus, they cannot ensure that their marketing efforts are resulting in applications that help maximize cost-effective emission reductions.

We recommended that the local air districts develop and implement techniques to measure the effectiveness of their marketing methods. Specifically, local air districts should identify business sectors from which they will obtain applications for more cost-effective projects, evaluate whether their current marketing efforts are reaching those sectors, implement marketing efforts to target sectors not being reached, and assess whether their marketing efforts enable them to select projects with more cost-effective emission reductions.

Local Air Districts' Actions: Partial corrective action taken.

Two of the four local air districts included in our review are taking steps regarding this finding. The Bay Area air district stated that it initiated a marketing study and developed an updated marketing plan designed to maximize outreach. The Bay Area district also stated that its consultants will follow up with a report on the successes of the marketing strategy. The district anticipates this work will be completed in 2008. The South Coast air district stated that it entered into a contract with a company to complete this task and that it had received a final report, which contained a proposed marketing strategy. According to the South Coast district, it used this report for Moyer Program funds appropriated for fiscal year 2007–08. It also stated that the number of applications increased from 133 to 242 over the prior year and the number of applications from individual owner-operators or small businesses increased over prior years. On the other hand, the San Joaquin Valley air district acknowledged that as emission reductions become more expensive, it may be necessary to perform more targeted outreach while the Sacramento Metropolitan air district stated that, based on the results of a survey it conducted, it believes the best way to reach participants is to continue to provide a high level of customer support to applicants.

Finding #7: Timing requirements for preinspections can be overly restrictive.

Timing requirements for conducting preinspections—inspecting the engine to be retrofitted, repowered, or replaced to ensure that it is still operational—are overly restrictive. The Moyer Program guidelines generally require local air districts to perform preinspections after the districts have awarded funds but before they execute the related contracts. One district chose not to follow this requirement because delaying the execution of the contract would have delayed project implementation.

We recommended that, to help streamline the process for performing preinspections, the state board revise its requirement that local air districts must perform preinspections before executing contracts.

State Board's Action: Partial corrective action taken.

The state board amended its guidelines to give air districts flexibility to conduct preinspections after executing contracts provided that the districts include contract provisions for revising or voiding contracts based on information collected during the preinspections and any additional procedures necessary to ensure the projects provide acceptable emission reductions.

Finding #8: Local air districts use some best practices for contracting and administering Moyer Program funds.

During our visits to the state board and the four local air districts, we observed best practices that we believe can help districts select projects with lower costs per ton of intended emission reductions, reduce district workloads, and allow more time for project completion. Given the differences that exist among the districts, these practices may not be applicable in all cases. However, we believe they deserve serious consideration by the districts.

The Bay Area and South Coast air districts included a measure of pollution or the effects of pollution in their approaches for identifying disproportionately impacted communities—those communities with the most significant exposure to air contaminants, including communities of minority or low-income populations or both.

The state board included a measure of the cost per ton of emission reductions when selecting projects from disproportionately impacted communities for the multidistrict component of the Moyer Program, which increases the state board's ability to maximize emission reductions from multidistrict projects.

The Bay Area and Sacramento Metropolitan air districts include requirements in their contracts that projects selected from disproportionately impacted communities must continue to operate at least a specified percentage of their time in those communities after the project is completed and operational, which helps ensure that completed projects reduce emissions in disproportionately impacted communities.

The Sacramento Metropolitan air district uses only one application form for all its incentive programs, including the Moyer Program, which streamlines the application process for potential projects.

All but one of the four local air districts we visited had, by December 31, 2006, already allocated to projects their Moyer Program funds appropriated in fiscal year 2005–06, well ahead of the June 30, 2007, deadline. By making allocations before the deadline, these three districts allow more time for completing projects before the end of the two-year availability period.

Three local air districts issue one contract per project owner, as opposed to one contract per vehicle, which reduces the administrative burden on the districts.

The Bay Area and South Coast air districts included more detailed project milestones in their contracts, which allows the districts to more easily track the progress of their Moyer Program projects and take appropriate action if the projects veer off track.

The local air districts required projects to be completed before the statutory limit for expending funds, which helps districts ensure that they have sufficient time to perform required inspections and pay project owners before the two-year availability period for Moyer Program funds expires.

The Sacramento Metropolitan and San Joaquin Valley air districts delegated limited project approval and contract execution authority to staff of the local air districts, which may enable local air districts to issue contracts more quickly, thereby allowing more time for implementing projects before the end of the availability period.

The South Coast air district performed multiple inspections at the same time when possible. The district's staff found that this practice allowed them to save time and allowed the affected projects to move forward without unnecessary delay.

The South Coast and San Joaquin Valley air districts imposed stricter funding requirements on some projects, such as requiring certain types of projects to meet a lower threshold for cost per ton of emission reductions, or requiring project owners to pay a greater share of the costs. These practices could enable the districts to fund more projects with their Moyer Program dollars.

We recommended that, to improve their administration of the Moyer Program, local air districts consider implementing the following best practices:

- Include measures of pollution or the effects of pollution in their approaches for identifying disproportionately impacted communities.
- Include a measure for comparing the cost per ton of intended emission reductions when selecting projects from disproportionately impacted communities.
- Include in their contracts the requirement that projects selected from disproportionately impacted communities continue to provide benefits from reduced emissions to those communities after implementation.

- Use a single application for their Moyer Program application process.
- Allocate Moyer Program funds to applicants as soon as possible.
- Implement a system of one contract per project owner.
- Include in their contracts specific milestones against which the project owners and local air district staff can measure the progress of their projects.
- Include in their contracts the requirement that project owners complete projects and submit invoices a specific number of days or weeks before the June 30 deadline.
- Obtain delegated authority from their governing boards to approve Moyer Program projects and execute contracts. If their governing boards are not comfortable in providing delegated authority to approve all Moyer Program projects, obtain delegated authority to approve the more routine projects or projects costing less than a specified amount.
- Conduct consolidated preinspections to the extent practicable.
- Impose stricter standards (for example, caps on individual contract amounts or lower costs per ton of intended emission reductions) on project categories to the extent that such action does not reduce involvement in the Moyer Program.

Local Air Districts' Actions: Partial corrective action taken.

The four local air districts we reviewed have considered the best practices we identified. In many instances, the air districts have implemented or are implementing many of the best practices we identified. For instance, three of the four air districts report they have implemented the best practice of using one contract per project owner while the fourth has adopted it as a goal for 2008.

However, the air districts also indicate that some best practices are not practicable for them. Regarding best practices related to disproportionately impacted communities, the South Coast air district states that upon review by its legal counsel, it does not believe it is possible to incorporate language in its contracts that requires continued use of equipment in a specific location. We question the South Coast air district's limiting our recommendation for this best practice to a "specific location." Although our legal counsel has advised us that districts have considerable discretion when making spending decisions related to disproportionately impacted communities, districts must spend those funds to achieve statutory goals. As we mention in our audit report, the Bay Area and Sacramento Metropolitan air districts include requirements in their contracts that projects selected from disproportionately impacted communities must continue to operate at least a specified percentage of their time in those communities [emphasis added] after the project is completed and operational. This requirement helps local air districts ensure that completed projects reduce emissions in these communities as required by law. We do not suggest that the requirement be limited to a specific location.

Office of Spill Prevention and Response

It Has Met Many of Its Oversight and Response Duties, but Interaction With Local Government, the Media, and Volunteers Needs Improvement

REPORT NUMBER 2008-102, AUGUST 2008

Office of Spill Prevention and Response's response as of October 2008

In November 2007 the Cosco Busan, an outbound container ship, hit a support on the San Francisco—Oakland Bay Bridge, releasing about 53,600 gallons of oil into the bay. This event, known as the Cosco Busan oil spill, focused public attention on California's Office of Spill Prevention and Response (spill office), a division of the Department of Fish and Game (Fish and Game). The spill office, created in 1991, is run by an administrator appointed by the governor, who is responsible for preventing, preparing for, and responding to oil spills in California waters.

The spill office, along with the contingency plans it oversees, fits into a national framework for preventing and responding to oil spills, with entities at every level of government handling some aspect of the planning effort. When an oil spill occurs, the response is overseen by a three-part unified command consisting of representatives from the spill office; the party responsible for the spill and its designated representatives; and the federal government, represented by the U.S. Coast Guard (Coast Guard), which retains ultimate authority over the response.

Finding #1: The spill office has fulfilled most of its oversight responsibilities related to contingency planning but coordination with local governments could improve.

The spill office has met most of its oversight responsibilities for contingency planning but could improve several aspects of its oversight role. Specifically, the California Oil Spill Contingency Plan (state plan), which the spill office maintains, has not been updated since 2001 and is missing elements required by state law. The state plan also lacks references to other plans or documents that would better integrate it into the overall planning system. In addition, the spill office has carried out its duties to review and approve local government contingency plans (local plans) and to provide grant funding. However, only six of the 22 local governments participating have revised their plans since 2004, and seven of the 16 remaining local plans have not been revised since 1995 or before. Further, the spill office reported that few local governments in the San Francisco Bay Area have regularly participated in other oil spill response planning activities.

The outdated state plan and local plans and weak participation by local governments in oil spill response planning activities may have led to problems with integrating state and local government activities into the Cosco Busan response.

Audit Highlights . . .

Our review of the Department of Fish and Game's Office of Spill Prevention and Response (spill office) found that:

- » *The spill office has met many of its oversight responsibilities; however, the California Oil Spill Contingency Plan is outdated and missing required elements.*
- » *Only six of 22 local government contingency plans were revised after 2003 and local participation in joint planning efforts has been low.*
- » *The spill office, the Governor's Office of Emergency Services, and private entities responding to the November 2007 Cosco Busan oil spill met their fundamental responsibilities.*
- » *The spill office's shortage of trained liaison officers and experienced public information officers led to communication problems during the Cosco Busan oil spill.*
- » *The spill office's lack of urgency in calculating the spill volume from the Cosco Busan may have delayed the mobilization of additional resources.*
- » *Reserves for the Oil Spill Prevention and Administration Fund (fund) totaled \$17.6 million as of June 30, 2007, but are projected to drop by half over the next two years.*
- » *Payroll testing indicates the need to better assure that only oil spill prevention activities are charged to the fund.*

We recommended that the spill office regularly update the state plan and include references to sections of regional and area contingency plans that cover required elements. We also recommended that the spill office work with local governments to improve participation and should consider whether additional grant funding is needed.

Spill Office's Action: Pending.

The spill office said it has initiated an effort to update the state plan and expects to complete the update in fiscal year 2008–09. To help integrate local government participation before and during an oil spill, the spill office says that it expects to issue awards to local governments by the beginning of 2009 under a one-time budget augmentation of \$650,000. Finally, it is working with the San Francisco Bay and Delta Area Committee to include the participation of a local government representative in the unified command during oil spill responses.

Finding #2: The spill office is fulfilling most of its review and approval responsibilities for vessel contingency plans (vessel plans) and oil spill response organizations (response organizations).

The spill office has an established system for reviewing vessel plans and has ensured that vessel plans are approved before any vessel enters California waters. In addition, it has generally assured that annual tabletop exercises have been conducted for vessel plans, and has conducted drills to verify the rating and equipment information related to response organizations. However, the spill office has not always ensured that it receives and maintains documentation showing that annual tabletop exercises have been conducted for each vessel plan. In addition, the spill office does not require owners to submit reviews of their vessel plans after oil spills (postspill reviews) when applicable. The spill office's deputy administrator said that he believes the postspill review requirement is worthwhile, but that the spill office needs to consider whether it is reasonable to ask vessel owners to admit problems when the admissions may influence penalties.

We recommended that the spill office obtain and retain documentation related to completion of required tabletop exercises. We also recommended that the spill office determine whether postspill reviews are an effective means for identifying areas for plan improvement and then take steps to either ensure the reviews are submitted or eliminate them from its regulations.

Spill Office's Action: Pending.

The spill office said it was hiring and training new staff in November 2008 to address documentation problems related to tabletop exercises. It also said that it has trained employees on compliance with the postspill review regulation, but is evaluating the effectiveness of the regulation and is considering removing the regulation in 2009.

Finding #3: State and private entities met their fundamental duties in the Cosco Busan response, but communication breakdowns caused problems.

The spill office, the Governor's Office of Emergency Services, and private contractors responding to the Cosco Busan incident performed the fundamental duties set forth in oil spill contingency plans. However, changes are needed in several areas to improve responses to future oil spills. We found that weaknesses in the spill office's handling of its liaison role during the initial days of the response, including a shortage of communications equipment and trained liaison officers, led to communication problems with local governments. The counties we spoke with confirmed these problems and expressed dissatisfaction with the spill office's role as a liaison. In addition, the spill office's lack of urgency in reporting its measurement of the spill quantity, as well as the understated spill amounts reported by others, may have delayed the mobilization of additional response resources on the first day of the spill and contributed to the delayed notification of local governments.

We recommended that the spill office collaborate with area committees in California to identify potential command centers that are sized appropriately and possess all necessary communications equipment. Additionally, the spill office should continue with its plans to develop qualification standards for liaison officers and to train more staff for that role and should ensure that staff in its operations center provide all necessary support to liaison officers in the field. Moreover, the spill office should ensure that staff assigned as liaison officers participate in drills to gain experience.

We also recommended that the spill office collaborate with the Coast Guard to establish spill calculation protocols and establish procedures to ensure that staff promptly report spill calculations to the State on scene coordinator. Finally, the spill office should include spill calculations as part of its drills.

Spill Office's Action: Partial corrective action taken.

The spill office stated that area committees are continuing to identify potential command posts and that these sites will be incorporated in future area drills. It also said that it coordinated an extensive liaison officer training course for 30 of its employees, assigned liaison officers to all 13 drills in 2008 where an agency liaison officer was requested, and plans to develop specific training and experience criteria for staff assigned to spill incidents. The spill office indicates that in its next response to the bureau, it will describe additional steps it is taking to strengthen operations center support of liaison officers in the field. Finally, the spill office indicates that it has established spill calculation protocols with the Coast Guard, has directed its field response teams to report spill quantification results promptly to the State on-scene coordinator, and will make spill quantification protocols part of its drills.

Finding #4: A lack of information officers with oil spill experience impaired the spill office's ability to assist with media relations and an insufficient number of trained responders may have hindered wildlife rescue efforts.

When the Cosco Busan spill occurred, an information officer experienced in oil spill response was not available to represent the State within the information center. This deficiency during the early days of the response appears to have hindered the dissemination of information about the role of volunteers in spill cleanups. Additional missteps by the Coast Guard, which managed the information center, and the spill office, appear to have contributed to the public's frustration with the clean-up effort and received widespread media attention. In addition, insufficient staffing may have hindered wildlife rescue efforts carried out by the spill office and the Oiled Wildlife Care Network (wildlife network) after the Cosco Busan spill. The number of staff mobilized for recovery and transportation of oiled wildlife remained lower than the general guidelines laid out in the California wildlife response plan for the first three days of the spill. Staffing increased only after the unified command loosened the requirements for hazardous waste training for volunteers participating in the response. The network director noted that the wildlife network has had difficulty maintaining trained personnel capable of serving on recovery teams because of the requirement to have 24 hours of hazardous waste training, supplemented by a yearly eight-hour refresher course.

We recommended that public relations staff in Fish and Game's communications office participate in spill drills, and that the spill office develop protocols to ensure that key information, such as the role of volunteers, is disseminated early in a spill response. We also recommended that the spill office ensure that the wildlife network identifies and trains a sufficient number of staff to carry out recovery activities. Furthermore, the spill office should continue to clarify with California Occupational Safety and Health Administration (Cal/OSHA) whether reduced requirements for hazardous waste training are acceptable for volunteers assisting on recovery teams, and should consider working with the wildlife network to ensure that this training is widely available to potential volunteers before a spill.

Spill Office's Action: Pending.

The spill office said that communications office staff continue to be trained in incident command and oil spill response. It also indicated that it has a communications structure in place to issue key information to the public during an oil spill, and has identified funding to develop a Web site that can be activated during a spill to allow widespread access to key response information. Moreover, the spill office noted that Assembly Bill 2911 provided \$500,000 in additional funding for the wildlife network, which the spill office intends to distribute in the fiscal year 2009–10 budget. Finally, the spill office states it has corresponded with Cal/OSHA regarding training standards for volunteers engaged in oil spill responses.

Finding #5: The Oil Spill Prevention and Administration Fund (fund) has a high reserve balance and has paid for inappropriate personnel charges.

The amount of reserves in the Oil Spill Prevention and Administration Fund (fund) has increased significantly over the past several years, leading to a reserve of \$17.6 million at June 30, 2007, or six months of budgeted expenditures for the next year. A fee increase without corresponding expenditure increases and failure of the spill office to annually assess the level of the reserve, as required by law, contributed to the high balance. A more reasonable reserve for a fund with a fairly stable level of expenditures would be about one and a half months, according to the spill office's deputy administrator.

Money in the fund can only be used for statutorily defined purposes relating to spill prevention activities. Based on our review of selected transactions and spending trends from fiscal years 2001–02 through 2006–07, we determined that expenditures charged to the fund generally appear to be consistent with the spill office's authorizing statute. However, our review of a sample of 30 employees' labor distribution reports (time sheets), as well as our interviews with spill office managers and employees, disclosed several instances in which employee salaries are being charged to the fund for time spent on general activities. These instances include spill office employees who sometimes perform general activities and, in one instance, an attorney who works for another Fish and Game unit and performs no spill prevention activities.

We recommended that the spill office annually assess the reasonableness of the reserve balance and the per-barrel fee on crude oil and petroleum products. Further, we recommended that the spill office and Fish and Game provide guidelines to employees concerning when to charge activities to the fund, take steps—such as performing a time study—to ensure that spill prevention wardens' time is charged appropriately, and discontinuing charges to the fund for the attorney we identified.

Spill Office's Action: Partial corrective action taken.

The spill office indicated that it would prepare a plan projecting revenues and expenses for the fund by January 20, 2009. It also said that all staff will be trained on the proper use of the fund by the end of 2008, and that supervisors will now be responsible for ensuring staff compliance. Additionally, the spill office said that Fish and Game's Law Enforcement Division would conduct a time study of all enforcement personnel operating in the marine zone of southern California in the first quarter of 2009. Finally, the spill office made adjustments to correctly charge the time of the referenced attorney.

Finding #6: Restructuring of positions appears to have caused friction between the spill office and Fish and Game management.

Since 2000 Fish and Game has restructured 45.5 staff positions from the direct control of the spill office to other Fish and Game units. Although it does not appear to have affected the spill office's overall ability to carry out its mission related to the three largest restructured units, the limited problems

we did identify, plus serious reservations by both the past administrator of the spill office and the current deputy administrator, suggested the need for a better understanding between Fish and Game management and the spill office on their roles and authority related to these employees.

We recommended that the spill office and other Fish and Game units discuss their respective authorities and better define the role of each in the management of spill prevention staff consistent with the administrator's statutory responsibilities and the other needs of Fish and Game.

Spill Office's Action: Pending.

The spill office said that it continues to improve communication and cohesiveness on an internal level with Fish and Game.

California Environmental Protection Agency

Investigations of Improper Activities by State Employees, January 2008 Through June 2008

INVESTIGATION I2008-0678 (REPORT I2008-2), OCTOBER 2008

California Environmental Protection Agency's response as of September 2008

An employee of the California Environmental Protection Agency (Cal/EPA) failed to promptly submit time sheets that accurately reported her absences from work during the period August 2006 through June 2008. In addition, the officials responsible for managing her daily activities and for monitoring her time and attendance did not ensure that the employee documented her absences correctly and that Cal/EPA charged the absences against her leave balances. Consequently, Cal/EPA did not charge the employee's leave balances for the 768 hours that she was absent from work; instead, it paid her \$23,320 for these hours.

Finding #1: A Cal/EPA employee failed to promptly submit time sheets that accurately reported her absences from work during a 23-month period.

From August 2006 through June 2008, the employee did not submit monthly time sheets at the end of each pay period that accurately documented the time she spent working and the time she was absent. For the 23 pay periods we examined during the investigation, the employee never submitted time sheets for five pay periods, she submitted time sheets up to several months late for 12 pay periods, and she promptly submitted time sheets for just six pay periods. However, management declined to approve nearly all of the time sheets that the employee submitted late or on time because the time sheets either did not account for all absences or because the time sheets reported overtime work that had not received preapproval. Without the approved time sheets, Cal/EPA did not record the employee's absences or overtime in its leave accounting system. Consequently, Cal/EPA did not charge the employee's leave balances for the 768 hours that she was absent from work during the 23-month period; instead, it paid her \$23,320 for these hours.

Cal/EPA's Action: Partial corrective action taken.

Cal/EPA approved the 23 timesheets in September 2008. In addition, it reported in September 2008 that it had recalculated, updated, and corrected the employee's leave balances to reflect her actual absences and overtime worked, based on the latest approved time sheets, for all pay periods through August 2008. Further, Cal/EPA notified us that it planned to establish an accounts receivable for 24 hours the employee was docked pay in September 2006.

Investigative Highlight . . .

An employee of the California Environmental Protection Agency (Cal/EPA) failed to promptly submit accurate time sheets during a 23-month period. As a result, Cal/EPA did not charge the employee's leave balances for 768 hours when she was absent, and it paid her \$23,320 for those hours.

Finding #2: Cal/EPA officials failed to take sufficient actions to correct the employee's lax time reporting and because of their inaction, the employee's absences were not charged against her leave balances.

Not only did the employee fail to submit her time sheets accurately and promptly, but the Cal/EPA officials responsible for managing her day-to-day activities and monitoring her time and attendance also failed to ensure that the employee submitted monthly time sheets that correctly reported her absences and time worked. The employee worked for Official A, who assigned Official B and then Official C to monitor the employee's time and attendance and to approve her time sheets. In particular, the efforts made by Official A and Official C in 2007 and early 2008 did little to resolve the employee's failure to accurately report her absences and overtime, and to promptly complete her time sheets. Official A assigned Official C around March 2007 to monitor the employee's time and attendance and to approve her time sheets. In May 2007 Official A met with the employee to counsel her about her absenteeism. However, the meeting notes indicate that Official A did not discuss the employee's failure to submit her time sheets promptly and accurately. Furthermore, Official C offered evidence that she tried to pressure the employee to comply with the time-reporting requirements through some oral conversations and numerous e-mails but the employee did not comply. Yet, Official C took no action to enforce her requests for compliance.

Cal/EPA's Action: Partial corrective action taken.

In September 2008 Cal/EPA informed us that Official A had issued a counseling memorandum to the employee, which discussed the employee's failure to promptly submit time sheets that accurately accounted for her absences. Moreover, Cal/EPA notified us that Official C had issued another counseling memorandum to the employee, which described the implementation of administrative controls to ensure that the employee correctly accounts for her absences and promptly completes her time sheets and other time reporting documents. Furthermore, Cal/EPA reported that, as soon as possible, it planned to transfer the employee to another position with a different assignment that does not require significant overtime. It stated that the new assignment would allow the employee to be more closely monitored by a different supervisor.

Low-Level Radioactive Waste

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

REPORT NUMBER 2007-114, JUNE 2008

Department of Public Health's response as of December 2008

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

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

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

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

Audit Highlights . . .

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

- » *In June 2008 generators in California will lose access to one of the two low-level waste disposal facilities that currently accept their waste.*
- » *The Department of Public Health (department) has yet to follow a 2002 executive order requiring it to develop dose-based decommissioning standards, resulting in a lack of public transparency and accountability over its actions.*
- » *The department's Radiologic Health Branch (branch) cannot demonstrate that its inspections of those that possess radioactive material and radiation-emitting machines are performed timely in accordance with federal and state requirements.*
- » *The branch has poorly planned for its resource needs, is unable to justify the magnitude of its 2005 fee increases, and used old and incomplete data when asking for more staff.*
- » *More than five years after the effective date of the law, the branch is still unable to provide required information on the amount of low-level waste generated in California.*

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

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

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

Department's Action: Pending.

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

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public

REPORT NUMBER 2006-116R, JUNE 2007

State and Consumer Services Agency's response as of December 2007

The Joint Legislative Audit Committee requested the Bureau of State Audits review the effectiveness and efficiency of the Medical Board of California's (medical board) Physician Diversion Program (diversion program). In our review, we found that although the diversion program had made many improvements since the release of the November 2005 report of an independent reviewer, known as the enforcement monitor, there were still some areas in which the program needed to improve in order to adequately protect the public. For instance, although case managers appeared to be contacting participants on a regular basis and participants generally appeared to be attending group meetings and completing the required amount of drug tests, the diversion program did not adequately ensure that it received required monitoring reports from its participants' treatment providers and work-site monitors.

In addition, although the diversion program had reduced the amount of time it takes to admit new participants into the program and begin drug testing, it did not always respond to potential relapses in a timely and adequate manner. Specifically, the diversion program did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug. Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the diversion program did not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and did not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they were meeting program standards. Finally, the medical board, which is charged with overseeing the diversion program, had not provided consistently effective oversight.

Medical Board's Action: Discontinued the diversion program.

In July 2007 the medical board met and determined that it would allow the diversion program to sunset on June 30, 2008. Due to the termination of the program, the medical board did not address individual audit report recommendations in its responses to the audit. Rather, the medical board described its transition plan, which was approved by the board in November 2007. Key components of the plan are outlined on the following pages:

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) Physician Diversion Program (diversion program) revealed the following:

- » *Case managers are contacting participants on a regular basis and participants appear to be attending group meetings and completing drug tests, as required.*
- » *The diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors.*
- » *The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.*
- » *The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public's safety at risk.*
- » *Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.*
- » *The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.*

continued on next page . . .

- » *The diversion program has not been formally evaluating its collectors, group facilitators, and diversion committee members to determine how well they are meeting program standards.*
- » *The medical board has not provided consistently effective oversight of the diversion program.*

Self-referred participants:

- The diversion program will no longer admit new, self-referred physicians into the program.
- Self-referred participants with three years of sobriety will be referred to a Diversion Evaluation Committee (DEC) for a determination of whether the individuals can be deemed to have completed the program.
- On June 30, 2008, self-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program is inoperative and encouraging the physicians to find another monitoring or treatment program.

Board-referred participants:

- The medical board will notify individuals seeking admission into the diversion program in lieu of disciplinary action (board-referred) that the program will be inoperative June 30, 2008, and, at that time the medical board will refer the individuals to the Attorney General's Office and enforcement for further action. Being made fully aware of this condition, participants will be given the choice of entering the program or proceeding through the enforcement process.
- Current, board-referred participants with three years of sobriety will be referred to a DEC for a determination of whether the individuals can be deemed to have completed the program.
- On January 1, 2008, board-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program will be inoperative as of June 30, 2008, and that they must find another program that meets the protocols of the diversion program. In addition, the other program must be willing to report to the Medical Board's chief of enforcement on a regular basis and to immediately notify the board of any positive drug tests.

Board-ordered participants:

- The medical board will no longer approve a stipulation that requires participation in the diversion program as a condition of a disciplinary order or issuance of a probationary license.
- On July 1, 2008, the diversion program condition in all disciplinary orders will become null and void and will no longer be considered a condition of probation. However, individuals will still be required to abstain from drugs and alcohol and must submit to drug testing. Staff will continue to monitor the random drug tests of these individuals.

Out-of-state participants:

Staff will continue to liaison with programs in other states to ensure that out-of-state participants comply with that respective state's program until completion.

Department of Health Services

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

REPORT NUMBER 2006-110, APRIL 2007

Department of Health Services' response as of April 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the Department of Health Services¹ (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal). Specifically, we were asked to compare the department's enrollment and application procedures to those used by the federal Medicare program and to determine whether any information is shared between the two programs during the enrollment process. Additionally, we were asked to determine whether the department tracks and monitors the average time it takes to review a physician application and to identify the number of full-time staff assigned to review these applications. The audit committee asked us to identify the number of applications denied over the past year and the reasons for the denials. Further, we were asked to review the department's procedures for handling deficient applications and to determine when it notifies applicants about deficiencies. The audit committee requested us to identify the number of applications referred for further review in the past year, including the reason for the referral and the number that were denied. Finally, we were asked to identify the number of applicants requesting preferred provider status in the past year, the total number of applicants awaiting enrollment into the Medi-Cal program, and the number of applications the department did not process within the designated review period.

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

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

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

Audit Highlights . . .

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

- » *Because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives; however, the branch does not process some applications within the time periods specified in statute.*
- » *Branch staff continue to enter data incorrectly into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to track the status of applications effectively.*
- » *Some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could.*
- » *Given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.*
- » *The branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals.*

continued on next page . . .

- » *State law does not prescribe a required number of days in which the branch must approve or deny referred applications, and we noted that the department takes an inordinate length of time to process referred applications.*
- » *Because physicians applying to become providers in Medi-Cal and Medicare are asked to provide much of the same information, and the federal government is beginning two initiatives to ensure that more accurate and updated information is available about Medicare providers, the department may be able to streamline its application process by relying on some of Medicare's data in the near future.*

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

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

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

Department's Action: Corrective action taken.

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

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

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

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

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

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

Department’s Action: Corrective action taken.

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

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

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

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

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

Department's Action: Corrective action taken.

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

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

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

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

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

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

Department's Action: Corrective action taken.

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

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

Department of Mental Health, Coalinga State Hospital

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

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

Department of Mental Health's response as of October 2008

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

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

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

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

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

Mental Health's Action: Corrective action taken.

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

Investigative Highlight . . .

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

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

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

Department of Health Services

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

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

Department of Health Services' response as of October 2008

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

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

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

Health Services' Action: Corrective action taken.

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

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

Investigative Highlight . . .

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

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

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

Finding #2: The employee misused state resources.

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

Health Services' Action: Corrective action taken.

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

Nonprofit Hospitals

Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status

REPORT NUMBER 2007-107, DECEMBER 2007

Board of Equalization's, Franchise Tax Board's, and Office of Statewide Health Planning and Development's responses as of December 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to conduct an audit to ascertain whether the activities performed by hospitals that are exempt from paying taxes because of their nonprofit status truly qualify as allowable activities consistent with their exempt purpose. Specifically, the audit committee requested that we determine the roles of the entities involved in determining tax exemptions and the extent of oversight they exercise over nonprofit hospitals to ensure that they comply with requirements for tax exemption and community benefit reporting. It also asked us to examine the financial reports and any community benefit documents prepared during the last five years by a sample of both nonprofit hospitals and hospitals that operate on a for-profit basis and determine the value and type of community benefits and uncompensated care provided. In addition, the audit committee asked us to compare the community benefits provided by nonprofit and for-profit hospitals, and compare the types of care that both types of hospitals provide without receiving compensation (uncompensated care). Further, the audit committee asked us to review the financial information and the claims submitted to the State Board of Equalization (Equalization) or other agencies by nonprofit hospitals to determine whether they meet income requirements to qualify for tax-exempt status and to assess how tax-exempt nonprofit hospitals use excess income, to ensure that the uses are permissible and reasonable in terms of expansion of plant and facilities, additions to operating reserve, and the timing of debt retirement. The audit committee also asked us to determine the most current estimated total annual value of the taxation exemptions of both state corporation income taxes (income taxes) and local property taxes for nonprofit hospitals.

Finally, the audit committee asked us to determine whether the community benefits and uncompensated care provided by nonprofit hospitals meet the requirements for exemption from local property and state income tax. However, although state law outlines the requirements a nonprofit hospital must meet to receive an exemption from paying taxes, it does not specify community benefits and uncompensated-care costs as requirements. Additionally, although state law requires most tax-exempt hospitals to annually submit to the Office of Statewide Health Planning and Development (Health Planning) a community benefits plan (plan), which may include an uncompensated-care element, the law also clearly states that the information included in the plan a nonprofit hospital submits cannot be used to justify its tax-exempt status.

Audit Highlights . . .

Our review of tax-exempt hospitals revealed the following:

- » *About 223 of California's 344 hospitals are eligible for income and property tax exemptions because they are organized and operated for nonprofit purposes.*
- » *Comparing financial data reported by nonprofit and for-profit hospitals indicated the uncompensated care provided by the two types of hospitals was not significantly different.*
- » *Benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value are not consistently reported among nonprofit hospitals.*
- » *The values of tax-exempt buildings and contents owned by nonprofit hospitals are frequently misreported by county assessors.*
- » *Lacking more reliable data, we used the reported economic values of community benefits and tax-exempt property to estimate that reported community benefits of \$656 million for 2005 were roughly 2.7 times the estimated \$242 million in state corporation income taxes and property taxes not collected from nonprofit hospitals.*
- » *The Franchise Tax Board, which administers state income tax exemptions, could better use available tools, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for their tax exemption.*

Finding #1: Lack of specific guidance regarding the content of community benefit plans precludes any meaningful comparison of the plans.

Although state law requires that tax-exempt hospitals submit plans to Health Planning, it does not require Health Planning to review the plans to ensure that hospitals report the same types of data consistently, nor does Health Planning do so. Further, the law provides only limited guidance regarding the content of the plan and does not mandate a uniform reporting standard. Thus, in reviewing the plans that eight tax-exempt hospitals submitted from 2002 through 2006, we found significant variations in the plans that precluded us from performing any meaningful comparison of the economic values the hospitals reported. Although the guidance provided in the law does not require uniform reporting, two hospital associations offer hospitals some guidelines. Additionally, the Internal Revenue Services (IRS) is proposing a new schedule for hospitals to prepare to be included with the informational return that all income-tax-exempt organizations must file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs and could influence hospitals to pattern their plans after the schedule's methodologies and format.

We recommended that if the Legislature expects plans to contain comparable and consistent data, it consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans. We also recommended that if the Legislature intends that the exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it consider amending state law to include such requirements.

Legislative Action: Legislation proposed.

Assembly Bill 2942 was introduced to require a standardized format and methodology to be used when presenting community benefit information. The bill did not pass during the 2007—08 Regular Session.

Finding #2: Errors in reported property values reduce the reliability of estimated property taxes not paid by tax-exempt hospitals.

We attempted to estimate the amount of property taxes not collected from tax-exempt hospitals, using the values of the buildings and contents owned by tax-exempt hospitals that county assessors submitted on statistical reports to Equalization. Although we found numerous errors in the values that prevented us from ensuring the reliability of our calculation, this methodology resulted in an estimated \$184 million in uncollected property taxes in 2005. More specifically, we found errors in the reported values for four of the 12 hospitals we reviewed, representing a total error of about \$204 million. The errors for the remaining 211 nonprofit hospitals in the State that are eligible for tax exemption are unknown. Equalization performs surveys of county assessors to determine the adequacy of the procedures and practices they apply in valuing property for the purpose of taxation and for administering property tax exemptions.

To ensure that it provides accurate information regarding the value that is tax exempt, we recommended that Equalization consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

Equalization's Action: Corrective action taken.

Equalization indicated that its survey of county assessors now includes a review of the exemption values contained in the county assessors' annual statistical reports. It also stated that it uses a survey review worksheet to examine individual exemption claim records for proper classification by the county assessors and to ask questions of assessors personnel on their practices and procedures. Finally, Equalization issued a letter to all county assessors informing them of our finding and that it was incorporating these verification steps into its survey of the county assessors.

Finding #3: Recent legislation affects the Franchise Tax Board's responsibilities for granting income tax exemptions.

We found minor weaknesses in the process the Franchise Tax Board (tax board) used in the past to determine the eligibility of nonprofit hospitals for state income tax exemptions. However, legislation effective January 1, 2008, will allow the tax board to rely on the federal income tax exemptions determined by the IRS. Although it was unable to obtain IRS reports and other information on the federal review process and thus could not gain a full understanding of the method the IRS uses to determine eligibility for tax exemptions, the tax board contended that its research of the IRS web site, publications, and tax law enabled it to conclude that the IRS process is sufficient to ensure proper determination of state exemption status. The tax board also stated that because state and federal laws on tax exemption are essentially identical, the additional audits it plans to perform—made possible by the workload reduction resulting from its use of IRS eligibility determinations—will compensate for any differences in quality between the state and federal review processes. The tax board indicated, however, that until it identifies the actual savings in workload that may occur when the new law is implemented, it cannot evaluate the opportunities for performing audits of nonprofit hospitals or plan for the number or frequency of such audits.

We recommended that, after it identifies the staff resources that are no longer required for reviewing tax exemption applications, the tax board implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.

Tax Board's Action: Corrective action taken.

The tax board indicated that it has begun to realize staff resource savings from the new exemption application process and is redirecting those resources to perform compliance audits. The tax board also reported that for calendar year 2008 to date, it opened 55 audits and completed 24 compared to this same time last year, when it opened 10 audits and completed four.

Finding #4: The tax board has limited assurance that nonprofit hospitals remain eligible for state income tax exemptions.

The tax board does not use the tools available to it, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for income tax exemption. According to management staff at the tax board, annual filings, which contain information such as financial data and changes in business activities, offer the tax board's Exempt Organizations Unit (unit) a useful tool for reviewing ongoing compliance with the requirements for maintaining tax-exempt status. However, the unit does not review the information in the annual filings. Management at the tax board stated that the large volume of initial applications for income tax exemptions and limited personnel prevent unit staff from reviewing the annual filings. In the absence of monitoring by the tax board, hospitals exempt from income taxes sometimes submit annual filings that do not contain all the information required by the form or its instructions or information required under the California Code of Regulations (regulations).

Regular auditing is another tool the tax board could use to monitor the tax-exempt status of nonprofit hospitals. However, the tax board does not regularly conduct audits of tax-exempt hospitals, even though, based on data provided by the tax board, the revenues of these hospitals represent 17 percent of the total revenue of all tax-exempt organizations. According to the tax board, an audit can originate when members of the public express concern that a tax-exempt organization may be functioning in a manner requiring revocation of its tax-exempt status. The tax board indicated, however, that it could not identify any complaints that might have prompted audits of tax-exempt hospitals, because it does not maintain a central record of the receipt or disposition of those complaints. Rather, complaints against tax-exempt organizations are stored in the tax board's files and cannot be easily retrieved.

The tax board stated that the revenue information from annual filings entered into its automated record-keeping system could be used to identify income-tax-exempt nonprofit hospitals to be considered for audit. However, because the tax board has not ensured that all tax-exempt nonprofit

hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate a list of the hospitals that might require audits. According to the tax board, creating such a list would necessitate manually reviewing the hard-copy files of the approximately 72,000 tax-exempt organizations operating in the State to determine which are tax-exempt hospitals.

Finally, the tax board told us that the IRS expects to perform an audit within three to five years after each organization receives a federal tax exemption, and it would notify the tax board of any revocations. However, the tax board does not currently coordinate with the IRS to identify audits of California tax-exempt hospitals in a manner that would allow the tax board to adequately rely on IRS audits for assurance of continuing eligibility.

We recommended that the tax board consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities:

- Review the financial and other information from the annual filing submitted by hospitals exempt from income taxes.
- Ensure that the annual filing contains all the information the tax board's regulations specify as necessary for determining eligibility for an income tax exemption.
- Track complaints in a manner that enable the tax board to identify potential trends in noncompliance by income-tax-exempt hospitals and initiate audits of those hospitals.
- Adequately identify tax-exempt hospitals in its automated database, enabling it to use the information in the database to profile those hospitals and identify any potential noncompliance with the law.

The tax board should also gain an understanding of the frequency and depth of IRS audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.

Tax Board's Action: Partial corrective action taken.

The tax board stated that it is developing an audit program to review the annual filings from the hospitals to gain a better understanding of compliance issues and materiality thresholds for ongoing reviews. In addition, the tax board indicated that it is finalizing business requirements for enhancements to its case management system that will provide data collection, modeling, and audit selection capabilities. It plans to implement these enhancements in November 2009. The tax board also reported that it has implemented a new procedure to log all complaints into a computer database that documents the organization name, type, issue, and action taken. Additionally, the tax board stated that it has updated the codes in its business entities accounting system to separately identify tax-exempt hospitals from other types of charitable organizations. Finally, the tax board indicated that a Memorandum of Understanding with the IRS was signed September 2008, authorizing the tax board to receive federal information about exempt organizations including proposed and final revocations, audit adjustments, and reports.

Department of Social Services

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

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

Department of Social Services' response as of September 2008

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

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

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

Social Services' Action: Partial corrective action taken.

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

Investigative Highlight . . .

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

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

Sex Offender Placement

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

REPORT NUMBER 2007-115, APRIL 2008

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

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

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

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

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

Audit Highlights . . .

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

- » *The Department of Justice's (Justice) database contained more than 59,000 registered sex offenders living in California communities. Of these, 8,000 are supervised and monitored by the Department of Corrections and Rehabilitation (Corrections) until they complete their parole.*
- » *State laws and regulations and departmental policies do not require that licensing departments consider the criminal background of potential clients, including registered sex offenders, that the licensed facilities plan to serve.*
- » *State law does not generally allow sex offenders on parole to reside with other sex offenders in a single family dwelling that is not what it terms a "residential facility;" however, in several instances two or more sex offenders on parole were residing in the same hotel room.*
- » *The registered addresses in Justice's database for 49 sex offenders were the same as the official addresses of facilities licensed by the Department of Social Services that serve children.*
- » *Although state law does not prohibit two or more sex offenders from residing at the same "residential facility," it does not clearly define whether residential facilities include those that do not require a license, such as sober living facilities.*
- » *State law is also unclear whether the residence restriction applies to juvenile sex offenders; we found several instances in which Corrections placed juvenile sex offender parolees at the same location.*

continued on next page . . .

- » *Local law enforcement agencies generally told us they have not performed formal assessments of the impact sex offenders have on their resources and communities.*
- » *State laws generally do not require the departments or their contractors that place registered sex offenders to consider the impact on local communities when making placement decisions.*

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

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

Legislative Action: Legislation proposed.

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

Justice's Action: Corrective action taken.

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

Social Services' Action: Corrective action taken.

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

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

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

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

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

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

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

Legislative Action: Unknown.

Corrections' Action: Corrective action taken.

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

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

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

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

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

Corrections' Action: Pending.

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

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

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

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

Corrections' Action: Partial corrective action taken.

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

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

Veterans Home of California at Yountville

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

REPORT NUMBER 2007-121, APRIL 2008

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

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

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

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

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

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

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

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

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

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

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

Veterans Home's Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

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

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

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

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

Veterans Home's Action: Partial corrective action taken.

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

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

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

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

Public Health's Action: Corrective action taken.

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

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

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

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

Veterans Board's Action: Corrective action taken.

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

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

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

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

Veterans Affairs' Action: Corrective action taken.

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

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

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

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

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

Veterans Home's Action: Corrective action taken.

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

Department of Health Care Services

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

REPORT NUMBER 2007-122, JUNE 2008

Department of Health Care Services' response as of December 2008

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

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

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

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

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

Health Care Services' Action: Corrective action taken.

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

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

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

Audit Highlights . . .

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

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

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

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

Health Care Services' Action: None.

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

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

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

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

Health Care Services' Action: Partial corrective action taken.

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

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

Victim Compensation and Government Claims Board

It Has Begun Improving the Victim Compensation Program, but More Remains to Be Done

REPORT NUMBER 2008-113, DECEMBER 2008

Victim Compensation and Government Claims Board's response as of November 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the Victim Compensation Program (program) to determine the overall structure of victim compensation services and the role of each entity involved, and to assess the effectiveness of the structure and communication among the entities. The audit committee also asked us to review the funding structure for the program and determine any limitations or restrictions. We were also asked to determine the types of expenses made from the Restitution Fund in each of the last four years, including identifying the annual amount used for administering the program and the annual amount reimbursed to victims.

The audit committee requested us to determine and assess the Victim Compensation and Government Claims Board's (board) process of approving or denying applications and bills, including how it communicates its decisions to applicants. Additionally, the audit committee directed us to review a sample of applications and bills that the board received from 2003 through 2007 to determine whether it adhered to proper protocols for the approval process. The audit committee also asked us to review, for the selected sample, the amount of time various steps took. In addition, it asked us to determine whether the board has a backlog of applications and bills awaiting its decision, the extent of the backlog, and any efforts taken to reduce the backlog. Finally, the audit committee directed us to review and assess the board's overall process for outreach to potential victims of violent crimes and whether it considers the demographics of the populations it serves in establishing its outreach program.

Finding #1: Despite a significant decline in program payments, program support costs have increased.

From fiscal years 2001–02 through 2004–05, program compensation payments decreased from \$123.9 million to \$61.6 million—a 50 percent decline. Compensation payments have increased since fiscal year 2004–05, but not to the level they reached in fiscal year 2001–02. Despite the significant decline in payments, the costs the board incurs to support the program have increased. These costs—ranging from 26 percent to 42 percent annually—account for a significant portion of Restitution Fund disbursements. According to board staff, several factors contribute to the board's program support costs making up such a substantial portion of its total disbursements. One factor is that the board is a stand-alone entity that shares no administrative or overhead costs with other entities. Another factor contributing to the support costs is the level of review that state laws and regulations require board analysts to perform to ensure that they pay only eligible bills. Further,

Audit Highlights . . .

Our review of the Victim Compensation Program (program) at the Victim Compensation and Government Claims Board (board) revealed the following:

- » *From fiscal years 2001–02 through 2004–05, program compensation payments decreased from \$123.9 million to \$61.6 million—a 50 percent decline.*
- » *Despite the significant decline in payments, the costs to support the program have increased. These costs make up a significant portion of the Restitution Fund disbursements—ranging from 26 percent to 42 percent annually.*
- » *The program did not always process applications and bills as promptly or efficiently as it could have. We noted staff took longer than 180 days to process applications in two instances out of 49 and longer than 90 days to pay bills for 23 of 77 paid bills we examined.*
- » *The program's numerous problems with the transition to a new application and bill processing system led to a reported increase in complaints regarding delays in processing applications and bills.*
- » *Some payments in the Compensation and Restitution System (CaRES) appeared to be erroneous. Although board staff provided explanations for the payments when we brought the matter to their attention, the fact that they were unaware of these items indicates an absence of controls that would prevent erroneous payments.*

continued on next page . . .

- » *The board lacks the necessary system documentation for CaRES.*
- » *There are no benchmarks, performance measures, or formal written procedures for workload management.*
- » *Despite the board's efforts to increase awareness of the program, several victim witness assistance centers do not think the public is generally aware of program services. Further, the board has not established a comprehensive outreach plan.*

another significant contribution to program support costs is that the board contracts with 21 joint powers (JP) units to aid in reviewing bills and applications.

Although not all the work board analysts perform results in compensation payments, the correlation between compensation payments and program support costs provides an overall measure that is informative because it indicates the board's "return on investment" for the level of costs it incurs. Currently, the board does not have a goal that compares program support costs to compensation payments, nor does the board set other similar goals. Further, to aid its efforts to maximize assistance to victims and their families while maintaining a viable Restitution Fund, it is important for the board to develop a method or calculation to establish an annual target fund balance amount.

We recommended that the board establish a complementary set of goals designed to measure its success in maximizing assistance to victims and their families. These goals should include, but not be limited to, one that focuses on the correlation of compensation payments to program support costs and one that establishes a target fund balance needed to avoid financial shortfalls. Further, as the board monitors the goals it has created, it should ensure its cost structure is not overly inflexible and that it is carrying out its support activities in the most cost-effective manner possible.

Board's Action: Pending.

The board agrees that it should strive to maintain a balance between revenues and expenditures thereby ensuring fund stability to the extent it is within its control. The board also agrees that the program's administrative functions should be as cost-effective as possible given the complexities of the program and the need to provide timely compensation to victims of crimes.

Further, the board plans to focus on the following activities to meet the intent of the audit recommendations:

- Explore the feasibility of establishing goals designed to measure success in maximizing assistance to crime victims and their families.
- Regularly monitor program data and analyze key trends and indicators of both expenditures and revenue and adjust strategies as necessary to maintain fund stability. This includes an ongoing assessment of cash flow and prudent reserves.
- Continually evaluate the cost-effectiveness of administrative activities, those that result in payouts, those that ensure fund stability, and those that advance victim access to the program and to needed services.

- Support and promote funding received from existing revenue sources. This is specifically addressed in the board's action strategy to develop a restitution outreach and training program. Further, the board plans to regularly evaluate the cost-benefit of ongoing revenue-generating programs and activities.
- Manage program resources and costs to maximize the availability of federal grant funds.

Finding #2: The board generally complied with state laws and regulations regarding program eligibility.

State laws and regulations describe the requirements for determining if an applicant is eligible for the program. During the eligibility determination process, board staff determine whether both the crime and the applicant qualify under the program. Staff typically use crime reports to determine if a qualifying crime occurred, but according to state regulations they can consider other evidence. Although in our review of 49 applications we found that the board generally determined the eligibility of applicants appropriately, for one application the board lacked documentation to support the eligibility decision. For an additional application we reviewed, the board incorrectly determined eligibility for a crime that did not occur.

To demonstrate that it makes appropriate eligibility decisions on applications, we recommended that the board ensure that it correctly considers reports from other entities, such as law enforcement, and that it sufficiently documents the basis for its decisions.

Board's Action: Pending.

The board agrees that it should correctly consider reports from other entities and document evidence as a basis for its decisions. The board states that it will continue to emphasize the importance of fully documenting all eligibility decisions and that the board's training activities focus on the need to appropriately document decisions and future training activities will continue this focus.

Finding #3: The program did not always process applications and bills promptly.

State law related to eligibility determinations for the program requires the board to approve or deny applications, based on the recommendation of board staff, within an average of 90 calendar days, and no longer than 180 calendar days after the acceptance date for an individual application. For the 49 applications we reviewed, the board's average processing time was 76 days, which is well within the statutory average. However, the board did not make a determination within 180 days in two instances. We also noted various instances where the board did not demonstrate that it approved or denied the applications as promptly as it could have after receiving the information necessary to make the determination. In addition, state law requires the board to pay certain bills within specific time frames. Our review of 77 paid bills associated with approved applications found that the board's average processing time was 66 days. However, because the board took more than 90 days to pay some bills, it did not always meet statutory time frames.

The board's procedures for following up with outside entities to obtain necessary information to verify applications and bills are not sufficiently detailed and contribute to inconsistencies in staff efforts to obtain the information promptly. Additionally, even when staff initially request information and follow up promptly, some entities delay providing the necessary information. The board told us it is reaching out to some entities to emphasize the importance of providing requested information more promptly.

Our review of the board's practices for communicating with applicants found that the board uses standard letters to notify applicants of decisions. For example, state regulations require the board to notify an applicant if program staff recommend that the board approve an application or bill. The board recently revised its process to notify applicants of eligibility decisions once the board reaches its final decision, rather than when staff recommend the decision, which is not consistent with state regulations.

To improve its processing time for making decisions on applications and for paying bills, we recommended that the board identify the problems leading to delays and take action to resolve them. Further, we recommended that the board develop specific procedures for staff to use when following up with verifying entities and continue its outreach efforts to communicate the importance of responding promptly to its requests for information. Finally, to ensure that it complies with state regulations, we recommended that the board modify its process for when it notifies applicants of decisions or seek regulatory change.

Board's Action: Pending.

The board states that improving processing times for making decisions on applications and paying bills is being addressed as an early action item by the architectural adjustment section of its Compensation and Restitution System (CaRES) Optimization project charter. The specific improvements envisioned include correcting issues with the aging reports that will allow the board to more easily identify applications approaching the maximum processing time limit. Future training and development of staff will also assist in this area. The board also notes that its Pre-Scan Unit, fully operational in July 2008, identifies missing items on newly filed applications, reducing the processing times for all applications.

Further, the board states that its ability to process applications and pay bills in a timely manner is dependent upon the timely submittal of key information from verifying entities. To improve its success at obtaining such information, the board plans to develop a new procedure manual, which will provide specific direction to staff for processing applications and bills in CaRES. The manual will include specific time frames for follow up with nonresponsive verifying entities. Through its statewide provider forums, the board has been communicating to service providers the importance of prompt submittal of requested information to the board so staff can process payment requests in a timely manner. The board also states that it is reaching out to law enforcement during its law enforcement outreach seminars.

The board agrees with our recommendation concerning notification of applicants of the board's recommended decisions, and this change has been incorporated into the proposed regulation package the board will consider at a subsequent board meeting.

Finding #4: The board did not consistently explore alternative coverage of expenses or document its approval process.

Although the board has procedures for staff to follow when verifying whether bills are reimbursable from other sources such as insurance or public assistance, we found that board and JP unit staff were not consistent in their verification efforts. According to state law, the board may reimburse eligible individuals for pecuniary loss, subject to the limitations established by type of benefit. A pecuniary loss is an economic loss or expenses resulting from an injury or death to a victim of crime that has not been and will not be reimbursed from any other source. Because the board does not ensure that its staff and JP unit staff demonstrate that they follow procedures consistently to verify whether bills can be paid from sources other than the program, applicants may be treated inconsistently, and the board may use program funds inappropriately. Further, the board could not always provide documentation to support the formal approval of the applications and bills we reviewed. Because the board did not maintain documentation for the approvals of staff recommendations on applications and bills, it is unable to demonstrate the required approvals and may encounter legal problems if decisions are challenged.

We recommended that the board ensure that staff consistently verify and document their efforts to ensure that there are no other reimbursable sources. We also recommended that the board consistently maintain documentation of its formal approval of applications and bills.

Board's Action: Pending.

The board states that regarding the recommendation to consistently verify and document reimbursement sources, the board will ensure that the training and development classes for processing staff include appropriate emphasis on this matter. Further, the board agrees that it can make improvements in maintaining documentation.

Finding #5: The board does not have written procedures or time frames for processing appeals.

We reviewed five applications that the board denied and the applicant appealed. The board took more than 250 days to resolve four of the applications we reviewed. The fifth was more than a year old and was not yet resolved. According to the board's appeals manager, the process can be lengthy because it takes time to evaluate the appeals and obtain additional information as needed. Further, according to the appeals manager, the board does not have written procedures that govern the appeals process and has not established time frames for processing appeals. Without procedures and time frames, the board cannot ensure that appealed applications and bills are processed in a prompt manner.

To ensure that the board processes appeals of denied applications within a reasonable time, we recommended that it establish written procedures and time frames.

Board's Action: Pending.

The board states that it concurs with our recommendation to develop written procedures and time frames for the appeals process and it plans to develop a new procedures manual that will include this subject.

Finding #6: The board is experiencing problems with the transition to CaRES.

The board began making the transition to CaRES, its new system for processing applications and bills, in late June 2006 and began using CaRES exclusively after June 2008. Although the board expects to gain efficiencies and benefits from the use of the new system, it generally has not developed benchmarks or measured results. We also discovered that the board lacks necessary system documentation for CaRES. Further, the board has experienced numerous problems with the transition. Most troubling was our identification of payments that appeared to be erroneous. Although board staff provided explanations, asserting that the payments were appropriate and the data were flawed, the fact that they were unaware of these items indicates the absence of controls that would prevent such erroneous payments being made. In addition, interviews with representatives from victim witness assistance centers (assistance centers) revealed that the new system has caused an increase in complaints regarding delays in processing applications and bills.

To ensure that the board maximizes its use of CaRES, we recommended that the board develop goals, objectives, and benchmarks related to the functions it carries out under CaRES that will allow it to measure its progress in providing prompt, high-quality service; continue identifying and correcting problems within the system as they arise; address the structural and operational flaws that prevent identification of erroneous information and implement edit checks and other system controls sufficient to identify errors; seek input from and work with relevant parties, such as assistance centers and JP units, to resolve issues with the transition; and develop and maintain system documentation sufficient to allow the board to address modifications and questions about the system more efficiently and effectively.

Board's Action: Pending.

The board states that it is continuing its efforts to maximize its use of CaRES. The board states that it has developed the CaRES Optimization project charter that details activities it will undertake to ensure that CaRES performs all functions efficiently and reliably. Further, the board states that this charter sets forth the goals, objectives, and benchmarks related to the functions the board carries out under CaRES. The board also plans to implement edit checks and other system controls to ensure the identification of data errors. The board notes that it recognizes the importance of continuing to seek input from and work with all relevant stakeholders as it implements necessary improvements to CaRES. In addition, the board states that another key element of the project charter is the development and maintenance of system documentation.

Finding #7: Our analysis of CaRES data revealed that JP units process applications and bills more quickly than the board does.

Based on our review of CaRES, the board's average processing times for applications and bills were considerably longer than that of the JP units collectively. Board staff state that this is partly because assistance centers, which oversee a variety of services to victims, often assist the applicants in completing the applications and obtaining the necessary information before submitting the applications or bills. The average number of days for processing applications from the date the application was accepted was 64 days for the JP units and 80 days for the board. With respect to bills, the average processing time was 57 days for the JP units and 111 days for the board. The board has some tools that encourage applicants to contact the assistance centers. For example, the board developed an informational brochure that provides victims with contact information for their local assistance center. However, the board has opportunities to do more in this area.

To increase the number of applicants who work through assistance centers, we recommended that the board emphasize the advantages of doing so whenever possible.

Board's Action: Pending.

The board states that it will continue to encourage applicants to work directly with the county assistance centers.

Finding #8: The board's current process for managing program workload is informal.

The board has not established benchmarks, performance measures, or any formal written procedures for managing workload related to processing applications and bills. In addition, because the reporting function in CaRES, which would provide aging information, is not working yet, the board is currently relying on ad hoc aging reports that are not reliable. As a result, the board does not have critical information readily available to management to make decisions about managing its workload in the most effective manner.

To ensure that the board effectively manages the program workload and can report useful workload data, we recommended that it do the following: develop written procedures for its management of workload, implement the reporting function in CaRES as soon as possible, and establish benchmarks and performance measures to evaluate whether it is effectively managing its workload.

Board's Action: Pending.

The board states that it recognizes the need to effectively manage workload and that its CaRES Optimization project charter includes the specific task to develop the reporting function and that the data generated will be used to identify and manage workflow. With this reporting capability, the board states that it will be able to develop written workload management procedures and relevant performance measures to evaluate workload management.

Finding #9: The board lacks a comprehensive outreach plan to prioritize its efforts and did not consider demographics and crime statistics in developing its outreach strategies.

The board focused its outreach efforts during fiscal year 2007–08 on increasing awareness of the program among crime victims and the families of victims. Further, the board believes that the best avenue to create awareness of the program is to provide information and outreach materials to first responders—those individuals who generally first come into contact with crime victims or their families after a crime occurs. The board also expands awareness of the program through its key partners—JP units and victim advocates. Despite the variety of outreach efforts conducted by the board, it has not developed a comprehensive outreach plan. Without such a plan, it is unable to demonstrate that it has prioritized its outreach efforts, appropriately focused on those in need of program services, and spent program funds effectively. Further, the board did not consider demographics or crime statistics when developing its outreach efforts and priorities in fiscal year 2007–08 and has not quantified whether there are potential populations that are underserved. Finally, the board’s outreach efforts for vulnerable populations—those groups of individuals that are more susceptible to being victims of crime and those less likely to participate in the program—have been limited.

We recommended that the board establish a comprehensive outreach plan that prioritizes its efforts and appropriately focuses on those in need of program services. We recommended, as part of its planning efforts, that the board seek input from key stakeholders such as assistance centers, JP units, and other advocacy groups and associations to gain insight regarding underserved and vulnerable populations. We also recommended that the board consider demographics and crime statistics information when developing outreach strategies.

Board’s Action: Pending.

The board agrees that it should establish a comprehensive outreach plan that prioritizes and focuses its efforts on those in need of program services. According to the board, its project charter, entitled *Develop a Comprehensive Communication and Outreach Plan*, reflects the board’s commitment to conduct its outreach efforts pursuant to a written plan which focuses on reaching out to those in need of program services. The plan will identify target audiences, including underserved victim populations; determine communication strategies; develop key messages; and determine appropriate communication tools. The board states that in developing the plan it will seek input from key stakeholders, including first responders, as required by law, and advocacy groups associated with underserved and vulnerable populations. The board further agrees that the plan should consider demographic and crime statistics.

Finding #10: The board is still considering how to measure the effectiveness of its outreach efforts and does not specifically budget for outreach expenses.

The board announced the rollout of its new strategic plan for the years 2008 through 2012 in May 2008. One of the goals in this plan is to increase public awareness of the program by 10 percent by July 2009. However, as of October 2008, management was still considering future outreach efforts and how best to quantitatively measure the success of these efforts. Further, the board is missing an opportunity to track useful information from applicants regarding how they heard about the program. The board collects such information but had not summarized the information to measure outreach effectiveness. We also discovered that the board does not specifically budget for and report actual outreach expenses.

We recommended that the board define the specific procedures to accomplish its action strategies for outreach and establish quantitative measures to evaluate the effectiveness of its outreach efforts. Further, we recommended that the board use information from applicants regarding how they heard about the program as part of its overall efforts to measure outreach effectiveness. We also recommended that the board specifically budget for and report actual outreach expenses.

Board's Action: Pending.

The board states that metrics are being developed that will be incorporated into its Comprehensive Communication and Outreach Plan. Further, it states that these metrics will be used to measure the effectiveness of the outreach strategies. The board states that the measures will include, but not be limited to, applications received by county and by ethnicity; Department of Justice crime statistics by county and to the extent available by ethnicity; awareness surveys of first responders and community organizations; and surveys regarding how applicants learned of the program.

In addition, the board states that it recognizes the importance of budgeting for and reporting outreach expenses and that it is developing an outreach budget for the balance of fiscal year 2008–09. The board states that it will have established a specific budget and expenditure system for its outreach program by fiscal year 2009–10.

California Institute for Regenerative Medicine

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

REPORT NUMBER 2006-108, FEBRUARY 2007

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

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

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

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

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

Audit Highlights . . .

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

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

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

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

Institute's Action: Partial corrective action taken.

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

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

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

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

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

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

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

Institute's Action: Partial corrective action taken.

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

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

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

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

Institute's Action: Partial corrective action taken.

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

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

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

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

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

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

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

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

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

Institute's Action: None.

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

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

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

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

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

Institute's Action: Partial corrective action taken.

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

Department of Health Care Services

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

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

Department of Health Care Services' response as of November 2007

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

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

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

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

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

Investigative Highlight . . .

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

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

Health Care Services' Action: Partial corrective action taken.

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

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

Department of Housing and Community Development

Awards of Housing Bond Funds Have Been Timely and Complied With the Law, but Monitoring of the Use of Funds Has Been Inconsistent

REPORT NUMBER 2007-037, SEPTEMBER 2007

Department of Housing and Community Development's response as of August 2008

In November 2002 and 2006, California voters passed the Housing and Emergency Shelter Trust Fund acts to provide bonds (housing bonds) for use in financing affordable housing for low- to moderate-income Californians. The Department of Housing and Community Development (department) and the California Housing Finance Agency (Finance Agency) manage the programs funded by the housing bonds.

The California Health and Safety Code, sections 53533 and 53545, requires the Bureau of State Audits to conduct periodic audits of housing bonds activities to ensure that housing bond proceeds are awarded in a manner that is timely and consistent with legal requirements and that awardees use the funds in compliance with the law.

Finding #1: Awards of housing bond funds were timely.

The department and Finance Agency have generally met and sometimes exceeded the goals specified in awards schedules they established in 2002 and 2003 for the 2002 housing bonds. For all complete fiscal years we audited, except fiscal year 2002–03, actual awards exceeded estimated awards.

Finding #2: The department and the Finance Agency generally complied with legal requirements when awarding housing bond funds.

The department and the Finance Agency generally allocated and awarded housing bond funds for the intended programs, to the correct types of sponsors, and for the proper activities. We noted that the Finance Agency's California Homebuyer's Downpayment Assistance Program (Downpayment Assistance Program) and the department's CalHome, Joe Serna Jr. Farmworker Housing (Farmworker Housing Program), and Multifamily Housing programs complied with legal requirements. However, poor file management in the department's Emergency Housing and Assistance Program (Emergency Housing Program) made it impossible for us to verify if the department always assessed applicants' submissions according to criteria for their capability as set forth in program notices. These criteria include minimum standards.

We recommended that the department implement record-keeping procedures for the Emergency Housing Program to ensure that applicants who receive awards have been properly evaluated.

Audit Highlights . . .

Our review revealed that for the Housing and Emergency Shelter Trust Fund Act of 2002:

- » *Both the Department of Housing and Community Development (department) and California Housing Finance Agency (Finance Agency) generally awarded funds in a timely manner.*
- » *Both the department and Finance Agency generally complied with legal requirements for making awards; however, the department could not provide its rating and ranking tools in some cases for its Emergency Housing and Assistance Program (Emergency Housing Program).*
- » *Both the department and Finance Agency generally used appropriate monitoring procedures during the expenditure phase, but the department sometimes overrode controls concerning advance payments for the CalHome Program.*
- » *The department does not exert adequate monitoring over the completion phase for two of its programs—Emergency Housing and CalHome.*

Department's Action: Corrective action taken.

By the end of October 2007 the department indicated that it finalized standardized record filing and maintenance procedures for the Emergency Housing Program. In addition, by the end of February 2008, the department says it completed its file review and organization of existing files.

Finding #3: The department and the Finance Agency generally undertake appropriate monitoring procedures during the expenditure phase.

For the expenditure phase (the period from award commitment to final state payment to an awardee), the department and the Finance Agency have processes in place to ensure that awardees exhibit reasonable progress in meeting their goals and are only reimbursed for allowed costs. However, we found that for three of the 18 CalHome awards tested, 17 percent of our sample, sponsors received advances exceeding the 25 percent limit established in their standard agreements. For example, the department approved a 100 percent advance on the last day funds were available for disbursement to one awardee based only on a list of potential home buyers. In these cases, the department overrode what appears to be a reasonable policy to ensure the delivery of services close to the time of payment and to maximize the State's interest earnings. Had the department retained the funds advanced over the 25 percent threshold for the three awards, we estimate it could have earned \$42,000 in interest through July 2007 based on the effective yield of the State Treasurer's Office pooled money account.

We recommended that the department consider eliminating its process of overriding restrictions on advances for the CalHome Program.

Department's Action: Corrective action taken.

The department reported that it established clear procedures to guide staff in evaluating circumstances in which an advance above the 25 percent limitation may be appropriate and in documenting justifications received from awardees. In cases where advances are provided, the department stated that staff will evaluate actual performance, as measured by receipt of borrower summaries, at 60-day intervals following the advance.

Finding #4: For two programs, the department does not have adequate monitoring processes for the completion phase.

Of the five programs we reviewed, only Downpayment Assistance, Farmworker Housing, and Multifamily Housing had processes in place to adequately ensure compliance during the completion phase. This phase extends from the final state payment to fulfillment of all contract requirements. However, the CalHome and Emergency Housing programs administered by the department had weak or nonexistent monitoring during the completion phase. Consequently, the department cannot always be certain that sponsors are using bond funds to help intended beneficiaries, such as low- to moderate-income home buyers or homeless individuals.

We found that for 17 of the 18 CalHome Program awards we tested, the department had not verified any of the information provided whether through site visits or by reviewing original documentation, even though the sponsors had received all funds. For the remaining award, the sponsor had not yet received any funds. As a result, the department cannot be certain that sponsors complied with housing bond requirements related to occupants' income limits or their status as first-time home buyers.

Similarly, for the Emergency Housing Program, we found that the department had not performed site visits to verify sponsor activities for any of the awards we tested that were in the completion phase. Moreover, the program manager said that the program has not performed any site visits since 2005 and even then, it did not have formal policies and procedures governing the purpose and documentation

requirements for site visits. Without monitoring processes for verifying compliance, the department cannot ensure that sponsors use funds in accordance with housing bond requirements or that the program benefits the intended populations.

We recommended that the department give high priority to finalizing and implementing monitoring procedures for the CalHome and Emergency Housing programs, which do not currently have such procedures in place. In addition, we recommended that the department review its other housing bond programs that were not specifically evaluated in this initial audit to ensure that monitoring procedures are in place and operating.

Department's Action: Partial corrective action taken.

The department stated that it has finalized the design of its monitoring program of the CalHome program and that on-site reviews by CalHome staff are continuing. In regards to the Emergency Housing Program, the department says that in January 2008, it finalized its monitoring procedures and that on-site monitoring has begun.

The department indicates in-progress monitoring processes and, where appropriate, post completion/long-term monitoring processes are now in place for all bond programs not included in the audit with the exception of the new programs under Proposition 1C that are still in the initial design phase or have recently completed that phase. The department says that in these cases, monitoring program design is under way and that it intends to complete this effort before contracts are executed.

Department of Insurance

Former Executive Life Insurance Company Policyholders Have Incurred Significant Economic Losses, and Distributions of Funds Have Been Inconsistently Monitored and Reported

REPORT NUMBER 2005-115.2, JANUARY 2008

California Insurance Commissioner's, California Department of Insurance's and the Conservation and Liquidation Office's responses as of June 2008

The Joint Legislative Audit Committee (audit committee) directed the Bureau of State Audits to review the California Department of Insurance's (department) management of the Executive Life Insurance Company Estate (ELIC estate) and related litigation. Specific audit objectives included the following:

- Analyze the funds paid into and out of the ELIC estate since April 11, 1991.
- Determine how much money policyholders have received.
- Determine the percentage of policyholders who have received all of the payments they would have received if ELIC had not become insolvent.
- Determine the amount policyholders will receive in the future.
- Determine how the department has used the litigation proceeds that it has received, including payments made to policyholders, the national guaranty organization, and others.
- Determine the percentage of the department's projected \$4 billion loss to policyholders that was recovered by litigation including settlements, relating to the ELIC estate, after subtracting amounts distributed to policyholders and the national guaranty organization and others.

Finding #1: The California Insurance Commissioner (commissioner) has not consistently ensured that Aurora National Life Assurance Company (Aurora) complies with ELIC agreements.

The commissioner entered into agreements specifying how ELIC's insurance policies would be transferred to Aurora, how the former ELIC policies would be restructured, and how assets that remained under the commissioner's control and future litigation proceeds that he received would subsequently be distributed to policyholders.

The commissioner, Aurora, and the National Organization of Life and Health Insurance Guaranty Associations (national guaranty organization) are party to the ELIC agreements.

Audit Highlights . . .

- » *When the California Insurance Commissioner (commissioner) conserved the Executive Life Insurance Company (ELIC) on April 11, 1991, he reported the company's assets to be \$8.8 billion. Later, losses from the liquidation of ELIC investment securities reduced this amount by \$1.3 billion. Through December 31, 2006, the remaining \$7.5 billion has been increased by investment income, litigation proceeds, and other income, resulting in \$10.2 billion in total available assets.*
- » *Of the \$10.2 billion, the commissioner transferred \$6.7 billion to Aurora National Life Assurance Company for use in its role as successor insurer to ELIC and to pay policyholders who did not continue with the company. The commissioner has paid a total of \$2.7 billion to policyholders and other beneficiaries of the estate and has used \$528 million for administering the ELIC estate.*
- » *About \$325 million remained in the estate as of December 31, 2006. In 2007 the commissioner transferred \$311 million of these remaining funds to Aurora, most of which it reports as disbursed to policyholders and others in October 2007.*
- » *In August 2005 the department estimated policyholder losses at \$936 million, which equates to policyholders recovering 90 percent of their original policy rights.*

continued on next page . . .

» *Including factors not considered by the department, we estimated policyholder economic losses of \$3.1 billion as of August 2005, with policyholders recovering 86 percent of their expected ELIC account values.*

» *The commissioner has not consistently monitored, reported on, or accounted for the distribution of the assets of the ELIC estate.*

Key provisions of the ELIC agreements require Aurora to add interest to the funds it receives from the ELIC estate; calculate distributions to policyholders who opted to continue coverage with Aurora (opt-in policyholders) and other ELIC estate beneficiaries, such as the national guaranty organization, according to complex formulas; and determine the amount of ELIC funds that it pays to third-party companies that offset some policyholders' losses.

The commissioner, as trustee of the ELIC estate, has not consistently ensured that Aurora adds the proper amount of interest to the funds it receives from the ELIC estate, or that it accurately calculates the amounts that it distributes to policyholders and others based on provisions in the ELIC agreements. Between September 1993, when Aurora assumed ELIC's policies, and October 2007, one external examination has been conducted, and an internal examination by the commissioner's Conservation and Liquidation Office (CLO) is in the process of being conducted, to verify Aurora's compliance with some of the provisions of the ELIC agreements. However, the commissioner did not monitor other distributions that occurred from 1998 through 2006 for such compliance and therefore cannot provide policyholders and others the same level of assurance that the \$225 million Aurora distributed during this period of time was handled in accordance with the ELIC agreements.

To increase assurance that Aurora follows key provisions in the ELIC agreements, we recommend that the commissioner seek the right to review Aurora's future distributions of ELIC estate funds and review those distributions to ensure that it adds the proper amount of interest to the funds, and distributes the funds correctly.

Commissioner's Action: Partial corrective action taken.

A written request, dated February 27, 2008, was sent to Aurora and the national guaranty organization by the CLO. Although there have been numerous discussions with Aurora over the past several months, Aurora has not made a commitment to fulfill CLO's request. Completion of this recommendation will be dependent on Aurora's acceptance to CLO's request and the actual timing of future distributions.

Finding #2: Managers of the ELIC estate have not consistently reported on the disposition of ELIC's assets.

During the period from 1990, before the commissioner conserved ELIC, through 2006, we found that there is a lack of available information on ELIC's operations and the disposition of ELIC's assets. The commissioner has assigned various parties the responsibility of managing the ELIC estate since he conserved ELIC in April 1991. We found that the level of information varied depending on the entity managing the estate or trust at the time. Some of the reports that are either authorized by the insurance code or required by individual trust agreements have not been produced, and audits of the ELIC estate have not been consistently performed. Similarly the extent of audited financial statements available showing the disposition of ELIC's assets, including the receipt and distribution of ELIC funds, is related to which entity was managing the estate. We found that audited financial

statements were not available during the 1991 through 1993 period, and while the ELIC estate was extensively audited during the 1994 through 1996 period, it has not been consistently audited since 1997. Overall, inconsistent reporting has contributed to a lack of information available to former ELIC policyholders and other parties who have an interest in the ELIC estate.

In order to ensure that information is available to policyholders and other parties interested in the disposition of ELIC's assets, we recommended that the commissioner, as soon as practical after the end of each year and upon the termination of any trust, complete a report that includes the assets and liabilities; the amount of all distributions, if any, made to the trust beneficiaries; and all transactions materially affecting the trust and estate.

Commissioner's Action: Corrective action taken.

Summarized financial information along with a brief narrative of the ELIC estate and grantor trusts was posted on the CLO Web site in April 2008.

Finding #3: Managers of the ELIC estate have not consistently audited the estate.

In settling the ELIC estate, the commissioner established a series of trusts to receive and distribute funds to policyholders. Auditing requirements have been met for some of the trusts but not for others. For example, the consolidated audits performed of the ELIC estate from 1997 to 2000 are not comprehensive, and no audits were performed from 2001 to 2004. The purpose of the audits is to ensure that reported financial information is accurate.

By not producing the audits, the commissioner had no way to ensure that ELIC's financial statements were accurate and further reduced the amount of publicly available information on the disposition of the ELIC estate's assets.

In 2006 the CLO's chief financial officer requested the Department of Finance (Finance) to conduct a separate review of the ELIC estate and each of its trusts covering the 2005 and 2006 period. He stated that he plans to continue these reviews yearly until the trusts are closed.

In order to ensure that the financial information reported by the CLO is accurate, we recommended that the commissioner continue the practice of auditing the ELIC estate, and any trusts that remain open, on a periodic basis as implemented by the current chief executive officer in 2006.

Commissioner's Action: Corrective action taken.

Finance reviews for the year ended December 31, 2007, are scheduled to be completed by August 2008.

Finding #4: Inconsistent accounting practices and inconsistent availability of supporting documents hinder a complete accounting of the ELIC estate.

Since ELIC was first conserved in 1991, a variety of methods have been used to account for the estate. For example, from 1991 to 1993, the available financial information is primarily contained in unaudited financial statements prepared by outside contractors and unaudited financial statements included in the annual report to the governor. For the 1994 to 1996 period, audited financial statements exist for the various trusts; however, for the ELIC estate in 1994, only a balance sheet was included in the audit report. Financial reporting was not consistent from 1997 through 2006. For example, in 1998 a \$75 million indemnity payment was paid to Aurora pursuant to the rehabilitation plan. While the 1998 ELIC Trust audit reports a \$55.5 million expense for its portion of this amount, the CLO's general ledger does not report a \$19.5 million expense for the remaining portion that it paid from the ELIC estate. Additionally, the cash-flow statements prepared from 1991 through 1996 were not prepared during the period from 1997 through 2006.

Various trust agreements identify the recipients of ELIC estate distributions as opt-in and opt-out policyholders, Aurora, and the national guaranty association. Although the notes to the financial statements for the 1994 to 1996 period identified the amount of funds paid to opt-in and opt-out policyholders and refer to opt-in and opt-out accounts, the CLO accounting system does not maintain separate accounts to record distributions to these recipients. In addition, it does not maintain separate accounts to record payments made to the national guaranty organization or Aurora. Although there is no specific requirement for structuring the accounting records, maintaining subsidiary accounts that separately track payments to each category of trust recipient would aid the timely reporting of payments to recipients of ELIC estate distributions.

The lack of maintaining separate accounts for tracking the payments made to the four recipients of the trusts may have contributed to the delayed identification of a \$90 million posting error to the CLO general ledger distribution account in 1997 and a \$62 million posting error to the CLO general ledger distribution account in 2002, which the CLO did not correct until September 2007. Another reason that the distribution account errors may not have been promptly identified during the 1997 through 2006 period is that, although the CLO reconciles its cash account to subsidiary databases for distributions to maintain control of cash, it did not reconcile the distributions reported in its general ledger to the subsidiary databases in order to maintain control for correct financial reporting.

In order to ensure that it accurately records distributions in its primary accounting system, and ensure correct financial reporting, we recommended that the CLO periodically reconcile the distributions reported in its general ledger to its subsidiary databases.

Commissioner's Action: Corrective action taken.

The commissioner stated that the CLO will continue its practice of reconciling distributions to the Trust Administration System subsidiary databases and to the general ledger, and stated that the CLO has reformatted the financial presentation of the ELIC financial statements and has established separate accounts in the ELIC estate general ledger for each future distribution.

California Unemployment Insurance Appeals Board

Its Weak Policies and Practices Could Undermine Employment Opportunity and Lead to the Misuse of State Resources

REPORT NUMBER 2008-103, NOVEMBER 2008

California Unemployment Insurance Appeals Board's response as of November 2008

The California Unemployment Insurance Appeals Board (appeals board) is a quasi-judicial agency created in 1953 to conduct hearings and issue decisions to resolve disputed unemployment and disability determinations and tax-liability assessments made by the Employment Development Department. The appeals board is overseen by a seven-member board or its authorized deputies or agents. The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the appeals board's hiring, procurement, and administrative practices. Specifically, the audit committee asked that we review and evaluate the appeals board's hiring policies to determine whether its policies and procedures comply with applicable laws and regulations. In addition, the audit committee asked us to examine a sample of hires, promotions, and transfers to determine if each one complied with applicable laws, regulations, policies, and procedures.

The audit committee also requested that we determine the prevalence of familial relationships among appeals board employees, to the extent possible. In addition, we were asked to determine whether the appeals board's processes for handling grievances and equal employment opportunity (EEO) complaints are set up in a manner that allows employees to avoid the fear of retaliation. Furthermore, the audit committee asked us to review and evaluate the appeals board's procurement practices for office space, furniture, and other administrative purchases to ensure that they align with applicable laws, regulations, and appeals board policies. Finally, the audit committee asked us to review the appeals board's use of state property such as vehicles and fuel cards and determine whether such use is reasonable and allowable per applicable laws.

Finding #1: Although the appeals board's prehiring process identifies eligible candidates, managers did not consistently document the reasons for their hiring decisions.

We determined that the appeals board's prehiring process generally ensures that individuals it hires, promotes, and transfers are eligible for their positions. However, hiring managers were not always able to consider all of the applicants for a given position because of a freeze on outside hires. In addition, managers did not consistently document each of the steps in the hiring process or their reasons for hiring a particular candidate, making it difficult for an outside party to understand why the appeals board selected particular candidates. For example, there was no evidence that managers conducted interviews for some hires, most notably when hiring two former board members

Audit Highlights . . .

Our review of the California Unemployment Insurance Appeals Board's (appeals board) hiring, procurement, and administrative practices found that:

- » *Hiring managers were not always allowed to consider all applicants for a given position because of a freeze on outside hires.*
- » *Hiring managers did not consistently document their reason for hiring a particular candidate.*
- » *Nearly half of the employees who responded to our survey believed that the appeals board's hiring and promotion practices were compromised by familial relationships or employee favoritism.*
- » *The appeals board cannot currently enforce its new nepotism policy on persons who are not currently employed by the appeals board because the new policy should have been submitted to the State's Office of Administrative Law for approval as a regulation.*
- » *Employees submitted few equal employment opportunity (EEO) complaints or grievances during roughly the past five years, and 40 percent of employees responding to our survey indicated that they would have some fear of retaliation from their supervisors or upper management if they were to file either EEO complaints or grievances.*

continued on next page . . .

» *Certain weaknesses in the appeals board's controls over travel expenses prevent it from demonstrating the business purpose of some travel expenses and resulted in some questionable costs that may need to be recovered.*

» *The appeals board expends approximately \$5,000 per month for parking spaces, but it has not established any procedures to ensure that these spaces are only used for appropriate purposes.*

as administrative law judges. Consequently, the appeals board is vulnerable to allegations that its hiring decisions are unfair and that employment opportunities are not afforded to all candidates.

To better ensure that its hiring decisions are fair and that employment opportunity is afforded to all eligible candidates, and to minimize employees' perceptions that its practices are compromised by familial relationships or employee favoritism, we recommended that the appeals board do the following:

- Prepare and formally adopt a comprehensive hiring manual that incorporates the State Personnel Board's guidelines and that specifically directs hiring managers to do the following:
 - › Conduct and score hiring interviews using a structured interview format and a corresponding rating scale, and benchmark answers that describe the responses that reflect each level of performance on the rating scale.
 - › Maintain documentation of each of the steps in the hiring process for at least two years. For example, managers should maintain all applications received from eligible applicants and should preserve notes related to interviews and reference checks.
 - › Forward a memo to the appeals board's personnel services unit that documents the results of the hiring process, including the names of the candidates interviewed, the dates of the interviews, the names of the individuals on the interview panel, and the panel's selection, along with an explanation of why that candidate was chosen. After the appeals board approves hiring the selected candidate, the personnel services unit should maintain this memo for a period of two or more years so that it can demonstrate that the hiring process was based on merit and the candidate's fitness for the job.
- Before implementing another soft hiring freeze, the appeals board should carefully consider whether the projected budgetary advantages outweigh the risk that it may not hire the strongest and most qualified candidates during any such freeze.

Appeals Board's Action: Partial corrective action taken.

The appeals board reports that it is already taking measures to ensure that managers and supervisors are familiar with its updated hiring guide that prescribes the use of an interview format, rating scale, and benchmark answers. The guide also instructs that the recruitment file shall be maintained for two years. In addition, the appeals board stated it has created and begun utilizing a request-for-hire form, which requires the hiring office to obtain and document appropriate approvals and to include on the form the following information: the number of applications received for the position; the number of applicants interviewed; whether an official personnel file has been reviewed, references contacted, and if

the employee is related to an appeals board employee; and an explanation of why the proposed hire is the most qualified candidate. The appeals board further asserts that this form will be maintained with the position action package in its personnel services unit for five years.

Furthermore, the appeals board reports that it agrees that before implementing another soft hiring freeze for budget reasons, it should consider whether the projected budgetary advantages outweigh the risk of possibly not hiring the most qualified candidates. The appeals board also agrees that it should present this option to the board members for their consideration since it would have an impact on the budget, and the board members have the responsibility for adopting and approving the budget.

Finding #2: The appeals board has recently sought to establish certain restrictions over the hiring of former board members and relatives.

The appeals board hired a former board member as a full-time permanent administrative law judge in December 2004, apparently without interviewing other qualified applicants. This individual had passed the administrative law judge civil service exam, making him eligible for the position, and we do not doubt that prior board service gave him unique insights into how unemployment insurance cases ought to be decided. However, the appeals board's past practice of hiring board members for civil service jobs could undermine its employees' faith in the civil service selection process.

Notwithstanding, the appeals board recently adopted a policy prohibiting the hiring of a board member into any civil service position at the appeals board for a period of one year from the last day of that individual's term as a board member. We believe this policy would mitigate the potential conflict of interest inherent in hiring board members as civil servants. However, the appeals board cannot currently enforce this policy because, according to our legal counsel, it is actually a regulation that should have been submitted to the State's Office of Administrative Law for approval. Specifically, the Administrative Procedures Act requires a state agency to submit proposed regulations to the Office of Administrative Law for legal review and public comment if the proposed regulation applies to people or entities outside the agency. Generally, regulations that have not been subjected to this process are considered to be "underground regulations" that cannot legally be enforced. Moreover, a person may bring a lawsuit to have a court declare an underground regulation invalid.

We also found that familial relationships among appeals board employees appear to have a negative impact on many employees' perceptions of their workplace. For example, one-fourth of the employees who responded to a survey that we sent to all 639 employees and seven board members working as of April 2008, indicated that their supervisor or manager was related to another appeals board employee, and nearly half of responding employees believed that hiring and promotion practices were compromised by familial relationships or employee favoritism. Moreover, over a third of respondents indicated that familial relationships have a negative effect on supervision, security, or morale and/or created potential conflicts of interest. The appeals board recently adopted a more restrictive nepotism policy specifying that it retains the right to refuse to appoint a person to a position when doing so might create an adverse impact on supervision, security, or morale or involves a potential conflict of interest. However, the appeals board cannot currently legally enforce its new nepotism policy against persons not presently employed by the appeals board because it constitutes an underground regulation.

We recommended that the appeals board rescind its recently adopted, but legally unenforceable, policy that prohibits hiring a board member into any civil service position at the appeals board for a period of one year from the last day of that individual's term as a board member. Likewise, it should not enforce its new nepotism policy against persons not presently employed by the appeals board. Because both of these policies affect persons outside of the organization, the appeals board should submit new versions of these regulations to the Office of Administrative Law for approval.

Appeals Board's Action: Partial corrective action taken.

The appeals board reports that it will immediately explore promulgation of a regulation under the Administrative Procedures Act process to mitigate the potential conflicts of interest inherent in hiring former board members as appeals board civil service employees. In addition, the appeals board stated it would apply its current nepotism policy only to persons employed by the appeals board. Furthermore, the appeals board stated it will immediately address the possibility of promulgating a nepotism regulation that would extend the policy to persons not currently employed by the appeals board.

Finding #3: Many surveyed appeals board employees reported fearing retaliation if they filed EEO complaints or grievances.

The appeals board's EEO complaint process and grievance process are designed to mitigate the threat of retaliation by allowing employees to file or appeal EEO complaints or grievances with designated personnel and outside agencies instead of their direct supervisors. However, appeals board data indicate that employees filed just 14 formal EEO complaints and 10 formal grievances over roughly the last five years. The fact that employees filed few EEO complaints or grievances was confirmed by our survey. Of the employees responding to our survey, only 2 percent indicated that they had ever filed an EEO complaint, with 5 percent indicating that they had ever filed a grievance. In fact, 40 percent of responding employees indicated that they would have some fear of retaliation from their supervisors or upper management if they were to file either an EEO complaint or grievance. The survey also indicated that the degree of fear varied depending on employees' work location, position, and tenure with the organization. Moreover, 11 percent of survey respondents were not aware of the appeals board's EEO policy and 23 percent of respondents indicated that they were not aware of how to file a grievance. Thus, we believe the appeals board could do a better job of informing employees of the grievance process and EEO complaint process and explaining that they both include specific protections from retaliation.

To ensure that employees understand their right to file either an EEO complaint or grievance, and to reduce any associated fear of retaliation, we recommended that the appeals board notify employees annually of its EEO complaint process and grievance process, including the protections from retaliation included in both. For example, the appeals board should remind employees that they could pursue either EEO complaints or grievances with certain outside entities, especially if they believe they may have been retaliated against. The appeals board should also update its employee handbook to better emphasize these processes and procedures, and consider conducting training in this area on a periodic basis.

Appeals Board's Action: Pending.

The appeals board stated that by the end of December 2008, it will update its intranet site and issue a memo to all employees informing them of the EEO complaint process and grievance process. The appeals board asserted it is also exploring additional measures including creating an on-line tutorial regarding EEO complaint and grievance procedures, and protections from retaliation, which would require each employee to "sign-in and out" as verification that he or she completed the tutorial. Finally, the appeals board stated it is in the process of updating its employee handbook concerning EEO procedures, and anticipates it will also be completed by the end of December 2008.

Finding #4: Weak controls over travel expenses have led to the questionable use of state resources.

Although the appeals board has developed travel policies and procedures and included them in a travel manual, its manual does not include some important controls over employee travel expense reimbursements. For example, it does not require supervisors to preapprove an employee's travel plans, nor does it explicitly require supervisors to subsequently review an employee's travel claim to ensure that the travel is in the State's best interest. In addition, the appeals board's travel manual does

not provide guidance to employees on how to establish a headquarters designation. We also found that employees did not always adequately document the business purpose of their travel. Specifically, when we reviewed a sample of 20 travel expense reimbursements from January 2006 to January 2008, we found that supervisors approved each of the underlying travel claims; however, for seven of these payments, totaling \$8,942, the supporting documents did not adequately state the business purpose of each trip. In addition, the appeals board's former executive director, who received three of the 20 travel payments in our sample, was reimbursed for travel that did not always appear to be in the State's best interest. We noted eight instances in which the appeals board reimbursed the former executive director for lodging costs that exceeded the State's allowed rates, including one occurrence for which it reimbursed him \$259 for the cost of staying one night at the Omni Hotel in San Diego, when the maximum standard rate allowed for this area was \$110.

Furthermore, we found that the appeals board may have inappropriately reimbursed the former executive director for expenses that appear to be associated with commuting between his home and headquarters, because the location of his headquarters is in question. The former executive director's three travel payments totaled \$6,311, and we found that \$2,233, or 35.4 percent, of these costs were for travel between Oakland, the headquarters location he designated on his travel claims and the city in which his residence is located, and Sacramento. In reviewing the former executive director's supporting documents related to these three travel payments, we also noted that the State paid rental car companies approximately \$977 for his use of rental cars to travel between Oakland and Sacramento. Although the former executive director designated the Oakland field office as his headquarters on the travel claims we reviewed, his employee history and other forms in his personnel file showed that his position was located in Sacramento County. Since the Department of Personnel Administration (Personnel Administration) regulations generally define headquarters as the place where an employee spends most of his or her workdays or where the employee returns upon completion of a special assignment, and because it appears that Sacramento was the former executive director's proper headquarters designation, we question whether he should have been reimbursed for travel from Oakland to Sacramento.

To ensure that employees are reimbursed only for appropriate and authorized travel expenses, we recommended that the appeals board strengthen its travel policies and procedures by requiring supervisors to preapprove employees' travel plans and to subsequently review their travel expense claims to ensure that all travel is in the State's best interest. In addition, it should update its travel manual to provide guidance to employees on how to properly designate their headquarters location. Furthermore, the appeals board should ensure that employees are reimbursed only for those lodging costs that comply with Personnel Administration's regulations.

Finally, we also recommended that the appeals board review travel-related payments it made to its former executive director from the date of his appointment as executive director/chief administrative law judge in November 2000, to determine whether those payments were reasonable and allowable. To the extent that the appeals board identifies travel reimbursements that do not comply with regulations established by Personnel Administration, it should seek recovery from the former executive director.

Appeals Board's Action: Partial corrective action taken.

The appeals board stated that it updated its travel manual to require employees to obtain prior approval from their supervisor for any travel plans. In fact, the appeals board asserted it has already drafted a new request for travel form for its employees' use. In addition, the appeals board stated that the revised travel manual now explicitly requires supervisors to audit their employees' travel claims to determine the necessity, reasonableness, validity, completeness, and accuracy of the travel expenses. Furthermore, the appeals board asserted that it has updated its travel manual to include guidance to its employees on how to properly designate their headquarters location. The appeals board stated it has already posted its new travel manual on its intranet and asserts that it will also be sending a memo to all of its employees alerting them to the changes to its travel policies and procedures by the end of December 2008.

Finally, the appeals board reports that it intends to ask the Employment Development Department for assistance in reviewing all of the travel-related payments it made to the former executive director from the date of his appointment as executive director/chief administrative law judge in November 2000, to determine whether those payments were reasonable and allowable. The appeals board hopes to complete this review by February 2009, and asserts that to the extent it identifies travel reimbursements that do not comply with Personnel Administration's regulations or that are not in the State's best interest, it will seek recovery from the former executive director.

Finding #5: Although the appeals board appears to comply with state leasing and purchasing requirements, it needs to adopt controls over its paid parking spaces.

The appeals board appears to comply with state leasing and purchasing requirements when it acquires office space, furniture, and equipment. In addition, we found that the appeals board's use of three leased state vehicles and associated fuel cards appears reasonable and allowable. However, during our review of the lease agreements and discussions with the appeals board, we noted that the appeals board pays for parking spaces at various locations. Specifically, the appeals board maintains a total of 35 parking spaces at a cost of approximately \$5,000 per month at its offices in Oakland, San Francisco, Los Angeles, Inglewood, and Sacramento. According to the acting executive director, the paid parking spaces were initially intended to accommodate state vehicles, visiting Employment Development Department staff who are attending hearings, and claimants. However, the appeals board leases only three state vehicles, one each for the Sacramento, Orange County, and San Diego field office locations. In addition, the acting executive director is not aware of any appeals board policies or procedures governing the use of these paid parking spaces. Without such controls, the appeals board has little assurance that these paid parking spaces are being used for their intended purposes, and that employees are not inappropriately using them to park their privately owned vehicles at their headquarters.

We recommended that the appeals board develop and implement procedures to ensure that its paid parking spaces are used only for authorized purposes, and that employees are not inappropriately using them to park their privately owned vehicles at their headquarters.

Appeals Board's Action: Pending.

The appeals board stated that it has already begun developing procedures to ensure that its paid parking spaces are only used for authorized purposes in compliance with current regulations. Specifically, the acting executive director met with staff in December 2008 to review the draft paid parking procedures and action plan. In that meeting, she asked staff to make certain changes to the procedures and the action plan, and to return the revised documents to her prior to the January 2009 board meeting, at which time she will present them to the board members for review and discussion.

Finding #6: The appeals board does not adequately account for its information technology and communications equipment (IT equipment).

The appeals board cannot currently account for all of its IT equipment. According to the Employment Development Department's data, the appeals board spent nearly \$2 million on such equipment from July 2005 through March 2008. At the request of the acting executive director, the appeals board completed a limited IT equipment survey in February 2008. According to the acting executive director, the survey revealed that the appeals board was unable to determine with certainty the location of some of its IT equipment, including computers, cell phones, and personnel digital assistant devices (PDAs). For example, the survey indicated that the appeals board could not account for 10 of the 61 computers that its asset management records indicated were located at employee residences. These computers are used by appeals board staff, such as administrative law judges and typists, who have the ability to work from their homes when reviewing cases or typing decisions. Because the appeals board does not have

accurate data on the number of computers, cell phones, and PDAs it possesses, it cannot appropriately gauge when it needs to make additional purchases of these items. In addition, the appeals board runs the risk that such IT equipment could be lost, stolen, or misused.

We recommended that the appeals board take steps to resolve the discrepancies between the IT equipment identified in its survey results and its asset management records.

Appeals Board's Action: Pending.

The appeals board stated that by the end of February 2009, responsible employees from its IT and business services units will identify ways to streamline the process for managing IT-related assets, consider shifting responsibility from one unit to the other and explain how this would be done, and develop a timeline for any necessary transition. In addition, the appeals board reported that the statewide physical inventory of all its assets is underway and is scheduled for completion by June 30, 2009. This process includes a reconciliation of the data collected during the physical inventory process. The appeals board asserts that once the physical inventory and reconciliation processes are completed, it will have a thorough and up-to-date accountability of all assets.

State Bar of California

With Strategic Planning Not Yet Completed, It Projects General Fund Deficits and Needs Continued Improvement in Program Administration

REPORT NUMBER 2007-030, APRIL 2007

State Bar of California's response as of April 2008

The State Bar of California (State Bar), established by the California State Constitution, is a public corporation with a mission to preserve and protect the justice system. The law requires every person admitted and licensed to practice law in a court in California to be a member unless the individual serves as judge in a court of record. The State Bar's 23-member board of governors (board) establishes policy and guides such functions as licensing attorneys providing programs to promote the professional growth of members of the State Bar.

State law requires the Bureau of State Audits (bureau) to audit the State Bar's operations from January 1, 2006, through December 31, 2006, but does not specify topics the audit should address. For this audit we reviewed the implementation of the State Bar's long-range strategic plan, its financial forecasts of expected revenues and expenditures, its administration of the Legal Services Trust Fund Program (legal services program), and its implementation of the recommendations from our 2005 audit. The 2005 audit assessed how the State Bar monitored its disciplinary case backlog, followed procedures for processing disciplinary cases, prioritized cost recovery efforts, and updated forecasts of revenues and expenditures.

Finding #1: The State Bar has not fully implemented its strategic-planning process.

In 2001 the State Bar's board began developing and implementing a strategic management cycle to guide the State Bar's activities. As part of that process, the board developed the State Bar's long-range strategic plan. As an outgrowth of the board's planning activities, the State Bar's staff engaged in a departmental strategic-planning process intended to enhance operations and build a culture of continuous improvement in the State Bar. Although the board adopted the strategic plan in 2004, the State Bar still has not completed its strategic-planning process. Specifically, the State Bar has not fully developed planning documents for each of its departments that are intended to implement the board's strategic goals and specify the indicators needed to measure departmental performance in meeting those goals. These departmental plans were to include annually updated action plans intended to identify the actions necessary to meet strategic goals and prioritize the allocation of resources.

The State Bar completed the preliminary departmental plans by December 2005. The executive director instructed each of the departments to include all ideas and comments from staff in its operational plans recognizing that the plans would require edit and revision. The State Bar expected to finalize the plans during 2006. However, according to the State Bar's executive director, several

Audit Highlights . . .

Our review revealed that the State Bar of California:

- » *Began a strategic planning process in 2001; however, development of many departmental plans and performance measures are incomplete.*
- » *Does not prepare annual budgets based on the results of strategic planning, but rather on projected costs for current levels of staff and resources.*
- » *Is pursuing an increase in annual membership fees from active members to offset a projected deficit of almost \$12 million in its general fund by December 2010.*
- » *Continues to await approval of additional authority to collect money related to disciplinary cases, but does not expect the new authority to significantly increase collections in the short term.*
- » *Needs to improve administration of its Legal Services Trust Fund Program to ensure that it maximizes revenue from interest on trust accounts attorneys establish and appropriately completes required monitoring activities.*
- » *Reduced its backlog of open disciplinary cases to 256 cases, moving closer to its goal of 200 backlogged cases.*
- » *Needs to continue improving its processing of disciplinary cases by consistently using checklists and conducting random audits.*

challenges, such as reorganization of several departments and the retirement of three key senior executives, have slowed the revision process. The State Bar currently expects to complete the revisions to the departmental plans by July 2007.

In addition, the State Bar has begun to evaluate its information technology systems and is concerned that they may not be capable of effectively capturing performance measurement data identified in the departmental plans. The State Bar estimates the cost to upgrade its information technology systems will total \$3.4 million to \$5.8 million per year from 2008 to 2013; however, it has not yet identified a source of funds to pay for these upgrades.

Further, because its strategic-planning efforts are still incomplete, the State Bar has not been able to determine whether it is accomplishing the board's strategic goals and does not currently tie its annual budget to its strategic plan and performance measurement efforts. Rather, the State Bar's budget process focuses primarily on estimating the cost of current staff and other resources using known and anticipated price increases.

To ensure that the strategic plan is fully implemented in an effective and timely manner, we recommended that the State Bar do the following:

- Complete revisions of the departmental plans that will serve to implement the board's strategic goals and ensure that each departmental plan contains meaningful performance indicators that will measure how successfully goals are being met.
- Limit performance measurement to indicators that can be accurately tracked on an ongoing basis and measure desired outcomes.
- Ensure that its departments, during their departmental plan revision process, identify the objectives and performance measures that can be attained, considering existing resource levels and information technology capabilities. In addition, on an ongoing basis the departments should revise their annual action plans to update this information given additional information technology upgrades.
- Take the steps necessary to ensure its information technology systems can capture the required performance measurement data to support the projects needed to accomplish strategic-planning objectives, or devise alternative means of capturing this data such as using an Excel spreadsheet.

State Bar's Action: Partial corrective action taken.

The State Bar completed revisions to the 14 departmental plans as of April 30, 2007, including identifying performance measures, and indicated that, going forward, performance measures and action plans will be revised to reflect changes in organizational structure or priorities and will be utilized in developing annual budget documents.

In addition, as part of the overall review of departmental plans, the State Bar has evaluated the usefulness, validity, and source of data and collection strategies for the performance measures. The State Bar has reviewed all departmental plans to determine whether the measures can be captured with the State Bar's existing technology.

Also, the State Bar has completed business case development for three primary functional areas; admissions, discipline, and courts. The State Bar stated that the final business case, association management, will be completed in the fall of 2008. To facilitate performance measurement, its information technology department continues working to develop reporting tools, in many cases using data from its systems combined with data from other sources for reporting purposes.

Finding #2: The State Bar projects deficits in its general fund.

Because it estimates the fees it will collect from the increased volume of membership will not keep pace with its rising costs, the State Bar forecasts it will face a deficit of nearly \$12 million in its general fund by December 31, 2010. The State Bar uses its general fund to account for membership fee payments and revenues it receives that are not related to other fund activities and to account for the expenses for maintaining, operating, and supporting its attorney disciplinary process. The State Bar established its Public Protection Reserve Fund (reserve fund) in 2001 to set aside a portion of its general fund as a buffer in the event of a revenue shortfall, like that which occurred after 1997 when it was unable to obtain timely statutory authority to assess the base annual membership fee that funds its disciplinary function and other operations it pays for from its general fund. However, use of the reserve fund to mitigate the projected general fund deficit will not likely provide a satisfactory solution to the State Bar's projected imbalance between revenues and expenses in its general fund. It estimates that even if it uses the balance of the reserve fund to partially offset the projected deficit in its general fund, the combined balance in the two funds will still result in a deficit of about \$6.3 million by December 31, 2010.

The State Bar's authority to assess a base annual membership fee is temporary, and historically the State Bar has needed the Legislature to reaffirm that authority every one to two years. Its current authority expires on January 1, 2008, unless extended before that date. The State Bar noted that to remedy the expected deficit, it is in ongoing discussions with key members of the Legislature to obtain statutory authority to increase the base annual membership fee for active members. The State Bar has determined it will need a \$25 increase in the fee to eliminate its projected general fund deficit and provide funding for information technology upgrades. However, as previously discussed, it has not successfully completed its strategic planning process that will allow it to identify the resources it needs to meet its strategic goals and base its budgeting process on these identified resources. This fact could hamper its efforts to justify a fee increase.

In addition, the State Bar does not anticipate that pending approval by the California Supreme Court (supreme court) of procedures to help recover its costs to discipline members or recover payments to members' clients from the Client Security Fund will have an immediate significant impact. This new enhanced collection authority, when implemented, will allow the State Bar to use money judgment authority to attempt to collect costs from disciplined attorneys.

The State Bar is preparing to implement its enhanced collection authority when approved. According to the State Bar's chief financial officer, in anticipation of the supreme court's approval, the State Bar is attempting to organize available information regarding the unpaid amounts. For example, the State Bar is trying to find the most current addresses of debtors and merge that information with other pertinent data, such as case numbers, restitution orders, and amounts owed. In addition, the State Bar is formulating a policy to guide staff in determining which cases will be affected by the rule, and therefore should be pursued, and which cases will be most fruitful in terms of potential collections.

However, the State Bar does not expect that its current collection rate will increase appreciably in the near future. According to the State Bar's assistant chief general counsel, the disciplined attorneys whose debts make up most of the unpaid amount were disbarred or resigned with disciplinary charges pending. He stated these attorneys are generally financially distressed and unable to repay clients or the State Bar at the time of their disbarment or resignation. The chief assistant general counsel further stated that, according to the State Bar's outside counsel, in five to 10 years some of the disciplined attorneys will have sufficient earnings to seek loans and will want to reestablish their credit and disbarred attorneys may want to seek reinstatement to practice law. He noted that credit-reporting agencies would pick up abstracts of judgments that have been recorded in county recorders' offices, but that if the State Bar wanted to directly report the debts, it would need procedures to comply with the federal Fair Credit Reporting Act. The chief assistant general counsel stated that the State Bar is still considering the costs and benefits of reporting judgments to credit-reporting agencies.

To effectively allocate its resources and justify its membership fees we recommended that the State Bar align its budgets with the results of its strategic-planning process.

To ensure that it maximizes collection efforts and its ability to implement the Rules of Court as soon as the supreme court approves procedures allowing their use, we recommended that the State Bar do the following:

- Complete its database and input all available information on the Client Security Fund and disciplinary debtors.
- Implement its proposed policy for pursuing debtors.
- Complete its assessment of the costs and benefits of reporting judgments to credit-reporting agencies.

State Bar's Action: Partial corrective action taken.

The State Bar reports it is continuing its effort to organize and input available information regarding the unpaid amounts into an automated system. The purpose is to merge into a database the most current addresses of debtors, case numbers, restitution orders, amounts owed, and other pertinent data about debtors that is kept separately by different State Bar departments and must be manually collected and organized. After an internal review of current procedures and processes to ensure that judgments filed are accurate and the data has integrity as information moves through the system, the State Bar's information technology department recommended the purchase of a software application and Web-hosted services of a third-party vendor. A contract has been negotiated, but not yet executed.

The California Supreme Court approved the Rule of Court in April 2007. In July 2007 the Board of Governors adopted a pursuit policy for court ordered disciplinary costs and Client Security Fund obligations, which was immediately implemented. The State Bar reported that, as of April 2008, it has filed 169 requests for entry of judgments to enforce assessments ordered in 313 disciplinary matters.

In March 2008 the State Bar completed its interviews of collection agencies currently under contract with the Administrative Office of the Courts and has contracted with the selected vendor to provide debt collection services, which include the reporting of judgments to credit reporting agencies.

The State Bar's 2008 adopted budget has been redesigned to link its budget with its strategic planning process. The proposed budget is aligned with the State Bar's organizational and functional structures as defined by its strategic plan and presents basic workload and performance information in major program areas.

Finding #3: The State Bar needs to improve its legal services program and attorney discipline system.

For grant year 2006–07 the State Bar awarded \$26.7 million in grant funds from the legal services program to provide civil legal assistance to indigent Californians. The funds for the program come primarily from interest on trust accounts attorneys establish for certain client funds, state budget appropriations, and an allocation of certain court filing fees. The State Bar does not ensure that all attorneys comply with the law requiring them to remit the interest on these trust accounts to the State Bar to support the legal services program. The State Bar reported that in 2006 it received about \$15.8 million from attorneys' trust accounts. However, because about 25 percent of the practicing attorneys in California do not remit interest earned on clients' trust accounts that qualify for the legal services program or report that they do not maintain trust accounts, the State Bar does not know whether it receives all the funds it should to support the legal services program.

The State Bar asks attorneys to report when they open or close trust accounts or no longer handle such client funds; however, it does not investigate nonreporting attorneys to determine whether they should establish trust accounts and remit the interest to the State Bar. According to the State Bar's deputy executive director, the State Bar has no authority to mandate reporting and would need an amendment to the statutes or to the Rules of Court to gain the authority to mandate reporting from its members.

Additionally, the State Bar is responsible for on-site monitoring of grantees to determine whether they comply with the program's requirements. However, it does not always adequately perform or document monitoring reviews of the legal services program grantees. Despite the State Bar's grantee-monitoring visits scheduled for the three-year period from January 1, 2004, through December 31, 2006, 12 grantees did not receive program-monitoring visits, and 51 did not receive fiscal-monitoring visits. Further, the State Bar does not always retain documentation needed to demonstrate that staff have completed all the steps in the monitoring process.

A 2005 bureau report assessed the efforts of the State Bar to address the backlog of disciplinary cases it began accumulating after temporarily losing its statutory authority in 1997 to assess a base annual membership fee. In 2005 the State Bar had 315 backlogged disciplinary cases. As of December 2006 the State Bar had reduced the backlog to 256 with the oldest cases dating back to 2003. This progress moved the State Bar closer to its goal of having no more than 200 backlogged cases.

Our 2005 audit also addressed the State Bar's inability to process disciplinary cases efficiently. In response, the State Bar created checklists to ensure that staff follow significant processing steps and developed random audit procedures to improve its oversight of the processing of disciplinary cases. However, the State Bar has not fully implemented either of these policies. Three of the 30 files we reviewed did not contain properly completed checklists, and the supervising trial counsels who oversee the disciplinary case investigators do not always perform the random audits required by the State Bar's policy.

To ensure that it receives all the trust account interest income available for its legal services program, we recommended that the State Bar consider conducting activities, such as interviewing or surveying a sample of members who do not report whether they have established trust accounts. This would allow the State Bar to determine whether some members are holding clients' funds without establishing trust accounts and remitting the interest to the State Bar. If the State Bar finds that the nonreporting members do, in fact, hold client funds that are nominal in amount or are held for a short period of time, it should seek the authority to enforce compliance reporting.

To properly monitor recipients of grants under its legal services program, the State Bar should ensure that it performs and documents all required monitoring reviews; in addition, it should develop a plan to perform the backlogged fiscal on-site monitoring visits while staying current with its ongoing monitoring requirements.

The State Bar should continue its efforts to reduce its backlog of disciplinary cases to reach its goal of having no more than 200 cases.

The State Bar should ensure that staff use checklists of significant tasks when processing case files and fully implement its 2005 policy directive for random audits of case files by supervising trial counsel.

State Bar's Action: Partial corrective action taken.

The State Bar stated it submitted to the Supreme Court for approval a proposal that would require each attorney to complete and maintain an online registration. If adopted by the Supreme Court, proposed Rule 9.8 requires lawyers to report whether the attorney or the attorney's law firm has established and maintained one or more trust fund accounts required under Business and Professions Code, Section 6211. According to the State Bar, in anticipation of the Supreme Court's

action on this proposal and to facilitate online reporting once it becomes mandatory, the State Bar launched its online reporting feature in April 2008, which will remain voluntary pending the Supreme Court's approval of its proposed requirement.

The State Bar stated that it is coordinating with the Administrative Office of the Courts to survey other grant-making organizations to assist in establishing best practices for planning its monitoring processes. The State Bar's Legal Services Trust Fund Program staff brought program and fiscal monitoring visits current as of December 31, 2007, and is on schedule to complete 2008 monitoring visits by the end of the calendar year.

Moreover, the State Bar's Office of the Chief Trial Counsel modified its department plan in May 2007 to, among other things, establish a revised goal of having no more than 250 open backlog cases at the end of each year, rather than the previous goal of 200 open backlog cases. Given staffing constraints, the State Bar felt that it would be difficult to achieve the revised backlog goal of 250 by the end of 2007 and, in fact, the backlog of open cases was 327 on December 31, 2007.

Lastly, the State Bar's Chief Trial Counsel issued a memorandum to all affected staff reminding them to use the checklists and directs appropriate supervisory personnel to perform random audits on a monthly basis with respect to the open investigation files of investigators assigned to original disciplinary investigations. The memorandum also directs supervisory personnel to adequately document the random audits and to confirm that any necessary corrective action has been taken.

DNA Identification Fund

Improvements Are Needed in Reporting Fund Revenues and Assessing and Distributing DNA Penalties, but Counties and Courts We Reviewed Have Properly Collected Penalties and Transferred Revenues to the State

REPORT NUMBER 2007-109, NOVEMBER 2007

The Department of Justice's, State Controller's Office's, and Administrative Office of the Courts' responses as of November 2008

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the implementation of the DNA act—specifically, the collection and management of money in county and state DNA funds. The audit committee noted that since the DNA act became effective, revenues associated with it were significantly lower than expected. Additionally, the Legislative Analyst's Office suggested that the revenue shortfall might be the result of counties not collecting the DNA penalty assessments or receiving only partial payments. Further, information posted on the Department of Justice (Justice) Web site showed that many counties, including five of the 10 largest, did not report collecting any DNA fund money for 2005. Consequently, the audit committee was concerned that the State may not be receiving its fair share of DNA fund money and that counties may not be using the funds as intended.

Finding #1: Reporting of data on county DNA identification funds needs to improve.

The DNA act requires the courts to levy a penalty of \$1 for every \$10, or fraction thereof, on all fines, penalties, or forfeitures imposed and collected by the courts for all criminal offenses, including violations of the vehicle code but excluding parking violations (initial DNA penalty). The DNA act also requires each county's board of supervisors to submit an Annual County DNA Identification Fund Report (annual report) to Justice and the Legislature detailing collection and expenditure information related to the initial DNA penalty. Further, the DNA act requires Justice to post data from the annual reports on its Web site. In July 2006 the DNA act was amended to levy an additional DNA penalty on all criminal and vehicle violations except parking violations (additional DNA penalty).

However, state law does not require counties to report collections related to the additional DNA penalty. Consequently, the information the counties report to Justice and the Legislature is incomplete and, as a result, the State cannot be fully assured that the counties are assessing and collecting all required DNA penalties. Based on our review of records maintained by the State Controller's Office (state controller), counties transferred to the State about \$2.3 million in additional DNA penalties from July 2006, the month the additional penalty became effective, through December 2006, an amount that is not reflected on the Justice Web site. Further, the state controller's records also show that 11 counties did not report transferring any money from the additional DNA penalty to the State for 2006. We contacted each of these counties and were informed by representatives

Audit Highlights . . .

Our review of the implementation of Proposition 69, the DNA Fingerprint, Unsolved Crime, and Innocence Protection Act (DNA act) revealed that:

- » *State law does not require counties to report collections related to the additional DNA penalty imposed by the July 2006 amendment to the DNA act; therefore, interested parties would not be able to obtain a complete picture of all the DNA penalty money collected and transferred to the State.*
- » *Information available on the Department of Justice's Web site as of June 2007 showed that 22 counties had not transferred any DNA money to the State in 2005 and 24 did not do so in 2006; however, based on the State Controller's Office's records, these counties actually transferred to the State \$1.6 million in 2005 and \$3.8 million in 2006.*
- » *Although there were no significant errors in assessing and distributing DNA penalties at the three counties we reviewed, some weaknesses in the courts' automated case management systems and internal controls resulted in minor errors in the assessment and distribution of DNA penalties.*

of nine of the 11 counties that they combined money they collected from the additional DNA penalty with their collections of the initial DNA penalty rather than identify their collections separately on the documentation sent to the state controller. Moreover, three of the nine counties indicated that they failed to transfer 100 percent of their collections to the State, as required by law. Rather, they only transferred 70 percent, the amount applicable to the initial DNA penalty. Additionally, an official from one county stated that, although the court was assessing and collecting the additional DNA penalty, due to a coding error, the county did not transfer its additional DNA penalty collections to the State until March 2007. Finally, an official from the court in the remaining county acknowledged that it did not begin assessing the additional penalty until September 2007.

Additionally, many counties failed to submit annual reports in 2005 and 2006. In particular, as of June 2007, 22 counties had not submitted the required annual reports to Justice for 2005 and 24 counties had not submitted the reports for 2006. Rather than report that the counties had failed to submit annual reports, the Justice Web site indicated that they had not transferred any DNA fund money to the State. However, based on records from the state controller, all but two counties had transferred certain DNA fund money to the State in 2005, and only one county failed to make the required transfers in 2006. The counties that did not submit annual reports on their 2005 collections actually transferred almost \$1.6 million to the State, and the counties that did not submit reports on their 2006 collections transferred almost \$3.8 million. Because the Justice Web site shows those counties as not transferring any money to the State, anyone attempting to use the data might erroneously conclude that many counties were not assessing any DNA penalties and that the State was not receiving money it was owed.

We recommended that the Legislature consider revising state law to require that counties include in their annual reports information on the additional DNA penalty established by Chapter 69, Statutes of 2006.

We also recommended that the Administrative Office of the Courts (AOC) contact the courts in the counties that did not report transferring to the State any money or only part of the money for the additional DNA penalty to determine whether they are appropriately assessing the penalty. Additionally we recommended that the state controller contact the auditor-controllers in the counties that did not report transferring to the State any money or only part of the money for the additional DNA penalty to ensure that counties and courts correctly assess, collect, and transfer the money to the State.

Finally, because state law requires Justice to make county-reported data available on its Web site, we recommended that Justice take several steps to ensure that data on county DNA fund activities are accurate. We recommended that Justice annually notify counties that they are statutorily required to submit reports on or before April 1 to the Legislature and to contact each county that does not submit an annual report by the deadline. Additionally, we recommended that Justice establish policies and procedures for posting county data on its Web site and clearly indicate on its Web site any county that failed to submit an annual report.

Legislative Action: Unknown.

AOC's Action: Corrective action taken.

The AOC stated that it is committed to taking immediate, necessary steps to correct issues identified in any audit of the judicial branch. The Administrative Director of the Courts has requested that AOC's internal audit services unit ensure that its audit programs continue to cover the testing of distributions in each of their future audits. However, AOC indicated that with an audit cycle of approximately four years, it is possible that the internal audit services unit may not be able to review implementation of changes in distributions at individual courts in as timely a manner as it would prefer.

Finally, the AOC stated that it provides support to the courts regarding the implementation of new legislation and information about changes in assessments and distributions. This support helps the courts discharge their duties with respect to ensuring that distribution changes are made on an accurate and timely basis.

State Controller's Action: Corrective action taken.

The State Controller indicated that it notified the 11 counties identified as not transferring or improperly transferring additional DNA penalty assessments to the State in April 2008. These counties were directed to the State Controller's Web site containing the July 2006 DNA Penalty Assessment Distribution Guidelines. Personnel contact information for the State Controller was also provided should counties require additional assistance. The State Controller also stated that all counties have remitted assessments to the DNA Identification Fund through November 2008. Finally, the State Controller's Division of Audits stated it will continue to monitor county compliance with the DNA Penalty Assessment Distribution Guidelines through its court audit program.

Justice's Action: Corrective action taken.

In its 60-day response dated February 8, 2008, Justice stated that it would begin sending out form letters every February to all counties reminding them that the report for the previous year was due. Additionally, Justice stated that if a county had not submitted a report by the April 1st due date, a formal reminder letter would be sent on May 1st. Also included in this response, Justice submitted its procedures for posting county DNA fund data on its Web site.

In its one-year response, Justice indicated that it sent a formal reminder letter dated May 1, 2008, to 13 counties that had not yet submitted the required report by the April 1, 2008, due date. However, nine of these counties still did not submit the required report. As a result, according to documents provided with its one-year response, Justice's Web site noted that these counties failed to submit an annual report.

Finding #2: Courts need to improve their methods of ensuring the accuracy of DNA penalty assessments and distributions.

Although we did not discover any significant errors in the transactions we reviewed for the county superior courts of Los Angeles, Orange, and Sacramento, we identified weaknesses in data entry and processing internal controls that could affect many of the DNA penalties processed by all three superior courts. The monetary impact of the errors ranged from 1 cent to \$54 per case. While not individually significant, the potential volume of the errors could prove to be material in amount.

For example, the DNA penalty distributions calculated by the case management system used by the Orange County Superior Court (Orange court) resulted in rounding errors affecting 22 of the 40 cases we reviewed. According to an official of the AOC, the case management system the Orange court uses is a precursor to the case management system that the AOC plans to eventually implement statewide. Additionally, based on a report issued by the Judicial Council of California (Judicial Council), California Superior Court criminal case dispositions totaled more than 6.4 million statewide for fiscal year 2005–06. Not every case disposition—the final outcome of a case, such as a case dismissal or criminal sentencing—results in penalty assessments. Nonetheless, the magnitude of the errors will be greatly increased unless the AOC ensures that the cause of the rounding errors in the precursor system is identified and corrected before it implements the new statewide system. Moreover, when an individual was allowed to make installment payments, the Orange court's case management system did not always distribute the payments according to the priority order established by law.

We also identified a data entry error related to a specific type of motor vehicle code offense occurring at one location of the Los Angeles County Superior Court (Los Angeles court). The resulting error appears to have been committed by one court employee and was recurring over at least a 12-month period between 2005 and 2006. Additionally, for three other cases we reviewed involving another Los Angeles court location, the court did not properly assess the DNA penalty for a particular type of misdemeanor offense. Finally, we found that the Sacramento County Superior Court (Sacramento court) erroneously transferred \$292,000 to the State for payments received for various vehicle code violations. Because the relevant violations had resulted in the court allowing the offenders to attend traffic school, by law the county should have retained the payments received from the offenders.

We recommended that the AOC work with the Orange court to estimate the total dollar effect of the rounding errors in calculating the penalty assessment distribution to determine whether it will have a significant financial impact on the State. If the AOC determines that the impact will be significant, it should ensure that the Orange court makes the necessary modifications to the distributions calculated by its case management system. Further, as it proceeds with developing the statewide case management system, the AOC should ensure that the system correctly distributes payments to the appropriate funds in accordance with all applicable laws and regulations. The AOC should also ensure that the Orange court reevaluates and makes necessary corrections to the distribution priority order programmed into its case management system. Additionally, the AOC should ensure that the Los Angeles court corrects any manual coding errors and strengthens internal controls over data entry. Finally, the AOC should ensure that the Sacramento court continues its efforts to correct any overpayments made to the state DNA fund.

AOC's Responses:***Orange County's Action: Corrective action taken.***

Although the AOC agreed that the 55 percent error rate we found in our sample was too high, it noted that the impact for each case was minimal, ranging from a 9-cent underpayment to a 1-cent overpayment. Nonetheless, the AOC stated that the Superior Court of Orange County implemented a change to its case management system on July 1, 2008, to address the rounding errors made by the system when it calculates the penalty assessment distribution.

The AOC also stated that the court reviewed approximately 750 funds to determine what the appropriate fund distribution should be and make any corrections needed. The distribution priority review was completed on April 8, 2008.

Finally, the AOC stated that the court and AOC personnel have devoted a significant amount of time to the development of the statewide California Court Case Management System (CCMS). Among the CCMS's many advantages, the one most directly affecting the assessment and distribution processes is the use of one statewide distribution table for all courts. This table will be updated after appropriate reviews of statewide legislation and local ordinance changes. The system will also make it easier to monitor and audit distributions.

Los Angeles County's Action: Corrective action taken.

The AOC affirmed that the Superior Court of Los Angeles County has taken steps to ensure that manual coding cashier errors are corrected and that internal controls are strengthened over data entry.

Sacramento County's Action: Corrective action taken.

The AOC stated that the Superior Court of Sacramento County has made all the necessary corrections to processes and database systems to properly capture and distribute penalties going forward. Additionally, in May 2008, the court successfully completed the reversal of all affected fees that caused the erroneous transfer.

Department of Justice

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

INVESTIGATION I2007-0958 (REPORT I2008-1), APRIL 2008

Department of Justice's response as of September 2008

We asked the Department of Justice (Justice) to assist us with the investigation. We substantiated that a manager and four subordinates at one of Justice's regional offices failed to properly report their absences on their time sheets for several months, in accordance with state regulations and Justice policy. In addition, Justice management failed to ensure the accuracy of their employees' time sheets.

Finding #1: A manager and four subordinates at Justice failed to properly report their absences for several months.

A manager and four subordinates at one of Justice's regional offices failed to properly report their absences for the nine-month period from April through December 2006. Because the employees did not use time sheets to track all their actual time worked, Justice was unable to determine precisely the amount of leave they took. Nevertheless, based on review of other documentation, we estimated that the manager and four subordinates did not account for 727 hours of leave for the nine-month period. As a result, the potential unearned income received by the manager and four subordinates totaled \$17,974.

We found that the manager improperly allowed the four subordinates to take informal time off as compensation for unreported overtime they worked either at home or at the office, and failed to ensure that the four subordinates accurately reported their time worked and leave taken. Although the scope of our investigation was limited to the nine-month period in 2006 for which we received documentation about unreported absences, Justice learned that the manager and four subordinates continued to inaccurately report their time worked and absences taken in 2007. Justice began to investigate the 2007 time reporting improprieties before we completed our investigation.

Justice's Action: Corrective action taken.

Justice initially distributed a memorandum in January 2008 to its division chiefs reminding them of their time reporting obligations and policies. In addition, Justice reported in March 2008 that it did not intend to seek adverse actions against the four subordinates. Instead, it decided to counsel the manager and the four subordinate employees about the importance of following Justice's policies regarding proper time reporting requirements and leave use. In July 2008 Justice completed its investigation of the five employees' time reporting and found that the manager and four subordinates continued to inaccurately report their absences in 2007. Although it concluded that as in 2006, the employees failed to follow proper state policy and state regulations, Justice did not quantify the extent of the employees' unreported absences because it had already proceeded to take corrective action for the employees' failure to

Investigative Highlight . . .

A manager and four subordinate employees at the Department of Justice failed to properly report on their time sheets an estimated 727 hours of leave over a nine-month period in 2006, amounting to almost \$18,000 in compensation that was potentially unearned. In addition, the manager failed to adequately monitor his subordinates' absences or time worked.

observe the proper time-reporting requirements. In concluding its corrective action, Justice provided in August 2008 the subordinate employees with training specifically covering Justice's policies and procedures about leave use and time reporting.

Finding #2: Justice's management failed to ensure the accuracy of their employees' time sheets.

Our investigation determined that the manager never verified the accuracy of his four subordinates' time and did not adequately monitor his subordinates' absences or time worked. In addition, the manager failed to adequately monitor and maintain complete records for the informal leave taken and overtime his subordinates worked to ensure there was conformity between the amount of informal leave they took and the extra time they claimed to have worked. Most important, he ignored the provisions of state regulations that require him to keep complete and accurate time and attendance records for each employee.

The manager's supervisor, who works at Justice's headquarters, did not sufficiently ensure the accuracy of the manager's time sheets. She also neglected her responsibility under Justice policy to provide meaningful oversight of his time reporting and to ensure that the manager properly monitored the time reporting by his subordinates.

Justice's Action: Corrective action taken.

In February 2008 Justice reported that it instructed the manager that he could not grant informal time off to any staff member. Justice also reported that it instructed the manager and his supervisor to ensure that all leave, overtime, and alternate workweek schedules are documented appropriately and they comply with state and Justice policies and procedures. Justice further counseled the manager's supervisor in April 2008 about the need to provide more diligent oversight of her employees. Moreover, Justice documented in the manager's probation report and in a counseling memorandum the manager's failure to follow Justice's policies and procedures for time reporting and leave use. Following this disciplinary action, the manager left Justice in July 2008. Justice subsequently promoted one of the four subordinates to replace him, and in August 2008 it provided the former manager's supervisor and the management's replacement with training specifically covering Justice's policies and procedures about leave use and time reporting.

Department of Justice

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

INVESTIGATION I2007-0728 (REPORT I2008-1), APRIL 2008

Department of Justice's response as of September 2008

We investigated and substantiated an allegation that the Department of Justice (Justice) absorbed the cost of the salaries and benefits of four employees who were released from work full-time at various times for 12 years to participate in union-related activities based on a series of side letters that it negotiated directly with a bargaining unit. These side letters were not submitted to the Department of Personnel Administration (Personnel Administration), nor were they ratified by the Legislature.

Finding: Justice created inefficiency by entering into side letters with a bargaining unit without Personnel Administration's oversight.

Justice created inefficiency in the collective bargaining process when it entered into a series of side letters with a bargaining unit, without either the appropriate approval or ratification. In particular, we determined that Justice released four employees from their normal work duties on a full-time basis to engage in union activities at various times for more than 12 years at a cost of approximately \$2.4 million. This arrangement was based on side letters that never were formally submitted to Personnel Administration, the agency designated by the governor to oversee the collective bargaining process. The side letters also were not ratified by the Legislature. Although we conclude it is unlikely that Justice could recover the cost of providing full-time release for these employees, we nonetheless believe that its actions bypassed controls and deprived Personnel Administration of knowledge of the full range of benefits conferred on the bargaining unit. As a result, Personnel Administration was not able to consider this in the negotiations process.

Justice's Action: Corrective action taken.

Justice reported that two of the employees returned to their assigned full-time duties in May 2008, following the expiration of their release time agreements. The remaining two employees no longer worked for Justice or the State at the time of our report.

Investigative Highlight . . .

The Department of Justice created inefficiency by entering into a series of side letters that were negotiated directly with a bargaining unit, rather than using the formal approval and ratification process; thus absorbing the salaries and benefits of four employees who were released from work full-time at various times for 12 years to participate in union-related activities at a cost of \$2.4 million.

Department of Corrections and Rehabilitation

Investigations of Improper Activities by State Employees, January 2008 Through June 2008

INVESTIGATION I2006-0826 (REPORT I2008-2), OCTOBER 2008

Department of Corrections and Rehabilitation's response as of September 2008

The Department of Corrections and Rehabilitation (Corrections) improperly granted nine office technicians increased pay to supervise inmates at its R. J. Donovan Correctional Facility (facility). The office technicians were not entitled to receive this increased pay because they did not supervise the required number of inmates or did not supervise inmates who worked the minimum number of hours required for employees to receive the increased pay. Consequently, between January 1, 2005, and February 29, 2008, Corrections paid these office technicians a total of \$16,530 more than they should have received.

Finding #1: Corrections improperly paid its employees for inmate supervision when they did not qualify for the pay.

From January 2005 through February 2008, Corrections made 239 payments to nine office technicians for inmate supervision; however, for 87 of these payments, Corrections could not demonstrate that the employees satisfied the requirements for earning this compensation. In some instances, employees had not supervised any inmates during a given pay period. In other cases, employees supervised only one inmate during the pay period, or they had supervised at least two inmates as required but the inmates did not collectively work the required number of hours for the employees to qualify for supervision pay. Thus, Corrections paid the employees a total of \$16,530 that they were not entitled to receive under the collective bargaining agreement. This amount constitutes 36 percent of the total spent for inmate supervision for the period that we reviewed.

Finding #2: Corrections failed to maintain adequate accounting and administrative controls that would prevent the improper payments.

Our investigation further determined that Corrections paid the nine employees incorrectly because the facility lacked proper controls—including adequate oversight—to ensure that the employees qualified for the increased pay by supervising at least two inmates who collectively worked for 173 hours. For example, according to our examination of inmates' time sheets—and our observation that inmates' time sheets were missing in certain instances—two of the nine employees who received supervision pay for August 2006 did not supervise any inmates during the month. Thus, these employees received the increased pay even in extreme cases in which inmates submitted no time sheets to support the employees earning supervision pay.

Moreover, the number of improper payments may be even higher given what we discovered about the facility's system for recording inmate supervision. Specifically, we found that employees who supervised inmates routinely signed inmates' time sheets regardless of whether the employees or the inmates were present for work.

Investigative Highlights . . .

The Department of Corrections and Rehabilitation:

- » *Improperly paid its employees \$16,530 for inmate supervision that the employees were not entitled to receive.*
- » *Failed to maintain adequate controls and oversight to ensure employees qualified for the increased pay.*

Our comparison of the inmates' time sheets to the employees' official attendance reports for four months in 2006 identified at least 34 days when employees signed their approval of the work hours that inmates recorded even though the employees were not present at the facility to supervise inmates on those days. For example, time sheets for August 2006 show that four employees certified inmates' work hours during a total of 16 days that these employees' official attendance reports show they did not work. As a result, we are concerned that the facility lacks sufficient controls to ensure the accuracy of the records that justify employees receiving extra pay for supervising inmates. In particular, if these records are inaccurate, we have no assurance that the employees receiving the increased pay have properly earned it.

Corrections' Action: Pending.

Corrections informed us that the findings of our investigation affect several areas of the facility, including personnel, inmate assignments, labor relations, and business services. As a result, it has assigned a team to determine the best approach for addressing our findings. In addition, Corrections stated that it would conduct a review for any statewide issues, and it would initiate recovery for any overpayments to its employees. Finally, Corrections reported that the facility would develop procedures to ensure that it correctly authorizes duties and pay associated with inmate supervision.

California Exposition and State Fair

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

INVESTIGATION I2006-0945 (REPORT I2007-1), MARCH 2007

California Exposition and State Fair's response as of March 2008

We investigated and substantiated an allegation that Official A, a high-ranking officer at the California Exposition and State Fair (Cal Expo), violated conflict-of-interest laws by participating in a state purchasing decision from which he received a personal financial benefit.

Finding: Official A violated state conflict-of-interest laws when he made or directed a governmental decision that authorized Cal Expo to purchase his personal vehicle.

Official A sold his personal vehicle to Cal Expo in July 2005. Because he was involved in the decision to make this purchase while acting in his official capacity and because he derived a personal financial benefit from this transaction, Official A violated the Political Reform Act of 1974 (act) and Section 1090 of the California Government Code (Section 1090).

Under the act, public officials at all levels of state government are prohibited from making, participating in making, or in any way attempting to use their official positions to influence a governmental decision in which they know or have reason to know they have a financial interest. Section 1090 prohibits a public official from participating in the formation of a contract or making a purchasing decision in which he or she has a financial interest.

Although Official A did not sign the initial purchase order authorizing the transaction, he met with Official B and Manager 1 before the purchase to discuss whether Cal Expo should acquire the vehicle. Official A, along with Official B and Manager 1, agreed Cal Expo should purchase the vehicle. Official B, who reports directly to Official A, subsequently approved a purchase order, and Manager 1, who reports directly to Official B, certified that he received the vehicle. Official A subsequently submitted an invoice to Cal Expo for the sale, and Cal Expo paid Official A \$5,900 with a check containing Official A's preprinted signature.

More than a year after it purchased the vehicle, Cal Expo became aware that the transaction was potentially a violation of the law and subsequently reversed the transaction by returning the vehicle to Official A and requiring him to pay back the \$5,900. However, Cal Expo's actions were not consistent with the remedies available under state law because Cal Expo was entitled to recover the \$5,900 it paid for the vehicle and to retain the vehicle itself. By simply returning the vehicle to Official A, Cal Expo did not pursue the remedy that would have provided greater protection of the State's interest.

Investigative Highlight . . .

An official at the California Exposition and State Fair (Cal Expo) violated conflict-of-interest laws when he sold his personal vehicle to Cal Expo.

Cal Expo's Action: Corrective action taken.

In March 2007 Cal Expo reported that it believed invalidating the transaction and returning the vehicle were appropriate remedies. It also believed, because of Official A's record, that formal disciplinary action and criminal prosecution were not warranted. However, Cal Expo shared our concern that this serious ethical breach merited further action. In July 2007 Cal Expo reported that its Board of Directors, management, and supervisory staff had completed an ethics training course. It also reported that at the Board of Directors' meeting in September 2007, it approved a new accounts payable policy, requiring two officials to sign any checks made payable to Cal Expo employees other than for travel reimbursements and prohibiting Cal Expo officials from signing any checks written to themselves.

In March 2008 Cal Expo reported that in keeping with its policy it planned to review the statements of economic interests covering calendar year 2007 for employees required to file, including Official A, to ensure compliance. Cal Expo further reported that it had reviewed its incompatible activities statement with maintenance and event services staff and that it planned to review the statement with all department managers at an upcoming staff meeting.

California Highway Patrol

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

INVESTIGATION I2007-0715 (REPORT I2007-2), SEPTEMBER 2007

California Highway Patrol's response as of November 2007

We investigated and substantiated an allegation that the California Highway Patrol (CHP) wasted state funds when it purchased numerous vans that it left virtually unused for at least two years.

Finding: The CHP wasted state funds.

Using three purchase orders, the CHP bought 51 vans for its Motor Carrier program, surveillance, and mail delivery. However, as of June 30, 2007, the 30 vans purchased in October 2004 and the 21 vans purchased in August 2005—at a combined cost of \$881,565—had not been used for the special purposes for which they had been purchased. In addition, the CHP has left all but five of the 51 vehicles virtually unused since it purchased them. Further, because the CHP did not postpone its purchases of the vans until it needed them, the State lost interest earnings of approximately \$90,385.¹

The CHP intended to use 48 vans for field inspections in its Motor Carrier program, two vans for surveillance purposes, and one van for mail delivery. Vehicles must be specially modified before they can be put to use for field inspections, surveillance, or mail delivery. However, the CHP does not expect to have any of the 48 vehicles that it purchased for field inspections modified and available for that use until October 2007—more than two years after they were purchased. The CHP completed the necessary modifications to the mail van in June 2007, and as of August 2007 it reported that the modifications to the two surveillance vans were only 50 percent complete because of the State's failure to approve a budget in a timely manner.

In addition, our review of vehicle mileage information shows that the CHP left 46 of the 51 vans almost entirely idle, parked on the CHP property in an outdoor location. Specifically, we determined that as of April 2007 the CHP had driven the 46 vans a total of only 401 miles—an average of nine miles for each van—since it had purchased them in 2004 and 2005. We found that 14 vans had not been driven at all, another 27 vans had been driven from one to 20 miles, and five vans had been driven from 21 to 34 miles. Most of the mileage related to trips to facilities where various items such as roof vents, antennas, and flooring needed to modify these vehicles for their intended purpose were installed. The CHP used the remaining five vans for temporary assignments or to transport equipment. As of April 2007 the Highway Patrol had driven each of the five vans between 167 and 3,420 miles, or an average of 1,901 miles.

¹ This amount is based on interest rates available to the State through its Pooled Money Investment Account Earning Yield Rate.

Investigative Highlights . . .

The California Highway Patrol:

» *Paid \$881,565 for 51 vans it had not used for their intended purposes more than two years after it purchased them.*

» *Did not postpone its purchase of the vans until it needed them, resulting in \$90,685 in lost interest earnings to the State.*

The CHP gave several reasons for not using the 51 vans for their intended purposes between the time it purchased them in 2004 and 2005 and the completion of our investigation in June 2007. The CHP told us that it planned to assign the vans to the field in fiscal year 2006–07. Further, it stated that modification of the vans had been delayed because of competing priorities, staff shortages, and the development of an equipment strategy that could meet all its users' needs. The CHP officials we interviewed told us that the vans were originally intended for modification and use within the CHP's normal replacement cycle time of approximately 18 months from purchase. However, the CHP stated that because of its workload, the labor-intensive installation of equipment in the two vehicles it purchased for surveillance was delayed beyond the normal cycle. In addition, the CHP officials stated that, although it completed modifications to the mail van, the CHP did not plan to use it until the mail van it was intended to replace either reaches the replacement mileage target of 150,000 miles or was no longer cost-effective to operate. Further, the CHP stated that modification of the 30 vans it received in October 2004—originally scheduled for April 2006—was canceled because of an unforeseen increase in demand for marked patrol cruisers. However, it appears the CHP had not yet developed an equipment strategy for the Motor Carrier program vans at the time it was modifying the marked patrol cruisers.

The CHP did not develop a workable strategy to make the 48 vans it purchased for the Motor Carrier program available for field use prior to making the purchases in 2004 and 2005. We believe the primary cause for delays was the CHP's attempt to develop a prototype vehicle design that could meet the needs of all of its employees who perform field inspections. The CHP developed two prototypes and it expected to complete the second prototype in September 2007, more than two years after it received its first shipment.

CHP's Action: Corrective action taken.

The CHP stated that as of November 6, 2007, all 51 vans had been assigned to locations across the State.

Santa Clara Valley Transportation Authority

It Has Made Several Improvements in Recent Years, but
Changes Are Still Needed

REPORT NUMBER 2007-129, JULY 2008

*Santa Clara Valley Transportation Authority's response as of
January 2009*

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits conduct a review of the Santa Clara Valley Transportation Authority (VTA). Specifically, we were asked to assess VTA's governance structure and the level of oversight its board of directors (board) and its executive management exercises over operations and financial records—including strategic planning processes. The audit committee also asked us to review VTA's financial reporting structure, its forecasting methods, and its long-term financial planning. Finally, the audit committee asked us to examine VTA's project planning and monitoring processes.

VTA is an independent special district responsible for providing both transit services and transportation planning within Santa Clara County (county). It is governed by a board consisting of two members from the county Board of Supervisors, five members from San Jose City Council, and five members from the city councils of other cities in the county. In March 2007 the HayGroup, a consultant VTA hired, published a report that proposed a comprehensive overhaul of VTA's organizational structure and practices.

Finding #1: The average tenure of board members is the shortest among comparable transit agencies.

In comparing the structure of the board with those of five other California transit agencies of comparable size and scope, we found the agencies' structures similar, but two differences in particular appear to be causing VTA to have the shortest board tenure of the six transit agencies: a shorter statutory term length and a rotation schedule devised to share board seats among the smaller cities in the county. In May 2008 the board approved changes designed to fix the rotation schedule problem, and a statutory change to the term length would only strengthen VTA's efforts in that regard.

Consequently, we recommended that VTA request the Legislature amend its enabling statutes to allow for a four-year board term. We also recommended that VTA monitor the effect of the governance changes approved by the board in May 2008 and determine whether additional changes to its governance structure are necessary. To this end, we recommended that VTA add board tenure to the performance measures it develops for its new strategic plan.

Audit Highlights . . .

Our review of the Santa Clara Valley Transportation Authority (VTA) revealed the following:

- » *The average tenure of VTA's board of directors (board) is shorter than that of comparable transit agencies, which is attributable to a shorter statutory term length and a rotation schedule devised to share five of the 12 board seats.*
- » *Board operations have improved, but VTA could use its advisory committees more effectively in developing policies and building regional consensus.*
- » *VTA has been operating without a comprehensive strategic plan for the past two years, but the organization had some elements of a strategic plan during that period and is developing a new plan to be published at the end of 2008.*
- » *Financial reports and plans generally conform to best practices, and recent improvements have made these reports clearer and more useful to decision makers.*
- » *Capital budgeting could be improved by including clearer information about the timing of expected project costs. Such an understanding could help the organization manage debt, investments, and cash flows more effectively.*
- » *Although VTA specifies the assumptions behind its operating forecasts in its short-range transit plans, it does not do so for its capital program forecasts.*

continued on next page . . .

- » *VTA is working to improve its long-term planning by establishing two debt reduction funds and updating its forecasting tools.*
- » *While VTA meets most best practices for project planning, it has not always identified funding for future operating costs or estimated the potential project revenues for some capital projects.*
- » *VTA generally has adequate policies in place to monitor projects, but it implements them inconsistently.*

VTA's Action: Partial corrective action taken.

VTA decided to not immediately pursue an increase in the statutory term length of its board members. Rather, VTA stated that it will monitor the effectiveness of the board's approved changes to encourage members to serve consecutive two-year terms, and will reconsider legislation if these policy changes do not result in longer average tenure for board members. To this end, VTA has added a measure of board tenure to its strategic plan and will have the board secretary compile tenure data annually.

Finding #2: VTA could use its advisory committees more effectively.

When we analyzed the process VTA used to advance two recent reforms—the proposal to improve board tenure and the development of new agency vision and mission statements—we found that VTA continued to miss opportunities to effectively involve pertinent advisory committees in policy development. Specifically, VTA belatedly offered completed proposals to key advisory committees—the policy advisory committee and the citizens advisory committee—for immediate responses and approval in one instance, and missed a chance to improve its relationship with its advisory committees in another.

To demonstrate that it values the expertise of its advisory committees, we recommended that VTA and its board take actions to ensure that advisory committees are involved in the development of policy solutions.

VTA's Action: Partial corrective action taken.

VTA stated that it is involving its advisory committees in a process of redefining their purpose and role. Subcommittees from each advisory committee are reportedly meeting on a monthly basis to draft mission statements, update their bylaws, review the board workplan, and provide suggestions for improving the committee process for providing input to the board. The bylaws of the citizens advisory committee have been amended to add a chairperson's report to the board and this regular report to the board commenced in October 2008.

Finding #3: VTA has been operating without a comprehensive strategic plan since 2006 but is crafting one to include within another planning document.

At least since 2006, VTA has not had a document purporting to be a strategic plan. Rather, as VTA officials explained, it has developed several planning documents that, taken together, represent VTA's strategic plan. We compared those documents with the Government Finance Officers Association's (GFOA) recommendations for strategic planning and found some components of a strategic plan but could not locate detailed action plans, measurable objectives, or performance measures linked to existing strategic goals. Therefore, we questioned

whether, without all the required elements, these various plans truly satisfy the purpose of a strategic plan. VTA indicated that it will include a new strategic plan in its countywide long-range planning document, which it expects to publish at the end of 2008.

We recommended that VTA implement its plan to create a comprehensive strategic plan and ensure that the new plan conforms to the practices recommended by the GFOA. In addition, we recommended that VTA complete its plans to implement the HayGroup's recommendations related to governance and strategic planning.

VTA's Action: Partial corrective action taken.

VTA included a strategic plan, which VTA states follows GFOA guidelines, in the final draft of the long-range planning document it distributed to its advisory and standing committees for review in December 2008. The board is scheduled to officially adopt the document in January 2009.

Of the 11 HayGroup recommendations related to governance and strategic planning, VTA indicates it has completed six with five others marked as "On-going". Of these five, VTA's work with its advisory committees, as previously described, has the potential to bring closure to three. Based on VTA's description, significant progress has been made on the two remaining recommendations (educating local appointing authorities on board-member qualifications and development of board member and advisory committee member training).

Finding #4: Changes to its capital budgeting and monitoring could improve VTA's finances and financial reporting.

Although VTA's financial reporting and planning generally follow best practices, we found that changing certain financial reports would allow VTA to more effectively plan and better evaluate its performance. In particular, revising its capital project budgets so that budgeted amounts represent what VTA actually plans to spend on its projects in a given year, and adding other more precise information, would provide the board with better information and could improve VTA's understanding of its cash needs for projects. In turn, a more accurate understanding of its cash needs could potentially reduce future financing expenses for capital projects.

To make the best use of its resources, we recommended that VTA create regular processes in which its fiscal resources division communicates with other VTA divisions regarding the cash needs of projects and activities. We also recommended that VTA update its capital budget to more fully report planned spending by year, capital carryover by source, and expected total project costs. Additionally, we recommended that VTA complete its plans to implement the HayGroup's recommendations related to financial planning, monitoring, and reporting.

VTA's Action: Partial corrective action taken.

VTA stated that it is developing a report that will include budgeted, actual-to-date, and projected expenditures by year and project, and would be implementing a review of project progress with executive management on a quarterly basis beginning with the quarter ending December 31, 2008. VTA further stated that, beginning the quarter ending March 2009, it will add to these reviews monthly projected cash flows for specified periods of time.

VTA indicated that its capital budget for fiscal years 2010 and 2011, which is currently under development for consideration by the board in spring 2009, will include planned spending by year, identify capital carryover by source, and report authorized project total costs. Of the 17 HayGroup recommendations related to financial planning, monitoring, and reporting, VTA indicates it has completed seven with 10 others marked as "On-going". Of these 10, VTA described significant progress being made in each area.

Finding #5: VTA forecasts revenues and expenditures in planning documents but does not fully explain assumptions or compare capital program forecasts to actual expenditures.

VTA forecasts major revenues and expenditures in its short-range transit plans and, while the assumptions behind its operating forecasts are specified, the same cannot be said of its capital program forecasts—revenue projections in particular. For example, forecasts for the Measure A Transit Improvement Program (Measure A program), which are documented in VTA's short-range transit plan published in January 2008, provide projections through fiscal year 2035–36 and include a revenue source that has not been secured. The projections contain a line labeled “VTA, Other Funding (includes new one quarter cent tax).” The document does not explain that this source will only be available if voters approve the increase. According to the general manager, this line in the short-range transit plan should have specified that the revenue source would be the “revenue equivalent to a quarter cent sales tax,” as revenues other than a sales tax increase are possible. We believe that any such assumptions about the source of projected revenues should be clearly explained. Furthermore as VTA's fiscal staff explained, VTA does not compare forecasts of capital spending documented in short-range plans with actual capital spending at the end of the year (as recommended by the GFOA).

To ensure realistic long-term financial planning, we recommended that VTA continue to update its planning tools and methodology and clearly explain assumptions that have material effects on overall forecasts. We also recommended that VTA regularly compile and report to management information that tracks all capital projects and compares spending and project progress to original projections.

VTA's Action: Corrective action taken.

VTA stated that it has continued to implement a new financial model that incorporates updated assumptions and will strive to include more thorough explanations of assumptions in future planning documents. As an example, VTA provided information showing that it highlighted the budget assumptions and guidelines to be used in developing its next biennial budget. These assumptions were reviewed and discussed by a standing committee of the board. VTA added that it has expanded and enhanced its existing capital project monitoring report to include all capital projects and that progress and spending on all capital projects are now reported to the board regularly.

Finding #6: Deficiencies in project planning and inconsistent project monitoring could limit effective decision making.

The project planning practices of VTA meet best practices in several areas, but opportunities for improvement remain. In particular, we found in our review of 10 selected projects that VTA created detailed plans for the projects but did not always anticipate the potential revenues a project might generate, secure necessary project funding for Measure A program projects, and identify the sources of funding for future operating costs. The principal causes of these deficiencies are that VTA has not documented its planning process and has not systematically required these elements of project planning. Consequently, VTA risks pursuing projects that it may not be able to financially support in the future.

VTA has established a series of project monitoring mechanisms that, if followed for all projects, would ensure that it implements projects within a structure of appropriate control. However, VTA implements its monitoring policies inconsistently, allowing some project managers to reduce the frequency and level of content in required monitoring reports. As a result, accountability is reduced and critical information may not be reaching decision makers in executive management and on the board.

To ensure adequate control over its project planning process, we recommended VTA develop written policies and procedures for project planning and evaluation. Specifically, we recommended that VTA create policies and procedures to clearly identify all project costs and revenues, and to estimate and have a plan for funding the operating costs resulting from capital projects. In addition, to achieve consistency in its project monitoring, we recommended that VTA ensure that its project managers

follow its construction administration manual or document when management has agreed to an exception. Finally, we recommended that VTA complete its plans to implement the HayGroup's recommendations related to project monitoring.

VTA's Action: Pending

VTA reports that it submitted in December 2008 a comprehensive index of planning manuals to its technical advisory committee and that in upcoming meetings the committee will review the content of the index to provide input on the final document. VTA added that it revised the capital project request forms and instructions for the biennial budget cycle currently being reviewed by management to require the following: total estimated cost, monthly capital expenditure projections for the first two years and annual expenditures for 10 years, incremental operating costs for five years (if any), and potential funding sources for both capital and operating costs.

Additionally, VTA provided us with draft written procedures describing how management will consider and document requests for variances from the Construction Administration Manual and indicated that it has completed two of the three HayGroup recommendations related to project planning and monitoring. VTA also described the progress it has made in implementing the remaining recommendation.

Department of Conservation

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

INVESTIGATION I2006-0908 (REPORT I2007-1), MARCH 2007

Department of Conservation's response as of January 2008

We investigated and substantiated an allegation that an employee with the Department of Conservation (Conservation) engaged in various activities that were incompatible with his state employment, including using the prestige of his state position and improperly using state resources to perform work for the benefit of his spouse's employer, a charitable organization.

Finding #1: The employee misused state resources to engage in improper activities.

We found that the employee misused state resources to engage in numerous activities that were incompatible with his state employment, including misusing the prestige of his state position. We believe that the nature and extent of these improper activities caused a discredit to the State. Specifically, the employee engaged in the following improper activities:

- Failed to disclose stock ownership in oil industry companies and regulated companies.¹
- Owned stock in a company at the time he issued permits to that company.
- Used state time and resources for fundraising.
- Solicited charitable contributions from oil industry companies and regulated companies.
- Used his state position to assist a charity.
- Requested and received personal discounts from a state vendor.
- Sent more than 65 e-mails that were insubordinate or of a nature to discredit the State.

The employee owns or has owned stock in a number of oil industry companies, including at least two regulated companies (Company A and Company J). However, he failed to disclose his ownership of stock in these companies, in violation of the Political Reform Act of 1974 (act).

As required by the act, Conservation requires the employee, who works in Conservation's Division of Oil, Gas & Geothermal Resources (division), and others in his job classification to annually complete

¹ The employee is required to disclose his stock ownership in companies regularly engaged in oil and gas exploration and related industries (oil industry companies), which includes regulated companies.

Investigative Highlights . . .

An employee at the Department of Conservation:

- » *Failed to disclose his stock ownership in at least 18 instances.*
- » *Owned stock in two companies at the time he made business decisions affecting those companies.*
- » *Misused state resources to assist his spouse's employer.*
- » *Used his state e-mail to directly solicit donations from oil industry and regulated companies.*
- » *Used the prestige of his state position to obtain discounts on his personal cell phone purchases.*
- » *Sent more than 65 e-mails that were insubordinate or were of such a nature to cause a discredit to the division.*

In addition, the employee's manager failed to adequately monitor the employee's improper activities and failed to disclose his own stock ownership in at least seven instances.

statements of economic interests because these employees have the authority to approve permits that allow companies to extract or produce oil or geothermal resources. Accordingly, the employee, his manager, and others in their job classifications are required to include on their statements of economic interests any investments in, interests in business positions in, and income from any business entity of the type that may be affected by their decisions. This includes, but is not limited to, stock ownership with a value of \$2,000 or more in businesses that are regularly engaged in the extraction and/or production of oil, gas, or geothermal resources.

We obtained the employee's statements of economic interests for each year from 2000 to 2005. In each statement, the employee certified under penalty of perjury that he had no reportable business interests. However, information the employee stored on his state computer that he later confirmed as accurate indicated that the employee failed to disclose reportable investments every year during this time period. In particular, we found for those years at least 18 instances where the employee failed to disclose that his stock ownership in various companies exceeded \$2,000 in value.

In addition, we believe the employee conducted himself in a questionable manner when he communicated with and approved permits for Company A, a company whose stock he owned at the time he approved its permit requests. Specifically, we believe that in doing so the employee may have violated the common law doctrine against conflicts of interest (doctrine). Similarly, we believe he also violated the doctrine when he made business decisions affecting Company B, the division's vendor for cellular phone services, while he owned stock in that company. The doctrine provides that a public officer is implicitly bound to exercise the powers conferred on him with disinterested skill, zeal, and diligence and primarily for the benefit of the public. Because he owned stock at the same time he approved permits for Company A and made purchases in his state capacity from Company B, we question whether the employee was able to make these business decisions with disinterested skill for the primary benefit of the State.

Further, we found that the employee misused his state e-mail—as well as other state resources—in a number of ways, and engaged in activities that were incompatible with his state employment while assisting his spouse in securing contributions on behalf of her employer, a charitable organization (Charity 1) in various capacities. These activities include soliciting donations from regulated companies even though he had been admonished for doing so in the past, and using his state position to facilitate Charity 1's potential purchase of a property on which he previously performed regulatory work.

The employee used his work e-mail account to send or receive more than 340 e-mails involving discussions of Charity 1 activities and events over the three-year period we reviewed. Nearly 80 of these e-mails involved soliciting donations for Charity 1 and in several instances he directly solicited donations from either oil industry or regulated companies. Many of the 340 e-mails indicate that the employee spent considerable state time and resources when serving as co-chairperson for an annual sponsorship event benefiting Charity 1 by assisting in planning and organizing the event and soliciting sponsorship donations from regulated and other oil industry companies for the event.

The employee also misused his state e-mail and improperly used his state position to facilitate Charity 1's attempt to purchase property from a property owner with whom he had previously interacted in his regulatory capacity as a state employee. The employee violated state law and Conservation's policy prohibiting its employees from using the prestige of their state positions for the gain of themselves or others when he contacted the property owner on behalf of Charity 1.

Moreover, the employee serves as the contact for the division's vendor for cell phone services, Company B. In this capacity, he has regular dealings with representatives of Company B. On two separate occasions the employee requested Company B to waive a \$35 fee associated with his personal cell phone purchases. In his e-mail requests, the employee informed Company B that a large number of Conservation offices switched to Company B based on his recommendations. One could easily surmise from this request that Company B may have felt compelled to provide the discount in exchange for his continued efforts to recommend Company B to other Conservation offices. The employee's e-mail records show that Company B's representative agreed to waive the fee on both occasions.

Finally, our review of the employee's e-mail records also indicates that he regularly misused his state e-mail and engaged in a pattern of behavior that likely could be considered insubordinate or apt to cause a discredit to the State. Specifically, for the three-year period we reviewed, the employee sent or received more than 130 e-mails regarding personal financial matters. Most of these e-mails pertain to the potential value of specific stocks. At least 15 of them involved discussions of potential investments in either the oil industry or oil and gas industry companies. Further, we found that the employee sent more than 65 e-mails to coworkers, superiors, representatives of oil industry and regulated companies, and others that we believe were insubordinate or were of such a nature as to discredit the division.

Conservation's Action: Corrective action taken.

Conservation reported that it pursued adverse action against the employee and he resigned from state service. In addition, Conservation reported it has taken action to ensure that similar misconduct is not repeated. Included in its corrective action, Conservation stated that it:

- Developed a web page that its employees can use to review ethics and conflict-of-interest requirements.
- Established an internal ethics advisory panel that issued a report in October 2007. In the report the panel concluded that the types of misconduct we identified were not widespread. The panel's report also included several recommendations for conservation to consider.
- Required all employees who complete statements of economic interests to complete the Attorney General's online ethics training seminar.

Finding #2: The manager failed to adequately monitor the employee and failed to disclose his own interests in oil industry companies.

Information the employee stored on his state computer indicates that the manager should have known that the employee was involved in charitable functions involving regulated companies and Charity 1. These documents show that the manager participated in the annual charity event in 2005 and 2006 for which the employee and a representative of a regulated company were co-chairpersons in 2006. Additionally, these documents indicate that nine oil industry companies were sponsors for the event. We determined that six of them had previously submitted applications to the manager's district office for approval. Thus, it appears that the manager was aware—or should have been aware—that the employee was again soliciting donations from the regulated companies.

Documents stored on the employee's state computer also indicate that Company L, a company engaged in an industry related to oil and gas exploration, paid the manager's \$150 entry fee for the annual charity event in 2006. When we questioned the manager, he stated that he was not certain whether Company L paid his entry fee but said he did not pay the fee. The manager added that he also did not pay for his entry into the previous year's event and stated that it was not uncommon for oil industry companies to pay for his entry into similar events. When we reviewed information relating to the annual charity event held in 2005, we found indications that Company M, which has submitted applications to the manager's office for his approval, paid his entry fee for the event. By accepting gifts from companies his office regulates, the manager may have violated conflict-of-interest laws and policies that prohibit a state employee from receiving any gift from anyone seeking to do business of any kind with the employee or his department under circumstances from which it reasonably could be substantiated that the gift was intended to influence the employee or was intended as a reward for official actions performed by the employee.

Finally, in the course of our interview, the manager also acknowledged that he has owned stock in a regulated company as well as in other oil and gas industry companies. Specifically, the manager informed us that in 2004 he held stock exceeding \$2,000 in value in three oil and gas industry companies, including Company A, and four oil and gas industry companies in 2005. When we asked why he did not report his ownership of stock in regulated companies on his annual statement of economic interests, the manager responded that he did not believe he owned enough to require him to report them.

Conservation's Action: Partial corrective action taken.

Conservation reported in January 2008 that it had entered into a settlement agreement with the manager that required him to retire after he exhausted his leave credits.

Department of Fish and Game

Its Limited Success in Identifying Viable Projects and Its Weak Controls Reduce the Benefit of Revenues From Sales of the Bay-Delta Sport Fishing Enhancement Stamp

REPORT NUMBER 2008-115, OCTOBER 2008

Department of Fish and Game's response as of December 2008

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to independently develop and verify information related to the Bay-Delta Sport Fishing Enhancement Stamp (fish stamp) program. Generally speaking, the audit committee's request focused on spending authority for the fish stamp revenues, the appropriateness of expenditures incurred in the program, and the required reporting to the fish stamp advisory committee (committee).

Finding #1: The Department of Fish and Game has not fully used revenues from the fish stamp program.

The Department of Fish and Game (Fish and Game) has not identified or pursued a course of action to ensure the full use of the revenues that it generates through sales of the fish stamp. Since the inception of the fish stamp program, Fish and Game has sold nearly 1.5 million annual fish stamps, generating \$8.6 million in revenue and interest; however, as of June 2008, it had approved only 17 projects representing \$2.6 million in commitments to funding. In addition, during the first two fiscal years in which it collected the fish stamp fee, Fish and Game did not request any spending authority to use the revenue to fund fish stamp projects. Further, during this same period Fish and Game did not reallocate unused funding from other accounts within the Fish and Game Preservation Fund (preservation fund), which holds money collected under state laws governing the protection and preservation of birds, mammals, fish, reptiles, and amphibians.

Therefore, it did not have the authority to spend any of the revenues generated to pay either for projects or for related administrative expenses. Even though it did request spending authority in fiscal years 2005–06 through 2007–08, Fish and Game still did not actively identify and fund projects up to the level of spending authority obtained. As a result, the balance in the fish stamp account continues to increase, and individuals who pay for fish stamps are not receiving the full benefit from their purchases.

To ensure that the fish stamp fulfills its intended benefit, we recommended that Fish and Game work with the committee to develop a spending plan that focuses on identifying and funding viable projects and on monitoring revenues to assist Fish and Game in effectively using the fish stamp revenues.

Audit Highlights . . .

Our review of the Department of Fish and Game's (Fish and Game) Administration of the Bay-Delta Sport Fishing Enhancement Stamp (fish stamp) program revealed the following:

- » *Fish and Game's use of the money collected from fish stamp sales has been limited.*
- » *Fish and Game and the fish stamp advisory committee (committee) have been slow in identifying and approving projects.*
- » *As of June 30, 2008, the fish stamp account had an unspent balance of over \$7 million, although a portion of this amount was committed to approved projects that have not yet been funded.*
- » *Fish and Game does not have an accurate accounting of either its administrative expenditures or individual project expenditures for the fish stamp program.*
- » *Periodic reports Fish and Game provides to the committee do not include all the required information.*
- » *During fiscal years 2005–06 through 2007–08, Fish and Game spent an estimated \$201,000 in fish stamp funds to pay for payroll costs and goods and services unrelated to fish stamp activities.*

Fish and Game's Action: Partial corrective action taken.

According to Fish and Game, its staff has prepared a draft spending plan that is currently being reviewed by management. The draft will be provided to the audit committee for comment and review at the next business meeting, scheduled for January 2009. Fish and Game officials expect a final spending plan to be completed by April 2009.

Finding #2: Weak controls limit Fish and Game's ability to monitor and report project activity.

Fish and Game does not have a sufficient system of internal or administrative controls to monitor fish stamp project activity. For example, the department's accounting system does not adequately track project expenditures. As a result, project expenditures are difficult to reconcile, and have been incorrectly charged to other funding sources. For example, in fiscal year 2005–06, Fish and Game approved using \$50,000 in fish stamp funds to enhance its efforts to enforce laws against sturgeon poaching. However, Fish and Game actually charged the \$50,000 to another of its funding sources. In another instance, the agreement for one fish stamp project required Fish and Game to pay a specified percentage of annual lease payments from the fish stamp account. However, according to a department official, Fish and Game paid this expenditure out of its general fund appropriation in fiscal year 2005–06 and 2006–07 rather than from the fish stamp account.

Additionally, information provided by Fish and Game to the committee both in periodic reports and in committee meetings is not always accurate or complete. Therefore, the committee is less able to make informed decisions on funding fish stamp projects.

To track and report project costs adequately, we recommended that Fish and Game improve the tracking of individual project expenditures by assigning each fish stamp project its own project cost account within the accounting system. Additionally, we recommended that Fish and Game require that project managers approve all expenditures directly related to their projects and periodically reconcile the records for their respective projects to accounting records and report expenditures to the staff responsible for preparing the advisory committee reports. We also recommended that Fish and Game reimburse its general fund appropriation for the lease payments that should have been paid from the fish stamp account.

Further, we recommended that Fish and Game should, at least annually, provide the committee with written reports of actual project expenditures and detailed information on project status as well as total administrative expenditures. Finally, we recommended that Fish and Game ensure that the information it communicates to the committee is accurate.

Fish and Game's Action: Partial corrective action taken.

Fish and Game reports that fish stamp staff and the Accounting Services Branch have met to discuss options to better track and monitor project expenditures. Fish and Game decided that project costs could be isolated with a unique index code. The index code is associated with the division, unit, or region performing the work. In situations where project costs cannot be isolated by an index/project cost account (PCA) combination, new PCA's will be added as needed. All new projects funded by the fish stamp will be uniquely identified by an index code or PCA.

Additionally, according to Fish and Game, officials have contacted all fish stamp project managers requesting detailed expenditure data to date and will continue to request this information quarterly or as needed depending on the project's duration. Fish and Game officials also stated that fish stamp staff have begun reconciling expenditures with CalSTARS reports. Fish stamp staff will also be requesting detailed expenditure information quarterly or as needed. Fish and Game expects to have all project expenditures reconciled by the beginning of 2009.

Fish and Game also reports that the fiscal year 2006–07 lease payments have been adjusted from its general fund appropriation and reflected in the fish stamp account. Fish and Game is continuing to research the prior year payments and expects to complete adjustments by April 2009.

Fish and Game plans to provide the committee with a detailed financial overview at the next business meeting, scheduled for January 2009. According to Fish and Game, the detailed overview will include administrative costs, project costs, amount encumbered, actual expenditures, and project status. Finally, according to Fish and Game, fish stamp staff always strive to provide accurate information and are continuing to work to ensure budget and expenditure data are accurate.

Finding #3: Expenditures charged to the fish stamp account were inaccurate.

During fiscal years 2005–06 through 2007–08, Fish and Game charged expenditures totaling an estimated \$201,000 to the fish stamp account that were unrelated to fish stamp activities. Although state law cites a broad definition of expenditures allowed under the fish stamp program, the expenditures we identified as inappropriate were payroll and invoice costs that were not related to any approved fish stamp project or administrative activity.

In addition, Fish and Game did not charge the account for certain administrative expenditures it incurred during the fish stamp program's first two fiscal years. Appropriate administrative expenditures would include costs for staff assigned to facilitate operating the program. These administrative expenditures also include indirect charges, which are agency wide costs proportionally distributed among all the agency's funds or accounts. The manager of the program management branch stated that the administrative expenditures for these two years were charged to the nondedicated account within the preservation fund. Based on invoices provided by Fish and Game, we know that during fiscal years 2003–04 and 2004–05, Fish and Game incurred at least \$18,000 in administrative expenditures for printing the fish stamps sold in 2004 and 2005. We also know that Fish and Game should have charged these costs to the fish stamp account but that it did not do so.

We recommended that Fish and Game provide guidelines to its employees to ensure that they appropriately charge their time to fish stamp projects. In addition, we recommended that Fish and Game discontinue the current practice of charging payroll costs to the fish stamp account for employee activities we identified as not pertaining to the program. Finally, we recommended that Fish and Game determine whether it inappropriately charged any other expenditures to the fish stamp account and make the necessary accounting adjustments.

Fish and Game's Action: Partial corrective action taken.

Although Fish and Game did not directly address our recommendation that it provide guidelines to staff concerning when to charge activities to the fish stamp account, it believes that regular reconciliations of project manager detailed expenditures against CalSTARS reports will ensure that any inappropriate charges made to the fish stamp account will be identified and corrected.

Fish and Game reports that current year charges that were inappropriately made to the fish stamp account have been corrected. Fish and Game has also retrieved some of the prior year time sheets that had inappropriate charges to the fish stamp account and are waiting on the receipt of other time sheets. Once these time sheets are corrected to reflect the appropriate charges, Fish and Game will make adjustments to correct the payroll costs to the correct funds. Fish and Game expects to have all payroll adjustments made by April 2009.

Department of Corrections and Rehabilitation

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

INVESTIGATION I2006-0665 (REPORT I2008-1), APRIL 2008

Department of Corrections and Rehabilitation's response as of September 2008

We investigated and substantiated an allegation that the Department of Corrections and Rehabilitation (Corrections) wasted state funds by leasing unnecessary parking spaces from a private facility. In addition, Corrections mismanaged state resources by failing to properly oversee the parking spaces under its control, and it misused state resources by allowing state employees to park their personal vehicles for free in some of the leased spaces.

Finding: Corrections mismanaged state resources and wasted state funds by leasing more spaces than it needed.

Our review of vehicle parking assignments at a state-owned parking facility under Corrections' control and a nearby parking facility where it leased additional parking spaces revealed that, as of December 31, 2007, Corrections was leasing 26 more parking spaces than it needed for the state-owned vehicles at one of its regional headquarters. Although Corrections may have needed to lease 29 spaces when it first entered into the lease in August 2006, we found it needed only three of the leased spaces for that purpose as of October 1, 2007. As a result of failing to manage the number of parking spaces it needed, Corrections wasted at least \$11,277 in state funds from October 1, 2007, through December 31, 2007.

Our investigation found that Corrections had 56 parking spaces under its control as of October 2007. Of those spaces, 27 were state-owned spaces at the regional headquarters building and 29 were leased spaces at a nearby private parking facility. However, as shown in the table on the following page, as of December 31, 2007, Corrections was using only 10 of the 27 state-owned spaces for state-owned vehicles. For the remaining 17 spaces, three were left unused, employees were allowed to park their personal vehicles in seven of the spaces at no cost, and another seven spaces were assigned by Corrections to another state agency. Similarly, we found that Corrections parked state-owned vehicles in only 20 of the 29 leased spaces at the nearby private parking facility. Four of the remaining nine spaces at the private facility were unused and state employees were allowed to park their personal vehicles in five spaces for free. Corrections misused a state resource by allowing state employees to park their personal vehicles in five of the leased spaces.

Investigative Highlight . . .

The Department of Corrections and Rehabilitation wasted nearly \$11,300 in state funds by leasing unneeded parking spaces and misused state resources by allowing five employees to use them at no charge for their privately owned vehicles.

Table**Status of Parking Spaces Under Corrections' Control as of December 31, 2007**

ASSIGNMENT	STATE-OWNED SPACES	LEASED SPACES	TOTALS
State-owned vehicles	10	20	30
Unused	3	4	7
Privately owned vehicles	7	5	12
Other state agency	7	0	7
Totals	27	29	56

Corrections misused state resources by allowing state employees to park privately owned vehicles for free. Our review determined that since at least October 2007, the date of the information provided to us, five employees have parked privately owned vehicles at no cost in private parking facilities leased by the State. In addition, information we obtained suggests that three of these employees have parked privately owned vehicles in the private parking facility since at least January 2006. The information also suggests that Corrections allowed other employees to park privately owned vehicles at the State's expense before October 2007. When asked to clarify when specific individuals began parking privately owned vehicles at either the state-owned or private parking facility, officials at the regional headquarters informed us that the regional headquarters did not maintain records documenting when employees were assigned parking spaces. Further, when asked to explain the criteria used for determining which employees were allowed to obtain free parking for their vehicles, the officials told us that they followed the practice in place before their arrivals, which was to have supervisors assign spaces vacated by departing employees to the new employees hired to replace them. Corrections did not adequately maintain records to document when it began allowing its employees to use the parking spaces for their privately owned vehicles, so we could not quantify the full extent to which state funds were used to provide free employee parking. Nevertheless, Corrections misused state resources by allowing some leased parking spaces to be used for personal purposes.

Corrections' Action: Corrective action taken.

Although Corrections initially reported that it needed to lease five spaces at the private parking facility, it subsequently informed us that it canceled its lease with the private parking facility in April 2008. As a result, Corrections is no longer paying for the 29 parking spaces it had leased in the private facility. Based on the terms of its lease agreement, the cancellation resulted in an annual savings of more than \$50,000.

Department of Corrections and Rehabilitation

It Does Not Always Follow Its Policies When Discharging Parolees

REPORT NUMBER 2008-104, AUGUST 2008

Department of Corrections and Rehabilitation's response as of October 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) examine the Department of Corrections and Rehabilitation's (Corrections) adult parole discharge practices. Specifically, the audit committee requested that we review Corrections' discharge policies and protocols and determine whether they comply with applicable laws and regulations. The audit committee also asked us to review Corrections' internal controls over its parole discharge process and determine whether they are sufficient to ensure compliance with Corrections' policies and state law and to identify inappropriate employee conduct. In addition, the audit committee requested that we ascertain whether a sample of parolees were discharged in accordance with staff recommendations and to determine, to the extent possible, the frequency with which parolees received discharges contrary to staff recommendations. Further, the audit committee asked us to assess whether Corrections discharged a sample of parolees in accordance with its policies, protocols, and applicable laws and regulations. The audit committee also requested that we determine whether Corrections took any corrective action as a result of an internal investigation of one of its regions. Finally, the audit committee asked us to review any proposed changes to laws, regulations, policies, and protocols to determine any potential changes in efficiency and effectiveness related to the discharge process and the extent to which those changes might affect the parole administrators' authority.

Finding #1: Corrections failed to adhere consistently to its discharge policies.

Corrections' policies dictate who must complete a discharge review report and who has the final authority to discharge parolees; however, Corrections does not always follow its own policies. With the exception of deported parolees,¹ these policies require that parole agents initiate a discharge review before parolees complete their required period of continuous parole and that the parole agents recommend on a discharge report whether to discharge or retain the parolees. Unit supervisors must read discharge review reports and then decide to discharge parolees or to forward the reports to district administrators. Although in many cases the unit supervisor may discharge parolees, the district administrator or the Board of Parole Hearings (board) must review and discharge certain parolees.

¹ United States Immigration and Customs Enforcement may place a hold on all confirmed illegal immigrants in Corrections' custody. Upon release to parole, these parolees transfer to federal custody pending deportation to their country of origin. Corrections monitors the status of these parolees during the deportation process. We refer to these individuals as deported parolees. Corrections' current policies allow parole staff to use their discretion on whether to prepare discharge review reports for deported parolees.

Audit Highlights . . .

Our review of the Department of Corrections and Rehabilitation's (Corrections) adult parole discharge practices found that:

- » *Corrections' data indicate that the responsible parole units did not submit discharge review reports for 4,981, or 9 percent, of the 56,329 parolees discharged between January 1, 2007, and March 31, 2008, and that Corrections lost jurisdiction over these individuals.*
- » *District administrators, operating within their authority to exercise judgment, at times discharged parolees despite the parole agents' and unit supervisors' recommendations to retain the parolees without documenting the reasons for their decisions.*
- » *Because of errors made by Corrections' Case Records Office, the appropriate authority did not participate in making the decisions to retain or discharge six of the 83 parolees whose discharge reviews we evaluated for compliance with Corrections' policies.*
- » *Corrections reported that it has taken immediate corrective measures and has drafted new policies that, if implemented, will govern its parole discharge process.*
- » *Changes to state law that became effective January 1, 2008, and proposed revisions to Corrections' policies—if implemented—could increase each district administrator's role and authority in the discharge review process.*

Corrections' data shows that a total of 56,329 parolees were discharged between January 1, 2007, and March 31, 2008. During this 15-month period, Corrections' data indicate that the responsible parole units did not submit discharge review reports for 4,981, or 9 percent, of these parolees and that Corrections lost jurisdiction over these individuals. Nearly half of these cases involved deported parolees for whom Corrections' current policies require only that parole staff prepare formal discharge review reports if staff wish to retain the parolees. The remaining discharged parolees who did not receive discharge review reports were not deported parolees, but the responsible parole units had failed to follow policy and submit the required reports. Consequently, Corrections lost its opportunity to recommend that the board retain these parolees, whose number included 363 individuals originally convicted of violent or serious offenses.

Additionally, our review of a sample of 509 discharges indicated that in 31 instances, district administrators, operating within their authority to exercise judgment, discharged parolees despite the parole agents' and unit supervisors' recommendations to retain the parolees. In 15 of these 31 instances, district administrators did not provide explanations for overruling these recommendations and discharging the parolees. In response to these issues, Corrections reported that it has taken certain immediate corrective measures and has drafted new regulations and a new policy memorandum that, if implemented, will govern its parole discharge process.

To prevent the automatic discharge of parolees, we recommended that Corrections ensure that its staff promptly prepare discharge review reports for all eligible parolees. We further recommended that Corrections finalize and implement the draft regulations and policy memorandum that will detail the policy and procedures governing its parole discharge process. The new policy should require district administrators to document their justifications for discharging parolees against the recommendations of both parole agents and unit supervisors. Finally, the new policy should require that discharge review reports be prepared for deported parolees.

Corrections' Action: Pending.

Corrections reports that it has drafted new regulations and a new policy memo that, when implemented, will govern its parole discharge process. Specifically, Corrections stated that the proposed regulations have been vetted through departmental stakeholders and are now with its Regulations Policy and Management Branch, pending submission to the State's Office of Administrative Law. Corrections also stated that its draft discharge review policy and procedures memorandum is currently undergoing administrative and executive review, and it expects the new policy to be finalized and approved by the end of February 2009. The new policy is intended to clearly define all aspects of the discharge review process, and specifically addresses report preparation and levels of oversight and tracking. For example, the new draft policy memorandum requires district administrators to provide sufficient justification for their decisions to retain or discharge parolees. In addition, the draft policy prohibits deported parolees from discharging by operation of law without a substantive documented review.

Finding #2: Corrections did not always ensure that the appropriate authority participated in discharge decisions.

Under state law, only the board has the authority to retain a parolee. Corrections' discharge policy requires that the board must review each case in which it previously took action to retain a parolee or to revoke or suspend an individual's parole. However, the board is not always involved in the discharge process when it should be. For 83 of the 509 parole discharges that we reviewed, we performed additional testing to determine whether Corrections followed all of its discharge policies. We found that because of errors made by Corrections' Case Records Office, the appropriate authority did not participate in making the decisions to retain or discharge six of these parolees. In four cases the board should have made the final decision to retain or discharge the parolees, but was not given the opportunity. Corrections' staff should have sent the other two cases to district administrators for either a decision to discharge or a recommendation to the board to retain the parolees, but staff did not do so. In all six of these cases, the parolees were discharged. Although Corrections maintains data on actions

taken by the board against offenders' paroles and on the entity that discharged each parolee, which it could use to verify that the board was involved in discharge decisions when required, this data is not always accurate.

In addition, in August 2007 Corrections began requiring its regional administrators, or designees, to audit 10 percent of all discharge review reports submitted each month to district administrators under their supervision. It also began requiring its district administrators to audit 10 percent of the monthly discharge decisions reached by each parole unit under their jurisdiction, excluding those discharge reviews that the parole units initially submitted to the district administrators for disposition. Although Corrections provided information that indicated that between August 2007 and May 2008, it conducted 6,380 discharge audits and noted instances of noncompliance, it was unable to provide us with accurate data on the number of these instances of noncompliance identified through such audits. Finally, these audits occur after staff have already processed the parole discharges and retentions, and therefore the audits would not be effective in preventing inappropriate discharges from occurring.

To ensure that parolees are discharged in accordance with its policies and with state laws, we recommended that Corrections make certain that the appropriate authority makes decisions to discharge or retain parolees. To document more accurately whether its staff completed discharge reports, Corrections should ensure that staff members properly code in its database the reasons for parolees' discharges. Further, to better identify the entities that make final discharge decisions for given cases, we recommended that Corrections establish a more precise method for maintaining information about which entity made the final discharge decisions, such as a new discharge reason code or a new data field that will track this information.

Because we found some discharges that did not comply with Corrections' policies even after Corrections had implemented its protocol requiring that regional and district administrators review 10 percent of the discharge decisions made by subordinates, we also recommended that Corrections consider providing to parole staff and analysts from the Case Records Office additional training on its discharge policies. If, after providing this training, regional and district administrators find that staff are still not following discharge policies, Corrections should consider requiring that the respective administrators perform these reviews before discharge decisions are finalized.

Corrections' Action: Partial corrective action taken.

Corrections reports that in addition to enforcing and reemphasizing existing law and policy, its pending policy memorandum will more clearly define discharge and retain authority and bolster existing discharge review procedures. Corrections also stated that its proposed regulations will provide the clarity that existing law lacks, and will give its pending policy the force of law. Corrections' Case Records Office also redefined the manner in which discharged cases are entered into its database. According to Corrections, all Case Records Office staff have already been trained on the new recording procedures for entering the appropriate discharge reason and code into its database.

Finding #3: Corrections is taking actions to address discharge review reports that were altered inappropriately.

In December 2007 Corrections reported that an internal investigation determined that one of its district administrators discharged parolees after altering discharge review reports prepared by parole agents and unit supervisors who recommended retaining parolees. Corrections subsequently referred the investigation to the State's Office of the Inspector General, which launched an investigation and determined that the district administrator may have used poor judgment but it found no evidence of criminal or administrative misconduct. In addition, Corrections initiated an internal audit to determine whether a sample of parolee discharge decisions comply with state laws and its internal policies.

We recommended that Corrections' new policy prohibit unit supervisors and district administrators from altering discharge review reports prepared by others.

Corrections' Action: Pending.

Corrections' pending discharge policy and procedures memorandum, previously discussed, expressly prohibits unit supervisors and district administrators from altering discharge review reports prepared by others.

Appendix

Summary of Monetary Benefits Identified in Audit Reports Released From July 1, 2001, Through December 31, 2008

We estimate that auditees could have realized roughly \$1.26 billion of monetary benefits during the period July 1, 2001, through December 31, 2008, if they implemented our recommendations and/or addressed the improper governmental activities we found during our investigations. Table A provides a brief description of the monetary benefits we found, such as potential cost recoveries, cost savings, and increased revenues. Finally, many of the monetary benefits we have identified are not only one-time benefits, they are monetary benefits that could be realized each year for many years to come.

Table A
Monetary Benefits
July 1, 2001, Through December 31, 2008

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
July 1, 2008, through December 31, 2008		
2007-040 (September 2008)	<i>Department of Public Health: Laboratory Field Services Lack of Clinical Laboratory Oversight Places the Public at Risk</i> Increased Revenue—Net effect of Clinical Laboratory misstatements. If fee adjustments are properly made, this should be a one time benefit.	\$1,020,000
I2008-2 (October 2008) (Allegation I2006-0826)	<i>California Department of Corrections and Rehabilitation: Investigations of Improper Activities by State Employees</i> Cost Recovery—Recover improper payments that were made to employees for which they were not entitled.	17,000
I2008-2 (October 2008) (Allegation I2008-0678)	<i>California Environmental Protection Agency: Investigations of Improper Activities by State Employees</i> Cost Recovery—the Department paid an employee for 768 hours for which she was not at work and for which no leave balance was charged or used.	23,000
I2008-2 (October 2008) (Allegation I2007-1049)	<i>Department of Housing and Community Development: Investigations of Improper Activities by State Employees</i> Cost Recovery—Recover improper payments that were made to employees for which they were not entitled.	35,000
I2008-2 (October 2008) (Allegation I2007-0917)	<i>California Department of Corrections and Rehabilitation: Investigations of Improper Activities by State Employees</i> Cost Recovery—Recover improper overtime payments that were made to employees at San Quentin State Prison for which they were not entitled.	108,000
I2008-2 (October 2008) (Allegation I2007-0771)	<i>State Personnel Board: Investigations of Improper Activities by State Employees</i> Cost Savings—The Personnel Board approved contracts with a retired annuitant without providing reasonable justification for the contract or the contract amount. Although three different contracts were entered into, the amount of the contracts either varied, or the amount of work was unspecified.	14,000
Annualized carry forward for July 1, 2008, through December 31, 2008		\$95,797,000
2001-107 (October 2001)	Port of Oakland	3,750,000
2001-116 April 2002)	San Diego Unified Port District	175,000
2001-120 (March 2002)	School Bus Safety II	22,150,000
2002-009 (April 2003)	California Energy Markets	14,500,000
2002-101 (July 2002)	California Department of Corrections and Rehabilitation	21,750,000
2002-118 (April 2003)	Department of Health Services	10,000,000
2003-125 (July 2004)	California Department of Corrections and Rehabilitation	10,350,000
2003-124 (August 2004)	Department of Health Services	2,300,000
I2004-2 (September 2004)	Department of Health Services	4,500
I2004-2 (September 2004)	Military Department	32,000

continued on next page...

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
2004-105 (October 2004)	California Department of Corrections and Rehabilitation	145,000
I2005-1 (March 2005)	California Department of Corrections and Rehabilitation	59,500
2004-113 (July 2005)	Department of General Services	1,168,000
2004-125 (August 2005)	Department of Health Services	5,150,000
2004-134 (July 2005)	State Athletic Commission	16,500
I2005-2 (September 2005)	California Department of Corrections and Rehabilitation	96,500
I2006-1 (March 2006)	Department of Fish and Game and other state entities	4,150,000
Totals for July 1, 2008, through December 31, 2008		\$97,014,000
July 1, 2007 through June 30, 2008		
I2008-1 (April 2008) (Allegation I2006-0665)	<i>California Department of Corrections and Rehabilitation: Investigations of Improper Activities by State Employees</i> Cost Savings—Corrections leased 29 parking spaces at a private parking facility but did not use them.	\$50,000*
I2008-1 (April 2008) (Allegation I2006-1040)	<i>California Department of Social Services: Investigations of Improper Activities by State Employees</i> Cost Recovery—Recover improper payments that were made to contractors. Cost Savings—The Department will avoid future improper payments totalling about \$13,000.	26,000
I2008-1 (April 2008) (Allegation I2007-0958)	<i>California Department of Justice: Investigations of Improper Activities by State Employees</i> Cost Recovery—The Department paid compensation to five employees that employees may not have earned over a nine-month period.	18,000
I2007-2 (September 2007) (Allegation I2006-1099)	<i>Department of Mental Health: Investigations of Improper Activities by State Employees</i> Cost Avoidance—Misuse of state funds designated to purchase two law enforcement vehicles by using the vehicles for non-law enforcement purposes.	19,000
2007-037 (September 2007)	<i>Department of Housing and Community Development: Awards of Housing Bond Funds Have Been Timely and Complied With the Law, but Monitoring of the Use of Funds Has Been Inconsistent</i> Increased Revenue—Excessive advances are provided without consideration for interest earnings the State could receive. Without corrective action, this loss could continue for the life of the program.	38,000
I2007-2 (September 2007) (Allegation I2007-0715)	<i>California Highway Patrol: Investigations of Improper Activities by State Employees</i> Cost Avoidance—Purchase cost of \$881,565 for 51 vans it had not used for their intended purposes. A total of \$90,385 in lost interest because it bought the vans two years prior to when it needed them.	972,000
2007-109 (November 2007)	<i>DNA Identification: Improvements Are Needed in Reporting Fund Revenues and Assessing and Distributing DNA Penalties, but Counties and Courts We Reviewed Have Properly Collected Penalties and Transferred Revenues to the State</i> Increased Revenue—Counties did not always assess and collect all required DNA penalties.	32,000
Annualized carry forward from prior fiscal years:		\$191,594,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-116 (April 2002)	San Diego Unified Port District	350,000
2001-120 (March 2002)	School Bus Safety II	44,300,000
2002-101 (July 2002)	California Department of Corrections	43,500,000
2002-009 (April 2003)	California Energy Markets	29,000,000
2002-118 (April 2003)	Department of Health Services	20,000,000
2003-125 (July 2004)	California Department of Corrections	20,700,000
2003-124 (August 2004)	Department of Health Services	4,600,000
I2004-2 (September 2004)	Department of Health Services	9,000
I2004-2 (September 2004)	Military Department	64,000
2004-105 (October 2004)	California Department of Corrections	290,000
I2005-1 (March 2005)	California Department of Corrections	119,000
2004-113 (July 2005)	Department of General Services	2,336,000
2004-134 (July 2005)	State Athletic Commission	33,000
2004-125 (August 2005)	Department of Health Services	10,300,000

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
I2005-2 (September 2005)	California Department of Corrections	193,000
I2006-1 (March 2006)	Department of Fish and Game and other state entities	8,300,000
Totals for July 1, 2007, through June 30, 2008		\$192,749,000
July 1, 2006, through June 30, 2007		
I2006-2 (September 2006) (Allegation I2006-0663)	<i>Department of Forestry and Fire Protection: Investigations of Improper Activities by State Employees</i> Cost Recovery—Between January 2004 and December 2005 an employee with the Department of Forestry and Fire Protection improperly claimed and received \$17,904 in wages for 672 hours he did not work in violation of state law prohibiting individuals from intentionally submitting false claims for payment.	\$18,000
2006-035 (February 2007)	<i>Department of Health Services: It Has Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities</i> Cost Savings/Avoidance—A contractor consultant authorized long-term care Medi-Cal duplicate payments. Health Services will recoup approximately \$5.3 million from facilities that received duplicate payments and an additional \$780,000 for duplicate or overlapping payments made to one or more different provider entities. Since authorization for the duplicate payments occurred because of a flawed procedure, the error may have caused other duplicate payments outside those we identified.	6,100,000
I2007-1 (March 2007) (Allegation I2006-0945)	<i>California Exposition and State Fair: Investigations of Improper Activities by State Employees</i> Cost Recovery—An official within the California Exposition and State Fair (Cal Expo) sold his personal vehicle to Cal Expo. Because he was involved in the decision to make this purchase while acting in his official capacity and because he derived a personal financial benefit, this official violated the Political Reform Act of 1974 and Section 1090 of the California Government Code. Cal Expo has indicated that it has reversed the transaction regarding the vehicle, resulting in the reimbursement of \$5,900 to Cal Expo and the return of the vehicle to the prior owner.	6,000
I2007-1 (March 2007) (Allegation I2006-0731)	<i>Department of Health Care Services: Investigations of Improper Activities by State Employees</i> Cost Recovery—An employee violated regulations covering travel expense reimbursements and payment of commuting expenses resulting in an overpayment of \$7,453.	8,000
Annualized carry forward from prior fiscal years:		\$192,964,000
2001-102 (July 2001)	Department of Insurance Conservation and Liquidation Office	300,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-120 (March 2002)	School Bus Safety II	44,300,000
2001-128 (April 2002)	Enterprise Licensing Agreement	8,120,000
2002-101 (July 2002)	California Department of Corrections	29,000,000
2002-009 (April 2003)	California Energy Markets	29,000,000
2002-118 (April 2003)	Department of Health Services	20,000,000
2003-125 (July 2004)	California Department of Corrections	20,700,000
2003-124 (August 2004)	Department of Health Services	4,600,000
I2004-2 (September 2004)	Department of Health Services	9,000
I2004-2 (September 2004)	Military Department	64,000
2004-105 (October 2004)	California Department of Corrections	290,000
I2005-1 (March 2005)	California Department of Corrections	119,000
2004-033 (May 2005)	Pharmaceuticals	7,800,000 [†]
2004-113 (July 2005)	Department of General Services	2,336,000 [‡]
2004-134 (July 2005)	State Athletic Commission	33,000
2004-125 (August 2005)	Department of Health Services	10,300,000
I2005-2 (September 2005)	California Department of Corrections and Rehabilitation	193,000
I2006-1 (March 2006)	Department of Fish and Game	8,300,000
Totals for July 1, 2006, through June 30, 2007		\$199,096,000

continued on next page...

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
July 1, 2005, through June 30, 2006		
2004-113 (July 2005)	<p><i>Department of General Services: Opportunities Exist Within the Office of Fleet Administration to Reduce Costs</i></p> <p>Cost Savings/Avoidance—The Department of General Services (General Services) expects that the new, more competitive contracts it awarded for January 2006 through December 2008 should save the State about \$2.3 million each year. Cost savings reflect six months—January through June 2006.</p> <p>Increased Revenue—General Services identified 49 parkers it was not previously charging. By charging these parkers, General Services will experience increased revenue totaling \$36,000 per year.</p> <p>Cost Recovery—General Services reports it has recovered or established a monthly payment plan to recover \$45,000 in previously unpaid parking fees.</p>	\$1,231,000 [‡]
2004-134 (July 2005)	<p><i>State Athletic Commission: The Current Boxers' Pension Plan Benefits Only a Few and Is Poorly Administered</i></p> <p>Increased Revenue—If the commission raises the ticket assessment to meet targeted pension contributions as required by law, we estimate it will collect an average of \$33,000 more per year.</p>	33,000
2004-125 (August 2005)	<p><i>Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements</i></p> <p>Increased Revenue—We estimate that California school districts would have received at least \$53 million more in fiscal year 2002–03 if all school districts had participated in the program and an additional \$4 million more if certain participating schools had fully used the program. A lack of program awareness was among the reasons school districts cited for not participating. By stepping up outreach, we believe more schools will participate in the program and revenues will continue to increase. However, because participation continued to increase between fiscal years 2002–03 and 2004–05, the incremental increase in revenue will be less than it was in fiscal year 2002–03. Taking into account this growth in participation and using a trend line to estimate the resulting growth in revenues, we estimate that revenues will increase by about \$10.3 million per year, beginning in fiscal year 2005–06.</p>	10,300,000
2004-126 (August 2005)	<p><i>Off-Highway Motor Vehicle Recreation Program: The Lack of a Shared Vision and Questionable Use of Program Funds Limits Its Effectiveness</i></p> <p>Cost Recovery—Of the \$566,000 in grant advances we identified as outstanding from Los Angeles County, the division reports receiving a \$226,000 refund and determining that the remaining \$340,000 was used in accordance with grant guidelines.</p>	226,000
I2005-2 (September 2005) (Allegation I2004-0710)	<p><i>California Military Department: Investigations of Improper Activities by State Employees</i></p> <p>Cost Recovery—A supervisor at the Military Department embezzled \$132,523 in public funds; a court has subsequently ordered restitution of these funds.</p>	133,000
I2005-2 (September 2005) (Allegations I2004-0649, I2004-0681, I2004-0789)	<p><i>California Department of Corrections: Investigations of Improper Activities by State Employees</i></p> <p>Cost Recovery—The Department of Corrections (Corrections) failed to properly account for the time that employees used when released from their regular job duties to perform union-related activities. In addition to recovering past payments totaling \$365,500, Corrections can save \$192,500 annually by discontinuing this practice.</p>	558,000
I2006-1 (March 2006) (Allegation I2005-0781)	<p><i>California Department of Corrections and Rehabilitation: Investigations of Improper Activities by State Employees</i></p> <p>Cost Recovery—The Department of Corrections and Rehabilitation failed to exercise its management controls, resulting in gifts of public funds of \$70,255 in leave not charged.</p>	70,000 [§]
I2006-1 (March 2006) (Allegations I2005-0810, I2005-0874, I2005-0929)	<p><i>Department of Forestry and Fire Protection: Investigations of Improper Activities by State Employees</i></p> <p>Cost Recovery—Several employees of the Department of Forestry and Fire Protection received \$61,466 in improper overtime payments.</p>	61,000
I2006-1 (March 2006) (Allegations I2004-0983, I2005-1013)	<p><i>Victim Compensation and Government Claims Board and Department of Corrections and Rehabilitation: Investigations of Improper Activities by State Employees</i></p> <p>Cost Recovery—The Department of Corrections and Rehabilitation (Corrections) improperly awarded payments to a physician at Corrections totaling \$25,950.</p>	26,000

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
I2006-1 (March 2006) (Allegation I2004-1057)	<i>Department of Fish and Game: Investigations of Improper Activities by State Employees</i> Increased Revenue—The Department of Fish and Game allowed several state employees and volunteers to reside in state-owned homes without charging them rent, consequently providing gifts of public funds. A subsequent housing review conducted by the Department of Personnel Administration demonstrated that all 13 state departments that own employee housing may be underreporting or failing to report housing fringe benefits. As a result, the State could increase annual revenues as much as \$8.3 million by charging fair-market rents.	8,300,000
2005-120 (April 2006)	<i>California Student Aid Commission: Changes in the Federal Family Education Loan Program, Questionable Decisions, and Inadequate Oversight Raise Doubts About the Financial Stability of the Student Loan Program</i> Cost Savings/Avoidance—We recommended that the Student Aid Commission amend its operating agreement to require EDFUND to establish a travel policy that is consistent with the State’s policy and that it closely monitor EDFUND expenses paid out of the Operating Fund for conferences, workshops, all-staff events, travel, and the like. By implementing policy changes as recommended, we estimate EDFUND could save a minimum of \$44,754 annually.	45,000 ^{ll}
Annualized carry forward from prior fiscal years:		\$160,002,000
2001-102 (July 2001)	Department of Insurance Conservation and Liquidation Office	300,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-120 (March 2002)	School Bus Safety II	44,300,000
2001-128 (April 2002)	Enterprise Licensing Agreement	8,120,000
2002-101 (July 2002)	California Department of Corrections	14,500,000
2002-109 (December 2002)	Durable Medical Equipment	2,700,000 [#]
2002-009 (April 2003)	California Energy Markets	29,000,000
2002-118 (April 2003)	Department of Health Services	20,000,000
2003-125 (July 2004)	California Department of Corrections and Rehabilitation	20,700,000
2003-124 (August 2004)	Department of Health Services	4,600,000
I2004-2 (September 2004)	Department of Health Services	9,000
I2004-2 (September 2004)	Military Department	64,000
2004-105 (October 2004)	California Department of Corrections and Rehabilitation	290,000
2004-033 (May 2005)	Pharmaceuticals	7,800,000 ^{**}
I2005-1 (March 2005)	California Department of Corrections and Rehabilitation	119,000
Totals for July 1, 2005, through June 30, 2006		\$180,985,000
July 1, 2004, through June 30, 2005		
2003-125 (July 2004)	<i>California Department of Corrections: More Expensive Hospital Services and Greater Use of Hospital Facilities Have Driven the Rapid Rise in Contract Payments for Inpatient and Outpatient Care</i> Cost Savings—The potential for the Department of Corrections (Corrections) to achieve some level of annual savings appears significant if it could negotiate cost-based reimbursement terms, such as paying Medicare rates, in its contracts with hospitals. We estimated potential savings of at least \$20.7 million in Corrections’ fiscal year 2002–03 inmate hospital costs. Specifically, had Corrections been able to negotiate contracts without its typical stop-loss provisions that are based on a percent discount from the hospitals’ charges rather than costs, it might have achieved potential savings of up to \$9.3 million in inpatient hospital payments in fiscal year 2002–03 for the six hospitals we reviewed that had this provision. Additionally, had Corrections been able to pay hospitals the same rates as Medicare—which bases its rates on an estimate of hospital resources used and their associated costs—it might have achieved potential savings of \$4.6 million in emergency room and \$6.8 million in nonemergency room outpatient services at all hospitals in fiscal year 2002–03. Recognizing that Corrections will need some time to negotiate cost-based reimbursement contract terms, we estimate that it could begin to realize savings of \$20.7 million annually in fiscal year 2005–06.	††

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
2003-124 (August 2004)	<i>Department of Health Services: Some of Its Policies and Practices Result in Higher State Costs for the Medical Therapy Program</i> Cost Savings— Represents the savings the Department of Health Services (Health Services) would have achieved in fiscal year 2002–03 had it paid only the amount specifically authorized by law for the Medical Therapy Program. Of the total, \$3.6 million relates to the full funding of county positions responsible for coordinating with services provided by special education programs; \$774,000 relates to Health Services' method for sharing Medi-Cal payments with counties; and \$254,000 relates to Health Services' failure to identify all Medi-Cal payments made to certain counties.	\$4,600,000
I2004-2 (September 2004) (Allegation I2002-0853)	<i>Department of Health Services: Investigations of Improper Activities by State Employees</i> Cost Savings—We found that managers and employees at the Department of Health Services' (Health Services) Medical Review Branch office in Southern California regularly used state vehicles for their personal use. We estimate Health Services could save an average of \$9,260 each year because its employees no longer use state vehicles for personal use.	9,000
I2004-2 (September 2004) (Allegation I2002-1069)	<i>California Military Department: Investigations of Improper Activities by State Employees</i> Cost Savings—We found that the California Military Department (Military) improperly granted employees an increase in pay they were not entitled to receive. Because Military has returned all the overpaid employees to their regular pay levels, it should be able to save approximately \$64,200 each year.	64,000
2004-105 (October 2004)	<i>California Department of Corrections: Although Addressing Deficiencies in Its Employee Disciplinary Practices, the Department Can Improve Its Efforts</i> Cost Savings—The Department of Corrections could save as much as \$290,000 annually by using staff other than peace officers to fill its employment relations officer positions.	290,000
I2005-1 (March 2005) (Allegation I2003-0834)	<i>California Department of Corrections: Investigations of Improper Activities by State Employees</i> Cost Recovery—In violation of state regulations and employee contract provisions, the Department of Corrections (Corrections) paid 25 nurses at four institutions nearly \$238,200 more than they were entitled to receive between July 1, 2001, and June 30, 2003. In addition to recovering past overpayments, Corrections can save \$119,000 annually by discontinuing this practice. Although Corrections now contends that the payments to 10 of the 25 nurses were appropriate, despite repeated requests, it has not provided us the evidence supporting its contention. Thus, we have not revised our original estimate.	357,000
2005-030 (April 2005)	<i>State Bar of California: It Should Continue Strengthening Its Monitoring of Disciplinary Case Processing and Assess the Financial Benefits of Its New Collection Enforcement Authority</i> Cost Recovery—As a result of our recommendation that it prioritize its cost recovery efforts to focus on attorneys who owe substantial amounts, the State Bar sent demand letters to the top 100 disciplined attorneys and has received \$24,411 as of April 2006.	24,000 ^{‡‡}
2004-033 (May 2005)	<i>Pharmaceuticals: State Departments That Purchase Prescription Drugs Can Further Refine Their Cost Savings Strategies</i> Cost Savings/Avoidance—In a prior audit, we had noted that opportunities existed for the Department of General Services (General Services) to increase the amount of purchases made under contract with drug companies, and we recommended in this audit that General Services continue its efforts to obtain more drug prices on contract by working with its contractor to negotiate new and renegotiate existing contracts with certain manufacturers. General Services reports that it has implemented contracts that it estimates will save the State \$5.1 million annually. Cost Recovery—As we recommended, the Department of Health Services identified and corrected all of the drug claims it paid using an incorrect pricing method. It expects to recoup the nearly \$2.5 million in net overpayments that resulted from its error.	5,100,000 ^{§§} 2,469,000
Annualized carry forward from prior fiscal years:		\$111,920,000
2001-102 (July 2001)	Department of Insurance Conservation and Liquidation Office	300,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-120 (March 2002)	School Bus Safety II	44,300,000
2001-128 (April 2002)	Enterprise Licensing Agreement	8,120,000

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
2002-109 (December 2002)	Durable Medical Equipment	2,700,000 [#]
2002-009 (April 2003)	California Energy Markets	29,000,000
2002-118 (April 2003)	Department of Health Services	20,000,000
Totals for July 1, 2004, through June 30, 2005		\$124,833,000
July 1, 2003, through June 30, 2004		
2002-121 (July 2003)	<i>California Environmental Protection Agency: Insufficient Data Exists on the Number of Abandoned, Idled, or Underused Contaminated Properties, and Liability Concerns and Funding Constraints Can Impede Their Cleanup and Redevelopment</i> Increased Revenue—The California Environmental Protection Agency received \$1 million in revenues after it applied for a one-time federal grant.	\$1,000,000
2003-106 (October 2003)	<i>State Mandates: The High Level of Questionable Costs Claimed Highlights the Need for Structural Reforms of the Process</i> Cost Savings—If the local entities we audited file corrected claims for the errors we identified, the State will save \$4.8 million (\$4.1 million related to the Peace Officers Procedural Bill of Rights mandate and \$675,000 related to the Animal Adoption mandate). We also recommended that the State Controller's Office audit the Peace Officers Procedural Bill of Rights claims that have been filed. We believe that such audits could yield savings of up to \$159.6 million.	4,800,000
2003-102 (December 2003)	<i>Water Quality Control Boards: Could Improve Their Administration of Water Quality Improvement Projects Funded by Enforcement Actions</i> Increased Revenue—We identified 92 violations that require fine issuance and collection of the fines and three fines that were issued but not collected. The State Water Resources Control Board could increase its revenue if it collected these fines.	301,000
2003-117 (April 2004)	<i>California Department of Corrections and Rehabilitation: It Needs to Ensure That All Medical Service Contracts It Enters Are in the State's Best Interest and All Medical Claims It Pays Are Valid</i> Cost Savings/Avoidance—Recovery of overpayments to providers for medical service charges in the amount of \$77,200 and the establishment of procedures to avoid lost discounts and prompt payment penalties totaling \$18,600.	96,000
2003-138 (June 2004)	<i>Department of Insurance: It Needs to Make Improvements in Handling Annual Assessments and Managing Market Conduct Examinations</i> Increased Revenue—We estimate a one-time increase of revenue totaling \$7 million from the Department of Insurance's ability to make regulation changes that will result in capturing more specific data from insurers about the number of vehicles they insure. Future increases in revenue are undeterminable.	7,000,000
Annualized carry forward from prior fiscal years:		\$112,733,000
2001-102 (July 2001)	Department of Insurance Conservation and Liquidation Office	300,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-108 (November 2001)	California Department of Corrections and Rehabilitation	733,000 ^{llll}
2001-120 (March 2002)	School Bus Safety	44,300,000
2001-128 (April 2002)	Enterprise Licensing Agreement	8,120,000
2002-107 (October 2002)	Office of Criminal Justice Planning	23,000
2002-109 (December 2002)	Durable Medical Equipment	2,700,000 [#]
2002-009 (April 2003)	California Energy Markets	29,000,000
2002-118 (April 2003)	Department of Health Services	20,057,000
Totals for July 1, 2003, through June 30, 2004		\$125,930,000
July 1, 2002, through June 30, 2003		
2001-123 (July 2002)	<i>Deaf and Disabled Telecommunications Program: Insufficient Monitoring of Surcharge Revenues Combined With Imprudent Use of Public Funds Leave Less Money Available for Program Services</i> Cost Savings—Represents \$200,000 in known unremitted collections from intrastate telecommunication charges and \$68,000 in penalties and interest due for 2000 and 2001.	\$268,000

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
2002-101 (July 2002)	<p><i>California Department of Corrections and Rehabilitation: A Shortage of Correctional Officers, Along With Costly Labor Agreement Provisions, Raises Both Fiscal and Safety Concerns and Limits Management's Control</i></p> <p>Cost Savings—We estimate that the Department of Corrections (Corrections) could save \$58 million if it reduces overtime costs by filling unmet correctional officer needs. This estimate includes the \$42 million we identified in our November 2001 report (2001-108). Corrections stated in its response to this audit that, following our recommendation to increase the number of correctional officer applicants, it has submitted a proposal to restructure its academy to allow two additional classes each year. This action could potentially allow Corrections to graduate several hundred more correctional officers each year, thereby potentially contributing to a reduction in its overtime costs. However, any savings from this action would be realized in future periods. We estimate that Corrections could realize savings of \$14.5 million beginning in fiscal year 2005–06, with savings increasing each year until reaching \$58 million in fiscal year 2008–09.</p>	††
2002-107 (October 2002)	<p><i>Office of Criminal Justice Planning: Experiences Problems in Program Administration, and Alternative Administrative Structures for the Domestic Violence Program Might Improve Program Delivery</i></p> <p>Cost Savings—Represents estimated annual savings from the elimination of duplicative work conducted by the State Controller's Office. This savings would recur indefinitely. However, in 2008, we decided to carry forward this cost savings through fiscal year 2003–04 only.</p>	23,000
2002-109 (December 2002)	<p><i>Department of Health Services: It Needs to Better Control the Pricing of Durable Medical Equipment and Medical Supplies and More Carefully Consider Its Plans to Reduce Expenditures on These Items</i></p> <p>Cost Savings—Represents savings the Department of Health Services (Health Services) would have achieved in fiscal year 2002–03 had it updated its maximum price for blood glucose test strips and volume remained the same as it was in the previous fiscal year. Also, beginning in fiscal year 2003–04, Health Services could save an additional \$2.7 million annually if it purchases stationary volume ventilators instead of renting them.</p>	911,000
2002-009 (April 2003)	<p><i>California Energy Markets: The State's Position Has Improved, Due to Efforts by the Department of Water Resources and Other Factors, but Cost Issues and Legal Challenges Continue</i></p> <p>Cost Savings—In response to an audit recommendation, the Department of Water Resources (Water Resources) renegotiated certain energy contracts. Water Resources' consultant estimates that the present value of the potential cost savings due to contract renegotiation efforts as of December 31, 2002, by Water Resources and power suppliers, when considering replacement power costs, to be \$580 million. For the purpose of this analysis, we have computed the average annual cost savings by dividing the \$580 million over the 20-year period the savings will be realized. The estimated savings totaling \$580 million over 20 years varies by year from approximately -\$130 million to +\$180 million.</p>	29,000,000
2002-118 (April 2003)	<p><i>Department of Health Services: Its Efforts to Further Reduce Prescription Drug Costs Have Been Hindered by Its Inability to Hire More Pharmacists and Its Lack of Aggressiveness in Pursuing Available Cost-Saving Measures</i></p> <p>Cost Savings—For two drugs we found that the net costs of the brand names were higher than those of the generics because the Department of Health Services (Health Services) failed either to renegotiate the contract or to secure critical contract terms from the manufacturer—errors we estimated cost Medi-Cal roughly \$57,000 in 2002. Additionally, Health Services estimated that it could save \$20 million annually by placing the responsibility on the pharmacists to recover \$1 copayments they collect from each Medi-Cal beneficiary filling a prescription. We estimate the State could begin to receive these savings each year beginning in fiscal year 2003–04.</p>	††
Annualized carry forward from prior fiscal years:		\$61,053,000
2001-102 (July 2001)	Department of Insurance Conservation and Liquidation Office	300,000
2001-107 (October 2001)	Port of Oakland	7,500,000
2001-108 (November 2001)	California Department of Corrections	883,000
2001-120 (March 2002)	School Bus Safety II	44,300,000
2001-128 (April 2002)	Enterprise Licensing Agreement	8,120,000
Totals for July 1, 2002, through June 30, 2003		\$91,255,000

AUDIT NUMBER/DATE RELEASED	AUDIT TITLE/BASIS OF MONETARY BENEFIT	MONETARY BENEFIT
July 1, 2001, through June 30, 2002		
2001-102 (July 2001)	<p><i>Department of Insurance Conservation and Liquidation Office: Stronger Oversight Is Needed to Properly Safeguard Insurance Companies' Assets</i></p> <p>Cost Savings and Cost Recovery—Recovery of overpayment to a contractor for \$43,000 and recovery of reinsurance not yet billed at \$1,385,000. In addition, cost savings of \$300,000 under the Conservation and Liquidation Office's (CLO) new contract with its investment managers, which will recur for many years. The CLO reported that it recovered the overpayment as of December 21, 2001.</p>	\$1,728,000
2001-107 (October 2001)	<p><i>Port of Oakland: Despite Its Overall Financial Success, Recent Events May Hamper Expansion Plans That Would Likely Benefit the Port and the Public</i></p> <p>Increased Revenue—If the real estate division were to renegotiate its below-market leases to approximately 25 percent of their aggregate estimated fair market value, it could increase annual revenues. In 2002 three of the Port of Oakland's (Port) below-market leases expired. If the Port renegotiated these leases to 25 percent of market value, the Port would realize over \$7.5 million annually.</p>	7,500,000
2001-108 (November 2001)	<p><i>California Department of Corrections: Its Fiscal Practices and Internal Controls Are Inadequate to Ensure Fiscal Responsibility</i></p> <p>Cost Savings and Cost Recovery—Recover \$24,000 of overpayment on overhead; save \$150,000 of future overhead costs through fiscal year 2002–03; save \$733,000 by eliminating unneeded contractor, which will recur for many years; and save \$42 million spent on overtime by filing vacant positions, which will recur for many years. We estimate that savings for fiscal year 2002–03 could be \$883,000 (\$150,000 plus \$733,000) and savings of \$733,000 annually for periods thereafter. However, since it may take the Department of Corrections (Corrections) a few years to fill its vacant positions, it is reasonable to expect Corrections to incrementally realize overtime cost savings over a five-year period starting in fiscal year 2005–06.</p>	907,000
2001-120 (March 2002)	<p><i>School Bus Safety II: State Law Intended to Make School Bus Transportation Safer Is Costing More Than Expected</i></p> <p>Cost Savings—We recommended that the Legislature clarify what activities are reimbursable. In 2002 the Legislature passed Assembly Bill 2781, which specifies that costs associated with implementation of transportation plans are not reimbursable claims. Costs for a six-year period ending June 30, 2002, were \$235.8 million and the ongoing costs after June 30, 2002, are \$44.3 million each year thereafter.</p>	235,800,000
2001-128 (April 2002)	<p><i>Enterprise Licensing Agreement: The State Failed to Exercise Due Diligence When Contracting With Oracle, Potentially Costing Taxpayers Millions of Dollars</i></p> <p>Cost Savings—The State and Oracle agreed to rescind the contract in July 2002. As a result, we estimate the State will save \$8,120,000 per year for five years starting in fiscal year 2002–03.</p>	††
2001-116 (April 2002)	<p><i>San Diego Unified Port District: It Should Change Certain Practices to Better Protect the Public's Interests in Port-Managed Resources</i></p> <p>Increased Revenue—We estimate an increase in revenue of \$700,000 per year by obtaining market value rents. This monetary benefit will recur for many years, however, it is not anticipated to begin until 2007.</p>	††
2001-124 (June 2002)	<p><i>Los Angeles Unified School District: Outdated, Scarce Textbooks at Some Schools Appear to Have a Lesser Effect on Academic Performance Than Other Factors, but the District Should Improve Its Management of Textbook Purchasing and Inventory</i></p> <p>Cost Savings—We found that some publishers are not equitably providing free instructional materials (commonly referred to as gratis items) to different schools within Los Angeles Unified School District (LAUSD), as state law requires. Subsequently, LAUSD reports that it negotiated with publishers and thus far one publisher has actually provided approximately \$300,000 in gratis items.</p>	1,762,000
Totals for July 1, 2001, through June 30, 2002		\$247,697,000
Totals for July 1, 2001, through December 31, 2008		\$1,259,559,000

- * This monetary benefit amount represents the benefit identified for a 12-month period. The monetary benefit amount identified for this allegation in Table 1 of the investigations report I2008-2, is for a three-month period.
- † Based on our follow-up work (Report 2007-501) we will discontinue claiming \$7.8 million as of fiscal year 2007–08 because the Department of General Services' (General Services) two new pharmaceutical contracts will expire November 2007. (See related footnote ** below.)
- ‡ Based on our follow-up audit 2007-502, issued May 2007, we reduced General Services' expected \$3 million of cost savings we reported in 2005 to \$2.3 million of potential savings.
- § This monetary benefit was previously listed at \$66,000. Additional audit work resulted in additional cost recovery of more than \$4,000 and based on updated information from the Department of Corrections and Rehabilitation, we eliminated the improper holiday accruals we reported in 2007.
- || We will discontinue claiming \$45,000 as of this fiscal year. Recent changes to state law may impact the role previously performed by the Student Aid Commission (commission). Senate Bill 89 (SB 89), an emergency measure enacted as Chapter 182, Statutes of 2007, and signed by the governor on August 24, 2007, took effect immediately, and may affect the ownership of EDFUND, and impact the commission's oversight role. SB 89 prohibits the commission from authorizing EDFUND to perform any new or additional services unless they are deemed necessary or convenient by the Department of Finance for the operation of the loan program or for maximizing the value of the state student loan guarantee program. Similarly, the director must approve any expenditure by EDFUND. Moreover, SB 89 provides that all actions, approvals, and directions of the commission affecting the state student loan guarantee program are effective only upon the approval of the director. Thus, the director now has significant authority over the commission and EDFUND.
- # Although this cost savings was previously identified, it was not previously reported as cost savings.
- ** This monetary benefit was previously listed at \$5.1 million. However, according to General Services, its strategic sourcing contractor assisted it in negotiating two new pharmaceutical contracts for the period of November 2005 to November 2007 that General Services believed would result in increased savings to the State. Our follow-up report indicates that the State appears to have achieved savings of \$7.8 million during the first 10 months of these two new contracts. See report number 2007-501 (June 2007).
- †† Although we identified monetary benefits the auditee could reasonably expect to realize if it implements our recommendations, these benefits would be realized in a future period rather than the period in which the report was issued. Therefore, the appropriate amounts either are or will be included in future years' annualized carry forward.
- ‡‡ This monetary benefit was previously listed as \$2,700. The State Bar reported that it has since received an increased amount of cost recovery.
- §§ This monetary benefit was not previously reported because General Services had not yet implemented the contracts resulting in this savings.
- ||| We will carry forward \$733,000 through fiscal year 2003–04 only. Also, the \$42 million of overtime cost savings is included with and reported under the monetary benefits of a later Corrections audit, audit number 2002-101, issued July 2002.

Index

State and Local Entities With Recommendations From Audits Included in This Special Report

AUDITEE/ENTITY	PAGE REFERENCE
Administrative Office of the Courts	261
Air Resources Board	161
Cal Expo and State Fair	271
California Institute of Regenerative Medicine	227
California Postsecondary Education Commission	111
California Prison Health Care Services	37
Chiropractic Examiners, Board of	85
Conservation, Department of	281
Consumer Affairs, Department of	75, 109, 183
Contractors State License Board	109
Corporations, Department of	29
Corrections and Rehabilitation, Department of	37, 203, 269, 289, 291
Education, Department of	119, 145
Employment Development Department	103
Environmental Protection Agency	103, 175
Equalization, Board of	197
Fish and Game, Department of	169, 285
Franchise Tax Board	197
Gambling Control Commission, California	51
General Services, Department of	77, 103
Health Care Services, Department of	9, 15, 187, 195, 215, 237
Highway Patrol, California	77, 103, 273
Housing and Community Development	239
Insurance, Department of	243
Justice, Department of	103, 203, 261, 265, 267
Medical Board, California	75, 183
Mental Health, Department of	193
Motor Vehicles, Department of	103
Public Health, Department of	67, 177, 207
Secretary of State	149
Social Services, Department of	59, 201, 203
State Bar of California	255
State Controller's Office	261
Superior Court of California, Los Angeles	261
Superior Court of California, Sacramento	261
Toxic Substances Control, Department of	103
Transportation, Department of	103, 159
Unemployment Insurance Appeals Board	247

AUDITEE/ENTITY	PAGE REFERENCE
Veterans Affairs, Department of	207
Victim Compensation and Government Claims Board	219
Water Resources, Department of	23
LOCAL ENTITIES	
Alameda County	149
American River College	111
Bay Area Air Quality Management District	161
Cal State Polytechnic University-Pomona	121
California Community Colleges	137
California State University, Chancellor's Office	123, 129, 137
California State University, Long Beach	111
Fresno County	51, 149
Kings County	149
Los Angeles County	149
Orange County	149
Placer County	51
Riverside County	51
Sacramento Metropolitan Air Quality Management District	161
San Bernardino County	51
San Diego County	51, 149
San Joaquin Valley Air Pollution Control District	161
Santa Clara County	149
Santa Clara Valley Transportation Authority	275
Solano County	149
Sonoma County	51
South Coast Air Quality Management District	161
Stanford University	111
University of California, Office of the President	137
University of California, Berkeley	111
University of California, Los Angeles	111
University of Southern California	111