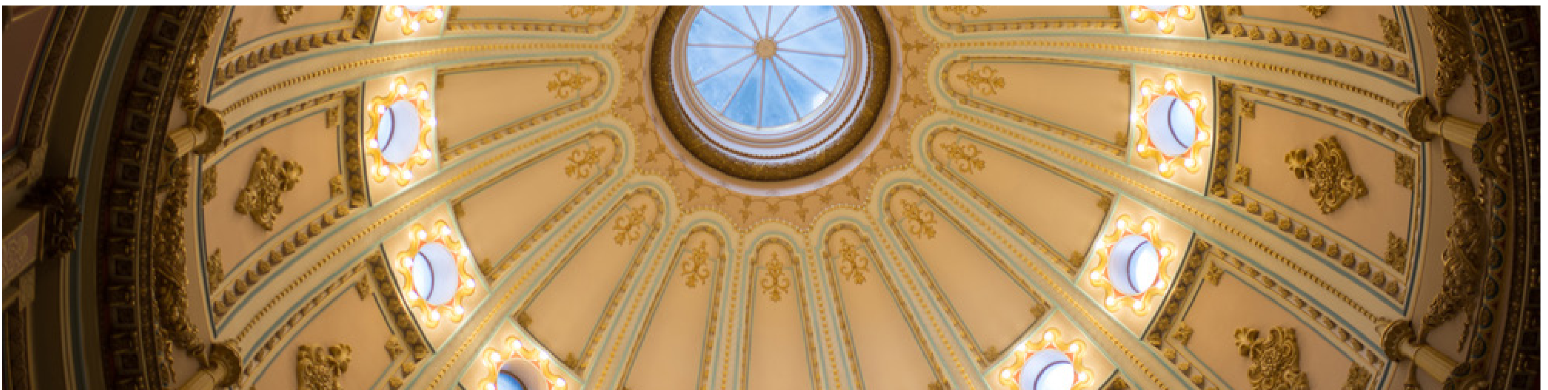
Recommendations for the Legislature From Audits Issued During 2021 and 2022

January 2023

REPORT 2022-701



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January 24, 2023
2022-701

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, CA 95814

Dear Governor and Legislative Leaders:

Over the last two years, the California State Auditor's Office issued reports on various topics as mandated by the Legislature through statute, the budget process, or approved by the Joint Legislative Audit Committee. We typically direct the recommendations we make as a result of these audits to the audited entities, but we also make recommendations for the Legislature to consider in the interest of more efficient and effective government operations. This report summarizes the recommendations we made to the Legislature during 2021 and 2022.

Several of the audits we have recently conducted include recommendations that address fraud detection and prevention. In one audit report, we evaluated the prevalence of fraud indicators in hospice agencies, and we found evidence to suggest a large-scale, targeted effort to defraud Medicare and Medi-Cal, particularly in Los Angeles County. We found that the state agencies responsible for overseeing hospice care in California have not taken adequate measures to prevent such fraud or to protect patients from unqualified and unscrupulous providers. We further found that the California Department of Public Health has not issued key regulations for hospice licensing, and the current licensing requirements are inadequate to protect patients. One of our recommendations is that the Legislature should require California's departments of Public Health, Health Care Services, Justice, and Social Services to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. The Legislature should also require the four departments to establish a working group to meet annually to conduct a risk assessment of the Medi-Cal hospice program statewide.

Other audits resulted in recommendations to increase the State's ability to respond to the affordable housing crisis. For example, our audit assessing state agencies' compliance with the Governor's 2019 executive order prioritizing the use of excess state-owned land to support the development of affordable housing found that although the executive order has proven effective in its intent, the Department of General Services (DGS) could accelerate the process by which it makes properties available. We recommended that the Legislature require DGS to conduct a review of all state-owned property and identify parcels that are potentially viable for affordable housing by July 2023 and every four years thereafter.

The Appendix of this report includes legislation that was chaptered or vetoed during the second year of the 2021–22 Regular Legislative Session and pertained to the subject matter discussed in our audit reports.

If you would like more information or assistance regarding any of the recommendations or the background provided in this report, please contact our office at (916) 445-0255.

Respectfully submitted,

GRANT PARKS
California State Auditor

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EDUCATION

Department of General Services' Office of Public School Construction and the State Allocation Board

2021-115 *School Facilities Program: California Needs Additional Funding and a More Equitable Approach for Modernizing Its School Facilities* (January 2022)

Finding: The School Facilities Program (facilities program) was established to provide financial assistance to school districts for facility construction and modernization. To help ensure that all students have safe and adequate facilities in which to learn, the facilities program funds grants to school districts to, in part, modernize existing school facilities. The State Allocation Board (Allocation Board) administers the facilities program. We estimate that California will likely need $7.4 billion to meet school districts' modernization funding requests over the next five years. This amount will address existing requests from school districts of $1.7 billion that the Allocation Board cannot fund with its current remaining bond authority, as well as $5.7 billion in additional requests that we estimate the State can expect to receive.

Recommendation: To meet school districts' anticipated requests for modernization funds, the Legislature should seek voter approval of at least $7.4 billion in bond authority for the modernization of school facilities.

Status: Not Implemented.

Finding: The system the Allocation Board and the Office of Public School Construction (OPSC) currently use for processing modernization applications likely limits the ability of less wealthy districts to modernize their school facilities. With the exception of modernization projects that address an imminent threat to the health and safety of students (health and safety projects), the Allocation Board approves funding for projects in order of their receipt. Because of this practice, the OPSC reviews and processes applications for the non-health and safety projects on a first come, first served basis, and districts can wait several years after submitting their applications to receive approval from the Allocation Board and subsequently to receive their funds.

Recommendation: To better ensure that the Allocation Board provides equitable funding for all districts that apply for modernization funds, the Legislature should require that the funds in future bond propositions be administered in the following manner:

- Require the Allocation Board to prioritize funding to projects that fit at least one of the following criteria:
  - Projects from districts meeting the financial hardship criteria.
  - Projects from districts in low-income areas.
  - Projects that address an imminent threat to the health and safety of students.
- Allow the Allocation Board to make preliminary apportionments to all districts requesting modernization funding that meet the financial hardship criteria.

Status: Not Implemented.

Finding: The OPSC does not prepare estimates of the need for modernization funding even though this information would benefit the Legislature and voters. Historically, the State has funded the facilities program with voter approved general obligation bonds. Estimates from the OPSC at least once every other year to anticipate the funding needed could be useful as the Legislature considers how much in bond authority it should ask voters to authorize through future bond propositions. Estimates would also give the Legislature greater assurance that it is not asking for too much funding from voters, some of whom may be concerned about increasing the State's debt.

Recommendation: To ensure that it receives information about future demands for modernization funding, the Legislature should require the Allocation Board to create estimates of future modernization funding requests and provide this information to the Legislature at least every other year beginning in fiscal year 2022–23.

Status: Not Implemented.

Finding: Because school districts are only eligible to receive funding to modernize school buildings that have reached certain ages and the OPSC does not know the number of buildings that have reached those age thresholds, the OPSC's deputy executive officer believes that it does not have sufficient data to estimate future need for modernization funding. However, we determined that one can use reasonable assumptions about future funding requests to reach an estimate of modernization needs. Specifically, the OPSC could use valid and reliable data—such as the data it already possesses, perhaps combined with data it could obtain through a survey of a statistically significant number of school districts every other year—to project the age of school buildings statewide. Using these data, the OPSC could slowly build a database of the age of school facilities, further assisting it in determining when school districts will likely seek modernization funding and the expected amount of funding. The OPSC could present these estimates every other year to the Allocation Board, which could then report this information to the Legislature when its bond authority begins to run low.

Recommendation: To ensure the quality of estimates of future requests for modernization funding, the Legislature should require that the OPSC gather valid and reliable data about the age of all school facilities in California and that the Allocation Board's estimates be based on this data. For example, the OPSC could survey a statistically significant number of school districts to gather data on the age of their school buildings. Further, the Legislature should require the Allocation Board to maintain any data the OPSC collects from districts for the purpose of building a comprehensive set of data on facility age for all California schools.

Status: Not Implemented.

ENVIRONMENTAL QUALITY

State Water Resources Control Board

2021-118 *State Water Resources Control Board: It Lacks the Urgency Necessary to Ensure That Failing Water Systems Receive Needed Assistance in a Timely Manner* (July 2022)

Finding: In 2019 state law established the Safe and Affordable Drinking Water Fund and directed the State Water Resources Control Board (State Water Board) to create an annual expenditure plan for the fund. The expenditure plan, in part, prioritizes funding for disadvantaged communities served by public water systems. Further, state law requires the expenditure plan to be based on a needs assessment, which the State Water Board annually conducts to identify the overall resources needed to bring failing water systems—those that are out of compliance with or that consistently fail to meet state and federal safe drinking water standards—into compliance with drinking water standards and prevent water systems that are at risk from failing, including public water systems, state small water systems, and domestic wells. The 2021 needs assessment examined more than 2,700 public water systems, identifying more than 600 such systems at risk of failing to provide an adequate supply of safe drinking water. Although the State Water Board has funding available to help failing water systems, it has not made processing applications a priority. The resulting delays have slowed the ability of water systems to address poor water quality. Over the last five years, the average amount of time it took for water systems to complete their applications, and then for the State Water Board to review them and award funding, was about two years. Further, for 55 of the nearly 300 projects approved during that time, the process took three years or longer. These lengthy delays in providing needed assistance put Californians' health at risk and increases the amounts that water systems will eventually need to spend to correct water quality problems. Although each of the projects we reviewed—and the causes for its delays—was unique, they all point to a larger and more fundamental issue: the State Water Board's process for awarding funding to failing water systems lacks urgency. The State Water Board's lack of goals and metrics for the length of time it should take to fund projects contributes to its lack of urgency for approving applications and inhibits its ability to identify areas of the review process that it could improve. The deputy director agreed that establishing benchmarks would help the State Water Board identify ways to improve the efficiency, timeliness, and transparency of its application process. However, developing these metrics and others has been included in State Water Board policy for two years, and the State Water Board has not yet implemented them. Further, the State Water Board did not have an estimated date for when it expected to implement them until we suggested that it establish one. The two years during which the State Water Board failed to develop these metrics is yet more lost time that has contributed to the delays for vulnerable Californians dependent on failing water systems.

Recommendation: To provide transparency and accountability in the State Water Board's efforts to assist failing water systems, the Legislature should amend state law to require the State Water Board by June 2023 to include its timeliness goals and its performance in comparison to those goals in the annual expenditure plans and reports it already submits to the Legislature. The Legislature should also require the State Water Board to include in those reports a list of drinking water project applications that have exceeded the board's timeliness goals and a brief description of the reasons for delays, its strategies for overcoming those delays, and its estimated time to execute funding agreements.

Status: Not Implemented.

California Public Utilities Commission and California Natural Resources Agency's Office of Energy Infrastructure Safety

2021-117 *Electrical System Safety: California's Oversight of the Efforts by Investor-Owned Utilities to Mitigate the Risk of Wildfires Needs Improvement* (March 2022)

Finding: According to California Public Utilities Commission (CPUC) data, there were 67 power shutoffs from 2013 through 2021, de-energizing thousands of circuits across California and affecting more than 3.6 million customers. The cost of the 62 power shutoffs for which there was duration information was more than $21 billion in total—based on Southern California Edison average cost estimates for residential and small or medium business customers. One significant aspect of the electrical grid that contributes to the need for power shutoffs is the number of miles of bare power lines in high fire-threat areas. Nearly 27 percent—more than 74,000 miles of the nearly 277,000 miles of the six utilities' power lines—are located in these areas. The utilities collectively reported that at least 54 percent of these power lines are bare lines. To minimize the need for power shutoffs to prevent wildfires, utilities must make improvements to reduce the likelihood that electrical equipment will cause a fire. However, it may well cost billions of dollars to address bare lines in high fire-threat areas. Based on one estimate, replacing bare lines with covered power lines in areas of high fire-threat would cost $28 billion. Further, despite the risk posed by bare lines, the geographic data and quarterly reports that utilities submitted to the Natural Resources Agency's Office of Energy Infrastructure Safety (Energy Safety Office) indicated that their hardening initiatives have addressed only a relatively small number of the miles of bare power lines in high fire-threat areas. In 2020 utilities reported that they had made changes to electrical equipment to make it more resistant to fire, or reduce the risk of it causing a fire, on only 1,540 miles of power lines. Even if all of these improvements were to bare power lines in high fire-threat areas, they would represent only 4 percent of such lines. In January 2022, a new state law (shutoff reduction law) began requiring that utilities identify circuits—sections of power lines within a utility's electrical grid—that have been subject to frequent power shutoffs, and the improvements the utilities have already taken or plan to take to reduce the need for and impact of future power shutoffs. To implement the shutoff reduction law, the Energy Safety Office requires utilities' 2022 mitigation plans to map and list frequently de-energized circuits and list the measures they have taken or will take to reduce the need for and impact of future de-energization of those circuits. Although such planned reductions in the scope and frequency of power shutoffs may represent an improvement, any power shutoff generally imposes risks and hardships. Further, if the Energy Safety Office is to minimize the need to use power shutoffs as a wildfire mitigation tool and meet its stated objective of pursuing wildfire mitigation activities that do not significantly impact electric utility reliability, it will need to ensure that utilities make improvements to the electrical grid that eliminate the need for power shutoffs in the weather conditions that have led to their routine use in the past. The shutoff reduction law could be strengthened by requiring that utilities identify the improvements that are necessary to prevent future power shutoffs on those circuits, such as moving power lines underground.

Recommendation: To prevent power shutoffs rather than only reducing their scope and impact, the Legislature should amend the shutoff reduction law to require that utilities describe in their mitigation plans the improvements that would be necessary to prevent power shutoffs on the circuits routinely affected by them—such as installing covered power lines—and the costs of those improvements.

Status: Not Implemented.

Finding: The three largest utilities have altered settings on their equipment, including circuit breakers and reclosers, resulting in unplanned power outages (unplanned outages) throughout the State. When there is excessive current flowing in a circuit—which could be caused by an object like a tree blown over in high winds making contact with an energized line—a circuit breaker or recloser automatically interrupts power to the circuit. Typically, after a preset duration, a recloser restores the power to determine whether the fault still exists and interrupts power again if it does. The recloser repeats this sequence a set number of times and, if it continues to detect the fault, it will de-energize the line. However, utilities are able to change settings on some breakers and reclosers so that they turn off the power more quickly if there is an issue on an energized line. Pacific Gas and Electric Company (PG&E) stated that adjusting these settings in 2021 to turn electricity off more quickly resulted in an approximate 46 percent reduction in ignitions in high fire-threat areas compared to the three-year historical average. Although those actions may have effectively prevented wildfires, PG&E's alteration of breaker and recloser settings in 2021, known as enhanced powerline safety settings (power-line settings program), also triggered hundreds of unplanned outages that affected more than a half million customers. According to the CPUC's website, all six utilities will include altering settings on their equipment (power-line setting measures) in their 2022 mitigation plans and both PG&E and San Diego Gas and Electric Company (SDG&E) have already indicated that they plan to use these settings in the future, resulting in more unplanned outages. In January 2022, the shutoff reduction law began requiring that utilities identify circuits—sections of power lines within a utility's electrical grid—that have been subject to frequent power shutoffs, and the improvements the utilities have already taken or plan to take to reduce the need for and impact of future power shutoffs. Despite the hundreds of unplanned outages and more than a half million customers affected by PG&E's use of the power-line settings program in 2021, the Energy Safety Office does not consider power-line settings programs to fall under the definition of a de-energization event as described in the shutoff reduction law. Thus, the Energy Safety Office does not require utilities' mitigation plans to identify the circuits that are frequently experiencing these unplanned outages or the measures the utilities have taken or plan to take to reduce the need for and impact of unplanned outages in the future.

Recommendation: To address the risks and hazards resulting from future unplanned outages, the Legislature should amend the shutoff reduction law to include circuits frequently de-energized as the result of utilities' power-line setting measures. In doing so, the Legislature will create a requirement that utilities identify in their mitigation plans the circuits frequently de-energized as a result of their power-line setting measures and the improvements they have made or plan to make to those circuits.

Status: Not Implemented.

Finding: The Energy Safety Office must issue safety certifications to utilities that demonstrate they meet certain criteria established in law—such as having an approved mitigation plan. These safety certifications affect requirements for utilities to repay certain amounts to a fund they can use to help pay for the costs of wildfires they cause. However, the law does not allow the Energy Safety Office to deny a safety certification based on a utility's failure to implement a prior mitigation plan—state law requires the Energy Safety Office to consider whether a utility is in the process of implementing its most recently approved mitigation plan when issuing a safety certification. The Energy Safety Office's inability to deny a safety certification based on poor implementation of prior mitigation plans led it to issue a safety certification to PG&E despite concerns about PG&E's progress in mitigating wildfire risks. In October 2020, before the Energy Safety Office issued PG&E's 2020 safety certification, a Federal Monitor concluded that it strongly appeared that PG&E had failed to adhere to its risk models when executing its wildfire risk reduction work, had completed the majority of its 2019 enhanced vegetation work in relatively low-risk areas, and performed approximately 1,000 inspections of

transmission towers outside of high-threat areas, but none of the planned enhanced inspections of transmission structures in its highest-threat areas. The Energy Safety Office noted these concerns in the issuance letter for PG&E's safety certification but nonetheless stated that PG&E had met the minimum statutory requirements for issuance of a safety certification. Thus, whether a utility substantially implements the projects in its mitigation plan has no bearing on the issuance of its safety certification as a result of these two factors: first, because the implementation of the plan is in progress, the Energy Safety Office performs only a limited review of whether a utility is implementing its current mitigation plan, and second, determinations of whether a utility substantially implemented its prior mitigation plans are not one of the criteria established in law for it to assess when issuing a safety certification.

Recommendation: To ensure that safety certifications encourage utilities to invest in safety and limit wildfire risks, the Legislature should require that, as a prerequisite of issuing a safety certification, the Energy Safety Office's most recently completed compliance assessment of a utility's mitigation plan must conclude that the utility has substantially implemented that plan.

Status: Not Implemented.

Finding: The CPUC's audits play an important role in ensuring that utilities safely operate the electrical grid, but they could be improved to better ensure utilities' compliance and help mitigate the risk of utility-caused wildfires. The CPUC's mission is to, among other things, assure that utility services are safe. However, the CPUC does not consistently audit all utility districts and, for those audits it does perform, it cannot demonstrate that it prioritizes districts that are in areas of increased fire risk. Although the safety and reliability program manager indicated that the CPUC's audit manual calls for it to audit each utility's districts within a five-year cycle, we found that the CPUC did not audit each power line distribution district (distribution district) within the most recent five-year period. The CPUC did not audit several districts that contain areas of elevated or extreme fire risk. Notably, during the five-year period from 2016 through 2020, the CPUC failed to conduct audits of distribution power lines in counties that contain areas of elevated and extreme fire risk, including portions of Butte, Tehama, and Shasta counties—where major fires have occurred in the past. Although the safety and reliability program manager stated that the CPUC used risk factors identified in the audit manual, including past audit performance, accident data, or indications of safety or reliability problems, she was unable to provide any documentation showing how the risk factors were applied when selecting which districts to audit. As a result, the CPUC could not demonstrate how it weighs the risk of utility-caused wildfires when prioritizing the audits it performs.

Recommendation: To better hold utilities accountable for safely operating the electrical grid, the Legislature should require the CPUC to do the following:

- Create and implement a risk-based audit plan for transmission and distribution infrastructure audits that prioritizes districts based on risk factors, including high fire-threat areas, and aligns with the requirement established in its audit manual to audit each district at least once every five years.

Status: Not Implemented.

Finding: The CPUC does not use its authority to penalize utilities when its audits uncover violations. In 2014 the CPUC adopted an electric safety citation program that gave staff the authority to issue penalties for certain violations of law and of General Orders, including those identified through audits.

However, as of November 2021, the CPUC had not issued any penalties resulting from violations that its safety and enforcement division found during audits. The safety and reliability program manager informed us that it is the CPUC's practice to issue penalties for significant issues, which may be found through incident investigations where individuals were hurt or killed or where buildings were destroyed, but that these types of immediate safety hazards are rarely found during audits. In our review of CPUC audits, we identified several instances where the CPUC identified violations of General Orders that were the same as those for which it issued penalties in incident investigations. Because the CPUC's mission includes assuring that utility services are safe, its focus should be on preventing deficiencies that could result in negative outcomes, rather than only imposing penalties after an incident such as a fire, injury, or death. Although penalties associated with audit findings may not result in the same dollar amounts as those applied after an investigation, issuing penalties based on audit findings would elevate the importance of the safety practices that CPUC audits review.

Recommendation: To better hold utilities accountable for safely operating the electrical grid, the Legislature should require the CPUC to do the following:

- Create a schedule of penalties for violations identified through its audit process and apply the schedule pursuant to its existing authority to impose penalties established in state law.

  Status: Not Implemented.

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GOVERNMENTAL ORGANIZATION

City of Calexico

2021-805 *City of Calexico: Past Overspending and Ongoing Administrative Deficiencies Limit Its Ability to Serve the Public* (October 2022)

Finding: The city of Calexico (Calexico) presents its key financial documents exclusively in English, which creates a language barrier that can limit the civic involvement of many of its residents. According to U.S. Census Bureau data for 2020, nearly 96 percent of Calexico residents primarily speak Spanish at home, and more than half of the Spanish-speaking population speaks English less than very well. Despite these facts, Calexico currently presents its proposed and adopted budgets in English only. Calexico has experienced strong civic involvement when it communicates in both English and Spanish, and recent comments from residents illustrate that their desire to participate in the budget process is hampered by a language barrier. Although Calexico has a particularly high percentage of residents who speak a language other than English at home, the Legislature may wish to address language barriers that affect public participation in budget processes among municipal governments throughout the State. More than 40 percent of the State's residents speak a language other than English at home, a rate that is double the national average. Further, California has the highest percentage of individuals in the country who self-identify as speaking English less than very well. If municipal governments presented key portions of budgets in both English, which is California's official language, and the languages that a majority of their residents speak at home, they could improve public participation. In turn, this participation could improve the public's perception of government performance and the value the public receives from its government.

Recommendation: To reduce barriers to civic engagement, the Legislature should consider encouraging or requiring all municipal governments to make key portions of public budgetary documents, such as proposed and adopted budgets, available in a sufficient number of languages to ensure that at least 75 percent of their residents can obtain the documents in their primary languages.

Status: Not Implemented.

City of Compton

2021-802 *City of Compton: Financial Mismanagement and a Lack of Leadership Have Threatened Compton's Ability to Serve the Public* (October 2022)

Finding: Although the city council for the city of Compton (Compton) is vested with all powers of Compton and is responsible for enforcing the provisions of the city charter, council members do not receive recurring training on important topics such as approving budgets, monitoring Compton's financial status, and overseeing Compton's operations. Four of the five council members are new to the city council since June 2021. According to one member, he did not receive an orientation when he was elected to the city council and had to request a copy of the city charter. He also indicated that Compton does not have an ongoing training program for council members that covers topics such as approving budgets and monitoring finances. By implementing a formal training program, Compton could help ensure that its council members are well prepared to succeed in their leadership roles. The council plays the biggest part in ensuring that Compton serves the public to its fullest capacity. More broadly, mandatory training for city council members could improve governance of

cities statewide. In several previous audits of other cities, both as part of our local high-risk program and through audits requested by the Legislature, we have identified similar issues with inadequate city council oversight of finances and operations. Further, California has already adopted statewide training requirements for city council members on topics such as ethics. In broadening the State's training requirements to include topics such as budgeting and oversight, the Legislature would need to consider charter cities' authority over municipal affairs.

Recommendation: Based on deficiencies with city council oversight that we discuss in this report as well as in several previous audits of other cities, to improve the governance of cities throughout California, the Legislature should consider requiring all individuals who serve on a city council to participate in recurring training related to municipal finance, budgeting, and the council's role in overseeing city operations.

Status: Not Implemented.

Indian Gaming Special Distribution Fund

2021-102 *Indian Gaming Special Distribution Fund: The State Could Better Manage Its Distribution Fund and Its Problem Gambling Programs* (August 2022)

Finding: The Indian Gaming Special Distribution Fund (distribution fund) exists to pay for specific activities related to tribal gaming, such as regulating tribal casinos and providing services to individuals suffering from problem gambling. Tribes that engage in gaming activities pay fees into the distribution fund, and these fees must be used by the State for specific activities. The State has allowed the distribution fund to accumulate an excessive reserve. As of June 2022, the distribution fund's balance of $127 million was enough to pay for nearly four years of expenditures, significantly higher than the level suggested by a Government Finance Officers Association best practice. There are two distinct steps the Legislature should take to help ensure that the distribution fund has sufficient, but not excessive, funding to fulfill its purposes. First, the Legislature should direct the California Gambling Control Commission (Gambling Commission) and Department of Finance (Finance) to identify a prudent reserve amount. Second, the Legislature should decide how to reduce the fund balance until it reaches that amount. One option for reducing the balance would be for the Legislature to increase the appropriations from the distribution fund for allowable activities. For example, the Legislature could decide to increase funding for the problem gambling prevention and treatment programs. Either alternatively or in addition to increased appropriations, the Legislature could return excess funding to tribes by refunding a portion of their distribution fund fees.

Recommendation: To ensure that the distribution fund maintains a prudent balance, the Legislature should require Finance to collaborate with the Gambling Commission to determine an appropriate reserve fund balance. The Legislature should then appropriate the excess reserve consistent with federal and state law. For example, it could increase the funding for the problem gambling prevention and treatment programs or it could return excess funds to tribes by refunding a portion of distribution fund fees.

Status: Not Implemented.

Finding: The State has not repaid nearly $2 million plus interest from a loan from the distribution fund that has been outstanding for 13 years, preventing either the use of these funds to regulate tribal gaming or their return to the tribes that paid distribution fund fees. In fiscal year 2008–09, state law established a remote caller bingo program to provide funding to help nonprofit and charitable organizations conduct fundraising. The law also created the Charity Bingo Mitigation Fund (bingo mitigation fund) and authorized a $5 million loan from the distribution fund to that fund to ease organizations' costs of transitioning to remote bingo games. The law designated the Gambling Commission as the administrator of the bingo mitigation fund, made it responsible for awarding the mitigation funding, and required nonprofit and charitable organizations to pay a percentage of revenue from each remote caller bingo game to the Gambling Commission until the loan was reimbursed. However, the State repealed the remote caller bingo statute, effective January 1, 2017, before the full loan amount was repaid. The bingo mitigation fund's remaining balance of $5,000 is not sufficient to repay the remaining debt of $1.7 million plus accrued interest of more than $370,000. Until the State repays this remaining loan balance and interest, $2 million is not available either to pay for important regulatory activities or for the use of the tribes that pay into the fund. The Legislature will need to take action to ensure repayment. When passing the law that established the remote caller bingo program, the Legislature intended the loan to be paid back by the participating organizations. Further, key stakeholders also cannot agree on who is responsible for ensuring the repayment, further underscoring the lack of clarity regarding the loan. In the absence of clarity about who should ensure repayment and with what resources, the Legislature—if it decides to repay the loan—could do so through the State's General Fund, the State's primary source of funding for state government. The Finance budget analyst was not sure whether the General Fund is a guarantor for repayment of the loan or whether the distribution fund could write off a loan as uncollectable. According to communications between the California Department of Justice (DOJ) and the State Controller's Office (SCO), the final interest amount cannot be determined until a repayment date is set for the loan. The SCO calculated the $370,000 interest amount based on a repayment date of June 30, 2022.

Recommendation: To ensure that the distribution fund receives the remaining amount loaned to the Charity Bingo Mitigation Fund, the Legislature should appropriate $1.7 million plus interest from the State's General Fund to repay the loan.

Status: Not Implemented.

Finding: The DOJ has not appropriately used some distribution funds. DOJ inappropriately charged staff time to the distribution fund for activities that were not related to its tribal gaming regulatory activities. State law establishes the allowable uses for the distribution fund, which include paying for costs that the State incurs to regulate tribal gaming and to operate problem gambling treatment and prevention programs (regulatory costs). State law also specifies the priority uses for the distribution fund. For several years, the Department of Justice's Bureau of Gambling Control (Bureau) has improperly used the distribution fund to pay for nontribal gaming enforcement activities. Our office's 2019 audit of the Bureau found that from fiscal years 2015–16 through 2017–18, the Bureau inappropriately charged the distribution fund for more than 27,000 hours that employees within its compliance and enforcement section spent on work related to card room enforcement. These inappropriate charges occurred in part because the Bureau had no process in place to reimburse the distribution fund when employees whose positions were supported by the distribution fund (tribal employees) spent time on activities that were unrelated to tribal gaming and therefore should not have been paid from the distribution fund (nontribal activities). The Bureau has also continued to charge the distribution fund for nontribal activities, although we were unable to identify the extent of these incorrect charges. For fiscal years 2018–19 through 2020–21, the Bureau's tribal employees

charged more than 2,200 hours of card-room enforcement activities to the distribution fund, as well as a smaller number of hours for activities such as providing protective services for the Office of the Attorney General (Attorney General) and assisting the Bureau of Firearms with investigations. However, the total number of inappropriately charged hours is unclear because tribal employees also charged large portions of their time—a collective 26 percent—under a broad and vague category called general law enforcement. State law does not specifically prohibit the use of the distribution fund to pay for nontribal law enforcement activities. However, these uses appear to be inconsistent with the intended uses of the distribution fund as outlined in the compacts between the State and the tribes that pay into the fund. Further, they are not among the priority uses of the fund listed in state law.

Recommendation: To determine the amount for the nontribal activities that the Bureau paid for using the distribution fund during fiscal years 2015–16 through 2019–20, the Legislature should require the Department of Justice's Bureau of Gambling Control to calculate and report that information to the Legislature by April 2023. To compensate the distribution fund for these improper expenditures, the Legislature should then create a special appropriation to reimburse the distribution fund.

Status: Not Implemented.

Metropolitan Water District of Southern California

2021-104 *Metropolitan Water District of Southern California: Its Leadership Has Failed to Promote Transparency or Ensure a Fair and Equitable Workplace* (April 2022)

Finding: The Metropolitan Water District of Southern California (MWD) has shown indifference or resistance to improving key areas affecting its organization and employees. Our 2004 audit concluded that MWD had struggled to establish an effective ethics office in compliance with state law, and we made several recommendations to strengthen the office's practices. Although MWD had agreed to implement our recommendations, this audit found that MWD's ethics office still suffers from insufficient policies and procedures, as well as threats to its independence. MWD has failed to comply with state law requirements for an independent ethics office since at least 2004, and it has not implemented key recommendations from our previous report, despite stating that it would do so. MWD also has not adopted best practices to strengthen the ethics office. Moreover, actions by MWD's leadership indicate that it does not respect or, at best, misunderstands the role and legal requirements of its ethics office and is unwilling to make real change. As a result, meaningful improvement will require the Legislature hold MWD accountable for implementing those requirements.

Recommendation: To ensure that the issues we discuss in this report are finally addressed, the Legislature should amend state law to include one or more mechanisms by which it can revoke or limit MWD's authority over key personnel and ethics processes in the event that MWD again fails to take corrective action.

Status: Not Implemented.

Finding: MWD's demonstrated failure to embrace transparency and accountability extends to its hiring processes. Despite MWD's pledge to improve its hiring practices in response to an audit our office conducted in 2004, we identified some of the same shortcomings nearly two decades later. For example, instead of following best practices, MWD operates a hiring process that gives significant discretion to individual hiring managers without corresponding safeguards to ensure that their decisions are free of favoritism or bias. As a result, MWD is unable to consistently ensure or demonstrate that its hiring decisions are equitable or reasonable. Similarly, MWD's process for promoting employees gives significant discretion to managers without sufficient accountability, allowing for the appearance of favoritism or bias. Further, MWD's processes for promoting employees provide significant discretion to managers but lack sufficient accountability. In 2005, shortly after we completed our 2004 audit, MWD instituted changes to its hiring process intended to better ensure fairness and prevent discrimination. However, MWD soon abandoned these improvements to its hiring process. Specifically, the EEO manager stated that MWD's chief operating officer at the time directed her to stop performing these activities in approximately 2007. MWD also has fewer requirements in place than it once did for documenting that the hiring process is unbiased.

Recommendation: To ensure that MWD does not again fail to implement our recommendations, the Legislature should adopt legislation requiring MWD to formally adopt procedures for hiring and promoting employees. In doing so, it should direct MWD to ensure that those procedures include specific guidance to human resources staff and hiring managers on when competitive hiring processes are required, as well as on evaluating and scoring applicants and documenting those reviews. Finally, the Legislature should require MWD to make those procedures available to all MWD staff and applicants and to train relevant staff on following those procedures.

Status: Not Implemented.

Finding: For more than 20 years, state law has required that MWD operate an ethics office to independently investigate rules violations by all members of the organization, including its board of directors. Yet MWD has failed to implement several best practices for ensuring this independence, leaving the office exposed to inappropriate outside influence. Of greatest concern is that MWD's general counsel and the former chair of its board inappropriately interfered in two ethics investigations from 2017, undermining the independence of the ethics office and causing the former ethics officer to change her conclusion in one of the cases. Further, while MWD's administrative code requires the ethics officer to propose ethics rules in areas such as lobbying and conflicts of interest, it does not specifically identify who has the authority to interpret those rules. This ambiguity regarding the ethics officer's authority threatens the office's ability to reach independent determinations on potential rule violations, particularly in instances involving high-ranking employees or board members. MWD's ethics office also lacks the authority to take specific actions to ensure that its work remains free from inappropriate influence. For example, MWD's ethics office does not have unimpeded access to documentation it needs to conduct its investigations. Instead, its administrative code permits the general counsel to disagree with the ethics officer over access to documents, such as access to documents that may be privileged. Such limitations undermine the independence of the ethics office's work, since best practices require that it have unimpeded access to information.

Recommendation: To ensure that MWD's ethics officer has the authority to independently investigate allegations of ethics violations, the Legislature should amend the requirements in existing state law to include the following:

- Establish MWD's ethics officer as the sole authority for interpreting MWD's ethics rules when conducting investigations into alleged ethics violations.
- Grant MWD's ethics officer the authority to contract with outside legal counsel for the purpose of receiving independent legal advice.
- Require any employee within MWD, including board members, to provide to the ethics officer any documents requested as part of an ongoing investigation without waiving any privileges that may apply.
- Prohibit any employee within MWD, including board members, from interfering in any way in an investigation.

> **Status:** Not Implemented. SB 480 (Stern, 2021) would have required the Metropolitan Water District of Southern California to establish and operate an office of ethics and adopt rules relating to inappropriate conduct, including ethics violations. This bill died on August 24, 2022.

State of California Information Security

2021-602 *State High-Risk Update—Information Security: The California Department of Technology's Inadequate Oversight Limits the States' Ability to Ensure Information Security* (January 2022)

Finding: Although one of the California Department of Technology's (CDT) key roles is to oversee information security development for the more than 100 state entities under the Governor's direct authority (reporting entities), it has yet to fully assess the overall status of the State's information security. CDT has failed to take proactive steps to expand its capacity to perform compliance audits, such as hiring more auditors or repurposing existing staff. Moreover, even though CDT requires reporting entities to complete self-assessments of their information security development each year, it has not used this information to inform the overall status of the State's information security.

Recommendation: To strengthen the information security practices of reporting entities, the Legislature should amend state law to require that CDT confidentially submit an annual statewide information security status report, including the maturity metric scores it has calculated and the results of the nationwide review, to the appropriate legislative committees no later than December 2022. This status report should include CDT's plan for assisting reporting entities in improving their information security.

> **Status:** Not Implemented. AB 2190 (Irwin, 2022) would have required the chief of the CDT Office of Information Security to submit an annual statewide information security status report to the Assembly Committee on Privacy and Consumer Protection and the Senate Governmental Organization Committee, with the first report required to be submitted

no later than January 2023. The bill would have also required the status report and any information or records included with the status report to be confidential and prohibit the information or records from being disclosed. This bill died in the Senate.

Finding: State law generally requires reporting entities to comply with the information security policies and procedures that CDT prescribes and to regularly report to CDT on their compliance. State law does not apply CDT's requirements to entities that fall outside of the Governor's direct authority (nonreporting entities). When we surveyed 32 nonreporting entities, we found that they have not adequately addressed their information security. Although 29 of the 32 nonreporting entities have adopted an information security framework or standards, only four reported that they had achieved full compliance with their chosen framework or standards. In our previous report, we identified gaps in oversight that have contributed to nonreporting entities' information security weaknesses. We also noted that some nonreporting entities have an external oversight framework that requires them to assess their information security regularly. We found that nonreporting entities with external oversight were generally further along in their information security development than those without such oversight.

Recommendation: To strengthen the information security practices of nonreporting entities, the Legislature should amend state law to require each nonreporting entity to adopt information security standards comparable to SAM 5300 and to provide a confidential, annual status update on its compliance with its adopted information security standards to legislative leadership, including the president pro tempore of the California State Senate, the speaker of the California State Assembly, and minority leaders in both houses. It should also require each nonreporting entity to perform or obtain an audit of its information security no less frequently than every three years.

Status: Implemented. AB 2135 (Chapter 773, Statutes of 2022) requires certain nonreporting entities to adopt and implement information security and privacy policies, standards, and procedures based upon standards issued by the National Institute of Standards and Technology and the Federal Information Processing Standards. The bill requires these state agencies to perform a comprehensive, independent security assessment every two years and authorizes them to contract with the Military Department, or with a qualified responsible vendor, for that purpose. Further, this bill requires certain nonreporting agencies to certify, by February 1 annually, to the President pro Tempore of the Senate and the Speaker of the Assembly, that the agency is in compliance with all adopted policies, standards, and procedures and to include a plan of action and milestones. The certification must be kept confidential and may not be disclosed, except that the information and records may be shared, maintaining a chain of custody, with the members of the Legislature and legislative employees, at the discretion of the President pro Tempore of the Senate or the Speaker of the Assembly.

Finding: Of the 20 surveyed nonreporting entities that allow employees to use personally owned devices for teleworking, only five provided any training on properly configuring and securing personal devices.

Recommendation: To strengthen the information security practices of nonreporting entities, the Legislature should amend state law to require nonreporting entities that allow employees to telework to develop telework policies and training comparable to those CDT requires.

Status: Not Implemented.

HEALTH & HUMAN SERVICES

Department of Health Care Services and the California Department of Tax and Fee Administration

2021-046 *Proposition 56 Tobacco Tax: The Department of Health Care Services Is Not Adequately Monitoring Provider Payments Funded by Tobacco Taxes* (November 2022)

Finding: State law allows the Department of Health Care Services (DHCS) to issue a temporary provider suspension if it becomes aware that a provider is under investigation for fraud or abuse. State law also requires DHCS, unless it makes a specified determination, to issue a temporary payment suspension when it receives a credible allegation of fraud and an investigation is pending against the provider under the Medi-Cal program. However, according to the chief of DHCS's Sanctions Section, it did not implement temporary suspensions in certain cases we reviewed because it was not aware of the criminal charges that would have justified the temporary suspension. Although DHCS has the authority to require providers to obtain criminal background checks, it is neither required to, nor does it, conduct those checks on the vast majority of providers. Some Medi-Cal providers are already required to obtain them by other entities. Specifically, many state licensing boards, such as the Medical Board of California, Dental Board of California, and California State Board of Pharmacy, require their applicants to undergo criminal background checks. These checks enable the boards to receive subsequent notifications of arrests and dispositions against the individuals. However, according to state law, a person authorized by law to receive state summary criminal history records or information cannot knowingly share those records or that information with someone not authorized by law to receive it. If DHCS were able to implement agreements with the state licensing boards to share such information, it could receive timely notice of the arrests of some providers when the arrest involves a credible allegation of fraud or indicates the provider is under investigation for fraud or abuse. This notification would enable DHCS to determine whether to impose a temporary payment suspension or temporary provider suspension against such providers when warranted. Our review of fee-for-service claims by providers that received Proposition 56 payments found that DHCS paid a total of $380,000 in both Proposition 56 funds and other Medi-Cal funds to 14 providers that state and federal lists had identified as ineligible. DHCS's failure to regularly issue temporary payment suspensions and temporary provider suspensions and its inability to obtain criminal history information from licensing boards might be placing a significant number of Medi-Cal beneficiaries at risk of receiving services from providers that DHCS should have suspended. In one example, the DOJ notified DHCS of a provider's conviction for grand theft and elder abuse in October 2020; however, DHCS did not implement the mandatory provider suspension until January 2021. Although DHCS processed this suspension within four months, the provider rendered another 2,200 services during this period. Further, DHCS could have imposed a temporary provider suspension or a temporary payment suspension as early as May 2020—the month when DOJ charged the provider with multiple crimes involving fraud, including grand theft, Medi-Cal fraud, and elder abuse. From the date of the charges in May 2020 through the date that DHCS formally issued a suspension in January 2021, this provider delivered more than 12,000 services, for which DHCS paid him $275,000. We believe that a significant number of additional instances may have occurred in which the amount of time that DHCS took to respond to providers' convictions exposed Medi-Cal beneficiaries to unnecessary risk.

Recommendation: To better protect Medi-Cal beneficiaries, the Legislature should consider amending state law to permit DHCS and the boards that license Medi-Cal providers to execute agreements that would allow those licensing boards to provide DHCS with timely information from the notifications sent to the licensing boards when Medi-Cal providers are arrested and the arrest involves a credible allegation of fraud or indicates the provider is under investigation for fraud or abuse.

Status: Not Implemented. (Report issued in November 2022.)

Department of Developmental Services

2021-120 *In-Home Respite Services: The Department of Developmental Services Has Not Adequately Reduced Barriers to Some Families' Use of In-Home Respite Services* (August 2022)

Finding: State law requires the Department of Developmental Services (DDS) and regional centers to solicit feedback from stakeholders to identify barriers to receiving services, including respite services. Regional centers must report to DDS annually on the results of these stakeholder interactions and identify actions to reduce disparities and increase equity in families' use of respite services. State law also requires DDS to consult with stakeholders to review demographic data and identify barriers to families' equitable access to respite services as well as actions to reduce disparities and increase equity. As the oversight agency responsible for ensuring that consumers have equal access to all services, state law requires DDS to allocate funding to the regional centers in order to implement the plans and recommendations developed as a result of stakeholder consultations. Thus, we would expect DDS to ensure that regional centers develop sufficient actions to address disparities and report to it on the implementation of those actions or recommendations. However, although DDS ensured that the regional centers we reviewed solicit feedback from stakeholders and report annually to it on disparities and challenges that families experience, it did not ensure that they identify specific, measurable actions and timelines for reducing these barriers. From fiscal years 2016–17 through 2019–20, the regional centers' planned actions to remove barriers and reduce disparities in the use of respite services have been insufficient. Although some of the actions the regional centers identified were described in detail, they often did not include measurable actions with expected outcomes or timelines, and many other actions were presented only at a high level, with insufficient detail. DDS neither ensures that the regional centers develop sufficient actions to reduce disparities and increase equity, nor does it follow up on these actions that are developed by requiring regional centers to report on the status of these actions or recommendations.

Recommendation: The Legislature should amend state law to require regional centers to include in their annual disparity reports to DDS—which show demographic data about the users of in-home respite services— specific, measurable actions to reduce barriers and disparities in the use of these services. At a minimum, these reports should identify the following:

- Concrete, measurable actions the regional center will take to improve access to in-home respite services.
- Timelines for completing those actions, including specific intervals for periodic updates on progress.
- Specific outcomes the regional center plans to achieve through these actions.

Status: Not Implemented.

Finding: State law requires DDS and regional centers to solicit feedback from stakeholders to identify barriers to receiving services, including respite services. Regional centers must report to DDS annually on the results of these stakeholder interactions and identify actions to reduce disparities and increase equity in families' use of respite services. From fiscal years 2016–17 through 2019–20, the regional centers' planned actions to remove barriers and reduce disparities in the use of respite services have been insufficient. Although some of the actions the regional centers identified were described in detail, they often did not include measurable actions with expected outcomes or timelines, and many other actions were presented only at a high level, with insufficient detail. DDS neither ensures that the regional centers develop sufficient actions to reduce disparities and increase equity, nor does it follow up on these actions that are developed by requiring regional centers to report on the status of these actions or recommendations.

Recommendation: The Legislature should amend state law to require DDS to submit a plan to the Legislature during the annual budget process that outlines the specific and measurable actions it will take to reduce barriers and disparities in the use of in-home respite services.

Status: Not Implemented.

Finding: State law also requires DDS to consult with stakeholders to review demographic data and identify barriers to families' equitable access to respite services as well as actions to reduce disparities and increase equity. As the oversight agency responsible for ensuring that consumers have equal access to all services, state law requires DDS to allocate funding to the regional centers in order to implement the plans and recommendations developed as a result of stakeholder consultations. Thus, we would expect DDS to ensure that regional centers develop sufficient actions to address disparities and report to it on the implementation of those actions or recommendations. However, although DDS ensured that the regional centers we reviewed solicit feedback from stakeholders and report annually to it on disparities and challenges that families experience, it did not ensure that they identify specific, measurable actions and timelines for reducing these barriers. From fiscal years 2016–17 through 2019–20, the regional centers' planned actions to remove barriers and reduce disparities in the use of respite services have been insufficient. Although some of the actions the regional centers identified were described in detail, they often did not include measurable actions with expected outcomes or timelines, and many other actions were presented only at a high level, with insufficient detail. DDS neither ensures that the regional centers develop sufficient actions to reduce disparities and increase equity, nor does it follow up on these actions that are developed by requiring regional centers to report on the status of these actions or recommendations.

Recommendation: To ensure that DDS takes adequate actions to verify that regional centers address barriers, the Legislature should amend state law to do the following:

- Require DDS to annually follow up with regional centers by instructing the centers to produce a status report each year on steps they have taken to reduce barriers to using in-home respite services.
- Require corrective actions from regional centers that DDS determines have failed to take sufficient action.

Status: Not Implemented.

Finding: We were unable to determine whether regional centers actually impose limits on respite hours in practice. Our testing of authorization files identified many instances when regional centers did not document their rationale for the number of respite hours they awarded. Neither state law nor DDS requires regional centers to document such rationale. However, prudent business practices suggest that regional centers need to consistently demonstrate how they determined the appropriate number of respite hours to authorize so that DDS, family caregivers, and consumers have assurance that regional centers are not applying limits on respite hours. Staff at DDS and the regional centers indicated that respite hours are authorized on a case-by-case basis depending on each family's circumstances. State law requires regional centers to consider services and other support in the community, home, work, and recreational settings when determining how many respite hours to authorize. However, neither this broad mandate nor state regulations specify how regional centers must carry out and document these considerations. In fact, the regional centers we reviewed do not follow a consistent process for documenting how they determine the number of respite hours they authorize. One of the four regional centers we reviewed—San Diego—has a respite assessment tool that it requires its staff to use to determine the number of respite hours to award. In its role overseeing regional centers, DDS is in an ideal position to develop a standard method for regional centers to justify their determination of hours and to document their rationale. Doing so would ensure transparency and support the regional center's decisions when responding to complaints or appeals about respite hours they authorize.

Recommendation: To promote transparency and accountability, the Legislature should require DDS to promulgate regulations establishing a standard method—similar to the assessment tool used by some regional centers—for regional centers to document their rationale for determining the amount of in-home respite hours they authorize.

Status: Not Implemented.

Finding: As required by state law, DDS's consultant completed a rate study in 2019 that recommended increasing the payment rates for respite services. Subsequently, the State enacted legislation in 2021 requiring that DDS implement the new rates incrementally between April 2022 and July 2025. In June 2022, the State accelerated that timeline and required DDS to fully implement the new rates by July 2024. The deputy director of administration believes that these rate increases will help increase the availability of respite workers. However, the increases may not be sufficient because the rate study's assumptions rely on a long-term average that is lower than the current one-year inflation rate as of March 2022. DDS indicated it does not plan to perform another rate study, and state law does not require it to regularly do so. DDS stated on its website in response to a question about annual cost-of-living adjustments that updates to the rate models after 2025 would be subject to approval through the State's budget process. Consequently, the planned rate increases may not be enough to attract and retain a sufficient number of respite workers, which emphasizes the need for DDS to regularly assess and update rates.

Recommendation: The Legislature should require DDS to, every two years, determine whether the current reimbursement rates for in-home respite services are sufficient to attract an adequate number of respite workers statewide and to adjust the rates accordingly.

Status: Not Implemented.

Finding: DDS has been slow to implement other recommendations from the payment rate study that could reduce barriers. The 2019 rate study also included recommendations that DDS adopt higher rates for workers who speak languages other than English and for workers with specialized training. However, in July 2021, the Legislature declared that DDS had not implemented these recommendations from the rate study. DDS indicated that it is in the process of implementing a financial incentive for bilingual respite workers, which it anticipates will start during fiscal year 2022–23. Similarly, DDS is establishing a broad training program to provide training for skills including crisis prevention and to increase wages for those respite workers who complete the training. However, this program is still in the planning stages, and DDS does not anticipate its implementation until summer 2023. DDS also received funds in the fiscal year 2022–23 budget to provide stipends of up to $1,000 for respite workers who complete some training. Although these recommendations were included in the rate study, the rate model implemented in April 2022 does not include enhanced rates for bilingual respite workers or those who have specialized training.

Recommendation: The Legislature should require DDS to, every two years, evaluate, develop, and implement incentives, as necessary, to attract in-home respite workers with skills and abilities that can reduce barriers, including the shortage of respite workers who are bilingual or who are trained in dealing with specific behaviors.

Status: Not Implemented.

California Department of Public Health, California Department of Health Care Services, and the California Department of Justice

2021-123 *California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse* (March 2022)

Finding: In the past 10 years, growth in the number of hospice agencies in Los Angeles County has vastly outpaced the need for hospice services. Although the majority of hospice services were provided by nonprofit organizations in the past, this recent wave of growth is almost exclusively in for-profit companies. Further, numerous indicators suggest that many of these hospice agencies may have been created to fraudulently bill Medicare and Medi-Cal for services rendered to ineligible patients or services not provided at all. The state agencies responsible for overseeing hospice care in California have failed to take adequate measures to prevent such fraud or to protect patients from unqualified and unscrupulous providers. The prevalence and number of fraud indicators in Los Angeles County suggest a large-scale, targeted effort to defraud Medicare and Medi-Cal. Despite these widespread problems in the hospice program, the California Department of Public Health (Public Health) and the two state agencies primarily responsible for identifying and investigating hospice fraud in Medi-Cal—the DHCS and the DOJ—have not sufficiently coordinated their efforts. The lack of such coordination has resulted in gaps in the system, which is designed to protect hospice patients from harm and to guard the State's Medi-Cal system against fraud. These siloed and disjointed efforts by state agencies are not sufficient to address the large-scale fraud that is likely occurring in the hospice industry.

Recommendation: To address fraud that is likely occurring in Los Angeles County, the Legislature should require Public Health, DHCS, DOJ, and the California Department of Social Services (Social Services) to immediately convene a taskforce to identify, investigate, and prosecute fraud and abuse by hospice agencies in that county. It should also require those four departments to establish a working group to annually meet to conduct a risk assessment of the Medi-Cal hospice program statewide, including performing analyses similar to those we conducted during this audit regarding growth in the number of hospice agencies, clustering of hospice agencies, and instances of medical personnel working at multiple hospice agencies. Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider risks related to home health agencies. These departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

> **Status:** Partially Implemented. The Budget Act of 2022, SB 154 (Chapter 43, Statutes of 2022) includes $1 million to establish and facilitate a Hospice Fraud Task Force including representation from the California Health and Human Services Agency, State Department of Public Health, State Department of Health Care Services, State Department of Social Services, and Department of Justice. This bill requires the taskforce to work to address fraud in the hospice services industry in California by identifying and investigating fraud and referring identified cases of suspected fraud to the Department of Justice for prosecution. By January 1, 2025, the task force shall provide a recommendation to the Legislature on whether or not the task force should be established permanently to continue its work on an ongoing basis.

Finding: Public Health—the state agency primarily responsible for the licensing and oversight of hospice agencies—has failed to take adequate action in the face of such widespread problems. We reviewed cases in which Public Health became aware of possible fraud during the licensing process and, instead of denying the licenses, it granted licenses to these hospice agencies. In these instances, it essentially enabled hospice agency operators who are possibly fraudulent to continue functioning, placing patients at serious risk of not receiving appropriate care. Public Health is responsible for licensing, inspecting, and investigating complaints related to hospice agencies. However, it has performed these functions incompletely and inadequately and, as a result, its oversight offers the public little assurance that hospice agencies will provide high-quality care. Its process for screening agencies' initial licensing applications fails to address instances when they hire unqualified personnel or when they establish excessively large service areas with long response times for caregivers. Perhaps most egregiously, we found instances where Public Health did not deny applications even when its staff identified information that indicated possible fraudulent behavior, such as applications containing potentially false statements.

Recommendation: The Legislature should require fraud training for any Public Health staff who are responsible for licensing and certifying hospice agencies, including training about the types of information that are necessary for making referrals to DOJ when they suspect fraud is occurring.

> **Status:** Not Implemented.

Finding: Public Health's lax licensing process has allowed the likelihood of large-scale fraud. According to state law, the licensing process is meant to protect the health and safety of patients by ensuring that hospice agencies are qualified to provide services. However, Public Health has not issued key regulations for hospice licensing, and the current licensing requirements are inadequate to protect patients. Public Health lacks requirements related to criminal background checks of key hospice agency personnel; verifying the need for hospice agencies in the proposed location; the size of the hospice agency's service area; the ratio of nurses to patients; and staff employment by multiple hospice agencies. Even when applicants submit required information, Public Health makes insufficient effort to verify that the information is accurate. It does not consistently confirm the experience, education, resources, or character of hospice applicants. When determining whether an applicant is of good moral character, Public Health simply requests that the applicant assert in the licensing application whether they have a criminal record. State law requires Public Health to conduct criminal background checks when approving licenses for certain other health agencies providing care in the home, such as for home health agency owners and administrators. However, state law does not have a corresponding requirement for hospice owners and administrators, which we believe places hospice patients' safety at risk.

Recommendation: To help ensure that hospice owners and hospice management personnel are of good moral character, the Legislature should revise state law to require that each hospice agency's owners, and the hospice agency's administrator, director of patient care services, administrator/director of patient care services designee, and medical director (hospice management personnel) submit electronic fingerprint images to DOJ for the furnishing of the person's criminal record to Public Health. The revision should also include a requirement that hospice owners and management personnel with certain criminal convictions, as determined by the Legislature, are prohibited from obtaining a license and are further prohibited from providing any hospice-related service before obtaining either a criminal record clearance or a criminal record exemption from Public Health.

Status: Not Implemented.

Finding: During the course of our audit, we identified numerous indicators of fraud and abuse connected to hospice agencies located in Los Angeles County. These indicators include rapid, disproportionate growth in the number of hospice agencies; excessive geographic clustering of hospice agencies; long durations of hospice services; high rates of patients discharged alive; and employees working for a large number of hospice agencies. Based on the available evidence, we are concerned that numerous unscrupulous individuals are likely creating hospice agencies and applying for licenses to fraudulently bill Medicare and Medi-Cal either for services that they are providing to patients who are ineligible for hospice care or for services that they are not providing at all. Such fraud places at risk the extremely vulnerable population of hospice patients, who are often physically and cognitively disabled and who rely on their hospice care providers to ensure that they receive adequate end-of-life care. From its enactment in 1990 until January 1, 2022, the California Hospice Licensure Act of 1990 (Licensure Act) has not required Public Health to assess the need for hospice services when issuing hospice licenses. In the absence of such measures, Los Angeles County has experienced significant growth of hospice agencies that is disproportionate to the estimated increase in its number of hospice patients and its demand for hospice services.

Recommendation: To protect against excessive and fraudulent growth in the number of hospice agencies, the Legislature should revise state law to require new, previously unlicensed hospice agencies to demonstrate an unmet need for hospice services in an area where they wish to operate. The law should require that the number of hospice agencies in a given geographic region closely aligns with measures of the need for hospice services. It should also define appropriate measures of need and identify the methodology hospice agencies must use to demonstrate need.

> **Status:** Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) revises and expands the department's application requirements, and additionally requires an applicant for a hospice agency license to, as a condition of licensure, demonstrate and provide evidence of an unmet need of hospice services in the geographic region the hospice would serve, except under specified circumstances. However, this bill neither requires that the number of hospice agencies in a given geographic region closely align with measures of need for hospice services, nor defines the appropriate measures of need and identifies the methodology hospice agencies must use to demonstrate need.

Finding: One critical consideration that Public Health has failed to adequately address in its licensing process is a hospice agency's ability to respond promptly to patient care and safety concerns. State law requires each home health agency to submit to Public Health proof of sufficient financial resources needed to operate its business as part of its licensing application. However, Public Health does not have a similar requirement for hospice agencies, even though this information would provide greater detail about the size of each hospice agency's operations.

Recommendation: To enable Public Health to better oversee the licensure of hospice agencies, the Legislature should require as a part of the licensure application the inclusion of financial information that is similar to the information required for home health agencies.

> **Status:** Not Implemented.

Finding: Public Health is responsible for licensing, inspecting, and investigating complaints related to hospice agencies. However, it has performed these functions incompletely and inadequately and, as a result, its oversight offers the public little assurance that hospice agencies will provide high-quality care. Its process for screening agencies' initial licensing applications fails to address instances when they hire unqualified personnel or when they establish excessively large service areas with long response times for caregivers. Public Health has issued licenses to hospice agencies with service areas of up to 31 counties, sometimes in areas of heavy traffic and long drive times. In fact, a complaint filed with Public Health alleged that dozens of hospice agencies located in Los Angeles County were providing substandard services to patients located more than 100 miles away. In our review of licensing files, we noted some instances where Public Health staff at its Sacramento County district office have raised questions as to whether the response time from the hospice agency to patient locations was likely to be long, such as greater than an hour. However, the district office was ultimately unable to limit the size of agencies' service areas because Public Health has not established such limitations in its regulations. In October 2021, the Legislature passed a general moratorium on licensing new hospice agencies beginning January 1, 2022, and lasting until one year after the publication of this report, to spur attention and action to improve what many stakeholders, including hospice providers themselves, agree is a regulatory system in need of reform.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish time and distance standards that define the maximum time and distance hospice agency staff may travel to reach patients, taking into consideration typical traffic conditions and whether the hospice agency is serving patients in rural or urban areas.

> **Status:** Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill requires the emergency regulations to establish time and distance standards as described in the audit recommendation.

Finding: One critical consideration that Public Health has failed to adequately address in its licensing process is a hospice agency's ability to respond promptly to patient care and safety concerns. For example, Public Health has not issued regulations governing the size of the geographic area that a hospice agency can serve or the ratio of nurses to patients. Consequently, it cannot regulate whether a hospice agency can accommodate its proposed service area or adequately serve all of its patients. Although its current procedure allows each of its district offices to make its own determination as to a hospice agency's service area size, Public Health rarely obtains evidence from hospice agencies to evaluate whether the staffing levels of the hospice agency align with its proposed service area coverage. Further, state law requires each home health agency to submit to Public Health proof of sufficient financial resources needed to operate its business as part of its licensing application. However, Public Health does not have a similar requirement for hospice agencies, even though this information would provide greater detail about the size of each hospice agency's operations.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish guidelines for assessing the appropriateness of a hospice agency's ratio of patients to nurses.

> **Status:** Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill requires the emergency regulations to establish standards for a hospice agency's ratio of nurses to patients.

Finding: Public Health has also not issued regulations to prevent hospice staff from working at many hospice agencies concurrently, a factor that directly affects patient care quality. In our review of Public Health's data and licensing files, we discovered many such cases. For instance, we reviewed an application in which the individual whom the hospice agency proposed would serve as its medical director was already the active or planned medical director for more than 30 other hospice agencies—a questionable number for a person who is charged with the responsibility of developing plans of care, directing the interdisciplinary teams, consulting with the patients' attending physicians, and liaising with other physicians in the community to coordinate efforts to ensure that each patient receives quality care. However, Public Health does not have regulations addressing this issue, and it licensed that hospice agency.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish a limit to the number of hospice agencies that hospice management personnel can be involved with concurrently.

> **Status:** Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill requires the emergency regulations to establish a limit for the number of hospice agencies that hospice agency management personnel can be involved with concurrently.

Finding: Public Health is responsible for licensing, inspecting, and investigating complaints related to hospice agencies. However, it has performed these functions incompletely and inadequately, and as a result, its oversight offers the public little assurance that hospice agencies will provide high-quality care. Its process for screening agencies' initial licensing applications fails to address instances when they hire unqualified personnel or when they establish excessively large service areas with long response times for caregivers. Moreover, because Public Health relies on hospice industry standards rather than its own regulations to guide its oversight, its initial licensing site visits do not effectively ensure adequate patient care and prevent fraud. It has also missed many additional opportunities to oversee hospice agencies because it fails to consistently obtain inspection reports from accreditors and frequently neglects to request meaningful information or perform inspections upon license renewal. Even when applicants submit required information, Public Health makes insufficient effort to verify that the information is accurate. It does not consistently confirm the experience, education, resources, or character of hospice applicants. Although its procedure requires Public Health to check its system and online sources for prior management experience in hospice agencies, it does not consistently do so. Further, it does not call references to verify employment or always follow up on discrepancies when the experience cited in the application does not match licensing records. Moreover, when determining whether an applicant is of good moral character, Public Health simply requests that the applicant assert in the licensing application whether they have a criminal record. State law requires Public Health to conduct criminal background checks

when approving licenses for certain other health agencies providing care in the home, such as for home health agency owners and administrators. However, state law does not have a corresponding requirement for hospice owners and administrators, which we believe places hospice patients' safety at risk.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Require hospice management personnel to have hospice-specific training or experience.

    Status: Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill requires the emergency regulations to require hospice agency management personnel to meet minimum standards of training and experience, including, but not limited to, hospice-specific training or experience.

Finding: Public Health has also failed to consistently verify the medical and nursing licenses of the professionals who work at the hospice agencies. Although its procedures require such checks for physicians and managing nurses, its staff did not document that they performed them for at least one medical position in eight of 10 licensing files we reviewed. For example, it did not verify the status of the license of a medical director whom we found had been placed on probation by the Medical Board of California for gross negligence and failure to maintain accurate medical records at the time the hospice agency reported hiring him. Further, Public Health's procedures do not require that it verify the licenses of hospice physicians whose work is managed by the medical director. As a result, it did not identify that one such individual's medical license showed a history of probation for gross negligence and repeated negligent acts. Moreover, Public Health has not created a policy that clarifies the types of problems pertaining to a medical license that would disqualify individuals from providing hospice services.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Require, as part of its review of the initial application, that Public Health verify that the hospice management personnel listed on the licensing application are, in fact, associated with the hospice agency, such as by contacting them by phone, and verify the work history of hospice management personnel by speaking with these individuals' previous employers by phone.

Status: Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill also requires Public Health to verify the status of professional licensure for hospice agency personnel and allows Public Health to verify the association of hospice agency management personnel listed on the licensing application with the hospice agency and to verify the work history of hospice agency management personnel. This bill states that verification may include contacting the hospice agency personnel or previous employers by telephone.

Finding: Public Health has also failed to consistently verify the medical and nursing licenses of the professionals who work at the hospice agencies. Although its procedures require such checks for physicians and managing nurses, its staff did not document that they performed them for at least one medical position in eight of 10 licensing files we reviewed. For example, it did not verify the status of the license of a medical director whom we found had been placed on probation by the Medical Board of California for gross negligence and failure to maintain accurate medical records at the time the hospice agency reported hiring him. Further, Public Health's procedures do not require that it verify the licenses of hospice physicians whose work is managed by the medical director. As a result, it did not identify that one such individual's medical license showed a history of probation for gross negligence and repeated negligent acts. Moreover, Public Health has not created a policy that clarifies the types of problems pertaining to a medical license that would disqualify individuals from providing hospice services.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Require Public Health to verify the status of the professional licenses for all hospice medical personnel, including contracted medical directors, as part of the initial license application. The regulations should also establish guidelines for when Public Health must deny the application of a hospice agency that is proposing to use medical personnel whose professional license records indicate the imposition of a disciplinary action. For instance, probation for gross negligence or fraudulent billing should be a cause to deny a hospice agency's application, even if the medical director's license is currently active.

Status: Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Further, this bill also requires Public Health to verify the status of professional licensure for hospice agency personnel. However, this bill does not specifically require the regulations to include

guidelines for when Public Health must deny the application of a hospice agency that is proposing to use medical personnel whose professional license records indicate the imposition of a disciplinary action.

Finding: Public Health's site visits of hospice agencies' business offices are also ineffective. Once it approves a licensing application, Public Health performs an initial site visit to ensure that the hospice agency will comply with hospice standards. Public Health performs its site visit before a new hospice agency is licensed and operating, which allows it to check for adequate office space and the ability to secure confidential personnel and medical files. However, Public Health has not developed any procedures for how to properly conduct initial site visits, other than a checklist of the hospice standards. Consequently, it lacks effective procedures to deter fraud, such as a requirement that it verify the identities of key hospice personnel. Further, some of what Public Health looks for during a site visit is impossible for it to evaluate before the agency begins operating. For example, hospice standards require the director of patient care services to devote a sufficient number of hours to the hospice agency, which is not possible to assess when the hospice agency has not yet been licensed. To be able to review such requirements, Public Health would need to perform a subsequent review after the hospice agency is licensed and operating. Consequently, the initial site visits have limited value in determining the fitness of the hospice agency to see patients.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish requirements for conducting an initial licensing site visit that include verifying the identities of all hospice personnel and ensuring that the hospice agency is set up to provide adequate care. Public Health should develop specific requirements for hospice office space and verify compliance with those requirements during the initial site visit.

Status: Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, the Department of Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. Requires the emergency regulations to establish specific requirements for hospice agency office space. However, this bill does not specifically require the regulations to include requirements for conducting an initial licensing site visit that include verifying the identities of all hospice personnel and ensuring that the hospice agency is set up to provide adequate care.

Finding: Public Health's site visits of hospice agencies' business offices are also ineffective. Once it approves a licensing application, Public Health performs an initial site visit to ensure that the hospice agency will comply with hospice standards. Public Health performs its site visit before a new hospice agency is licensed and operating, which allows it to check for adequate office space and the ability to secure confidential personnel and medical files. However, Public Health has not developed any procedures for how to properly conduct initial site visits, other than a checklist of the hospice standards. Consequently, it lacks effective procedures to deter fraud, such as a requirement

that it verify the identities of key hospice personnel. Further, some of what Public Health looks for during a site visit is impossible for it to evaluate before the agency begins operating. For example, hospice standards require the director of patient care services to devote a sufficient number of hours to the hospice agency, which is not possible to assess when the hospice agency has not yet been licensed. To be able to review such requirements, Public Health would need to perform a subsequent review after the hospice agency is licensed and operating. Consequently, the initial site visits have limited value in determining the fitness of the hospice agency to see patients.

Recommendation: To protect the health and safety of current and prospective hospice patients, the Legislature should require Public Health to issue emergency regulations within one year, while maintaining the general moratorium on new hospice licenses until Public Health issues the regulations. The emergency regulations should do the following:

- Establish requirements for follow-up inspections to the initial site visits within one year of initial licensing to verify that hospice agencies are complying with those hospice standards that cannot be assessed before the agencies begin providing care to patients. These inspections should be unannounced and take place after the hospice agency has begun caring for patients. During these inspections, Public Health should visit patients, ensure that the certifications of terminal illness are accurate, confirm that the hospice agency is providing adequate care, check hospice personnel identities and medical licenses, and ensure that the hospice agency has reported any personnel changes.

Status: Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, among other things, Public Health to issue emergency regulations to implement the recommendations in this audit report. This bill requires Public Health to maintain the moratorium on new hospice agencies until it adopts regulations, but no later than March 29, 2024, two years from the date we issued our audit report. However, this bill does not specifically require the regulations to include requirements for follow-up inspections to the initial site visits within one year of initial licensing to verify that hospice agencies are complying with those hospice standards that cannot be assessed before the agencies begin providing care to patients.

Finding: The license to operate as a hospice agency is valid for 24 months, after which the hospice agency must submit an application for renewal and a renewal fee of $2,971. Although the Licensure Act permits Public Health to inspect hospice agencies, it does not require Public Health to conduct an inspection as part of license renewal. Public Health does not generally require inspections of hospice business offices or patient locations after the initial licensing site visit. According to its procedures, Public Health may perform periodic inspections, which would allow Public Health to verify that the hospice agency is providing care according to standards. However, it performs these inconsistently because its policy suggests they should happen "as needed," which is an ambiguous guideline. As a result, it is possible for hospice agencies to operate for years without any meaningful state oversight to ensure that they are providing sufficient care to their patients and are not committing fraud. In addition, Public Health fails to gather crucial information about hospice agencies through its biennial license renewal process. When a hospice agency is required to renew its license, Public Health sends a notification that requests that the agency pay the renewal

fee and verify the names of the managing personnel recorded in Public Heath's licensing system, including key positions who are responsible for patient care such as the hospice administrator and medical director.

Recommendation: To ensure that all licensed hospice agencies comply with Public Health's newly adopted regulations, the Legislature should revise state law to require Public Health to conduct a license renewal for all currently licensed hospice agencies within two years after the regulations are adopted. It should also revise state law to require Public Health to perform license renewal inspections for all licensed hospice agencies periodically. If it performs them at least every 18 months, every other cycle will coincide with Medicare recertification inspections, which are required at least every 36 months.

Status: Not Implemented.

Finding: As of January 2022, Public Health data showed that roughly 1,400 hospice agencies, representing half of the total number in the State, had deemed status. Hospice agencies with deemed status have been deemed by a federally approved accreditor to meet Medicare requirements for certification. Since 2019 state law has required Public Health to issue licenses to hospice agencies that have been approved by an accreditor as long as the hospice agency also files an application and pays fees. Accreditors perform many initial site visits and certification/recertification inspections in California. However, before issuing a license to a deemed-status hospice agency, state law requires Public Health to receive from the accreditor copies of all accreditation reports or findings. Public Health's contracts with the accreditors require them to submit the results and a copy of their full reports for each initial site visit or recertification visit to Public Health. However, Public Health has not required the accreditors to provide complete documentation of their visits showing how they ensured that hospice agencies meet federal and state requirements. Instead, Public Health receives only a letter or report providing the final determinations of whether they accredited the hospice agency, sometimes with deficiencies listed. In the absence of such reports, there is limited information available about the quality of care that deemed-status hospice agencies are providing.

Recommendation: To increase oversight of deemed-status hospice agencies, the Legislature should amend state law to require Public Health to do the following:

- Collect and monitor full reports from accreditors for all current and future deemed-status hospice agencies.

Status: Not Implemented.

Finding: Public Health has not audited any deemed-status hospice agencies, even though state law and Public Health's contracts with the accreditors authorize it to do so. These audits are intended to verify that the agencies have met hospice accreditation requirements. In the absence of any audits or the reports we discuss above, Public Health will have difficulty verifying that accreditors are complying with state law when reviewing hospice agencies. The high proportion of complaints involving deemed-status hospice agencies is troubling, as is the lack of complete information about the quality of their services in general.

Recommendation: To increase oversight of deemed-status hospice agencies, the Legislature should amend state law to require Public Health to do the following:

- Annually audit a selection of at least 5 percent of deemed-status hospice agencies and monitor these agencies to ensure that they take any necessary corrective actions.

 Status: Not Implemented.

Finding: Public Health has not sought the establishment of statutory sanctions as a means to protect patients from violations of state hospice care standards. State law authorizes the imposition of monetary sanctions to protect the health and safety of individuals receiving care in settings such as long-term care facilities and hospitals. However, according to the acting deputy director of the Center for Health Care Quality, Public Health has not sought statutory changes to establish civil fines or other sanctions to address serious problems relating to hospice care, such as harm to patients. Recently, the Centers for Medicare and Medicaid Services made changes to federal hospice oversight that impose additional sanctions on hospice agencies that are similar to those for home health agencies, including the suspension of Medicare payments and the imposition of fines. However, the California Licensure Act of 1990 lacks meaningful sanctions for violations of state law or hospice standards.

Recommendation: The Legislature should revise state law to include a system of sanctions for Public Health to levy, including fines or license revocation, for the following:

- Violations of state law, regulations, or hospice standards by a hospice agency, including improperly certifying a patient as eligible for hospice care.

 Status: Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) adds to the list of reasons for which the department may deny, suspend, or revoke a hospice agency license, including improperly certifying a patient as eligible for hospice care, and demonstrating a pattern and practice of violations of state or federal standards during the last 3 years of a hospice agency owned, operated, or managed by the applicant or licensee.

Finding: We reviewed Public Health's results of its investigations performed in January 2021 and noted several concerns related to a hospice agency it reviewed. In addition, Public Health's inspections included troubling observations of staff being unavailable and patients unknowingly being admitted or not qualifying for services at certain home health agencies. Nonetheless, because Public Health indicated that it could not substantiate the occurrence of fraudulent activities at the investigated agencies, the investigation concluded with Public Health taking no action to suspend or revoke any of the licenses in question. Additionally, the California Licensure Act of 1990 does not currently have monetary penalties that Public Health can use to sanction hospice agencies that exhibit deficiencies, and it rarely uses its authoritative power of revoking a hospice agency's license. As a result, we are concerned that it is enabling fraud, abuse, and neglect to continue or reoccur, thus risking the health and safety of vulnerable hospice patients.

Recommendation: The Legislature should revise state law to include a system of sanctions for Public Health to levy, including fines or license revocation, for the following:

- Failure by hospice management personnel to be present for an inspection or complaint investigation.

> **Status:** Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) adds to the list of reasons for which the department may deny, suspend, or revoke a hospice agency license, including failure by hospice agency management personnel to cooperate with the department for the purposes of conducting an inspection or complaint investigation.

Finding: Although Public Health requires hospice agencies to report when they change owners or locations, it has not created guidelines for when these changes require a new inspection. It instructs hospice agencies to submit a new application form when such changes take place that asks for the same information as the original licensing application, such as the names of the owners and a copy of the lease, if applicable. However, it does not have a process for enforcing the submission of this application or have a requirement to perform an inspection when these changes take place. Consequently, hospice owners can sell their businesses or move to new locations with little to no oversight for ensuring that patients will continue to receive quality care. We examined one case in which a hospice agency changed its location without Public Health requiring a new inspection. That hospice agency has since received complaints for falsifying records and neglecting patients.

Recommendation: The Legislature should revise state law to include a system of sanctions for Public Health to levy, including fines or license revocation, for the following:

- Failure by a hospice agency to report a change in owner, hospice management personnel, or location.

> **Status:** Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) adds to the list of reasons for which the department may deny, suspend, or revoke a hospice agency license, including failure by a hospice agency to report a change in owner, hospice agency management personnel, service area, or location.

Finding: Public Health has not always investigated complaints in a timely manner. Based on the time frames it established, Public Health requires an onsite investigation to be initiated within two working days for complaints that are classified as immediate jeopardy—a situation in which the patient has been or is at risk of serious injury, harm, impairment, or death. For non-immediate jeopardy complaints that are high priority—a situation in which the patient has been or is at risk of harm that impairs mental, physical, and/or psychosocial status—Public Health's time frame for initiating the investigation is up to 45 calendar days. For both immediate jeopardy and non-immediate jeopardy high priority complaints, Public Health's time frame for completing the investigation is 30 days after the evaluator completes the onsite investigation. Thus, the expected completion date will vary depending on the investigation and is not a standard number of days. Consequently, this approach does not impose any meaningful limit to the amount of time Public Health takes to investigate a complaint. From 2015 through 2020, Public Health data show that it took an average of 163 days to complete its investigations. The long period to complete investigations can allow fraud, abuse, and neglect to continue.

Recommendation: To ensure that Public Health appropriately addresses the complaints it receives, the Legislature should require it to do the following:

- Establish time frames within which Public Health must initiate and complete its investigations of hospice complaints.

Status: Partially Implemented. AB 2673 (Chapter 797, Statutes of 2022) requires, upon receipt of a complaint, the department to make a preliminary review and, unless the department determines that the complaint is willfully intended to harass a licensee or is without any reasonable basis, it shall make an onsite investigation within 10 business days after receiving the complaint, except when the visit would adversely affect the licensing investigation or the investigation of other agencies, including, but not limited to, law enforcement agencies. In either event, the complainant shall be promptly informed of the department's proposed course of action.

Finding: The 10 complaints that we reviewed included multiple allegations of fraud and abuse, such as recruitment of patients ineligible for hospice care, falsification of medical documents, and forgery. However, Public Health's investigations of these 10 complaints were not always thorough and, as a result, it is unclear whether the alleged actions of some actually occurred. According to its policies and procedures for investigating complaints, Public Health substantiates an allegation by verifying with evidence that it occurred. Some allegations included in complaints likely go unsubstantiated because Public Health does not always seek sufficient evidence when it investigates them. Its investigative process entails reviewing documentation, making observations, and interviewing hospice personnel and other relevant individuals. Furthermore, the complaint investigation files did not always include robust evidence: seven of the 10 complaint files we examined either had inadequate evidence because Public Health did not gather or review proper documentation or because it did not interview all relevant individuals. Specifically, it failed to interview medical personnel, patients, and family members to gather critical information about the alleged events.

Recommendation: To ensure that Public Health appropriately addresses the complaints it receives, the Legislature should require it to do the following:

- Develop a comprehensive training manual regarding performing investigations. The manual should include specific guidance for interviewing witnesses, collecting and reviewing documents, and following up on discrepancies to properly and thoroughly address complaints.

Status: Not Implemented.

Finding: Public Health has not consistently provided members of the public with essential information about hospice agencies so that they can make educated decisions about the care they and their families receive. Public Health administers the California Health Facility Information Database (Cal Health Find), a repository of information about health care facilities, including hospice agencies. Public Health shares this information with the public through its Cal Health Find website to provide consumers with health care provider information, such as licensing and certification status, and complaints and deficiencies. Like similar websites provided by other government entities, Cal Health Find presents details about each hospice agency, including the owner and any substantiated complaints. Further, Cal Heath Find provides information about the process for submitting complaints against hospice agencies. It also includes a comparison feature like the one used in CMS's Care Compare website that allows users to compare health care providers. However, Cal Health Find's website lacks key information that would help members of the public make well-informed decisions when choosing a hospice agency. First, Cal Health Find has

outdated information related to ownership and licensing status of hospice agencies, which limits its usefulness to the public. Additionally, although Cal Health Find includes details of substantiated complaints, it provides limited information about unsubstantiated complaints, which includes cases where the investigation results lacked sufficient evidence to conclusively support the allegation. In contrast, the Community Care Facility Search website—which contains information on residential care facilities that Social Services licenses—includes unsubstantiated complaint allegations and a full report of the actions investigators took to reach their final determinations. It thus provides the public with useful perspective for making informed decisions. We believe that Public Health should differentiate these outcomes into two categories on its website: unsubstantiated— indicating that the allegations have been proven untrue—and undetermined—indicating that there was not enough evidence to make a determination. Those who rely on the Cal Health Find website would be better informed and better protected if Public Health shared this specific detail, thus ensuring full disclosure and transparency.

Recommendation: To help ensure that residents of long-term care facilities are not taken advantage of by unscrupulous hospice agencies, the Legislature should require Public Health and Social Services to develop materials to educate current and future residents of these facilities and their families about common hospice fraud schemes, including efforts to mislead residents to sign up for hospice care. It should also require Public Health to include this information on its website.

Status: Not Implemented.

Finding: Public Health administers Cal Health Find, a repository of information about health care facilities, including hospice agencies. Public Health shares this information with the public through its Cal Health Find website to provide consumers with health care provider information, such as licensing and certification status, and complaints and deficiencies. Like similar websites provided by other government entities, Cal Health Find presents details about each hospice agency, including the owner and any substantiated complaints. Further, Cal Heath Find provides information about the process for submitting complaints against hospice agencies. It also includes a comparison feature like the one used in CMS's Care Compare website that allows users to compare health care providers. Cal Health Find's website lacks key information that would help members of the public make well‑informed decisions when choosing a hospice agency. First, Cal Health Find has outdated information related to ownership and licensing status of hospice agencies, which limits its usefulness to the public. Although Public Health says that it updates the website weekly using the licensing information in its database, we identified a number of instances in which the website did not reflect current information. Consequently, an individual reviewing the website who is making decisions about hospice care would not have accurate information about that agency's actual status.

Recommendation: To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022, to include the following:

- Up-to-date information about the ownership and license status for each hospice agency licensed by Public Health.

Status: Not Implemented.

Finding: Although Cal Health Find includes details of substantiated complaints, it provides limited information about unsubstantiated complaints, which includes cases where the investigation results lacked sufficient evidence to conclusively support the allegation. In contrast, the Community Care Facility Search website—which contains information on residential care facilities that Social Services licenses— includes unsubstantiated complaint allegations and a full report of the actions investigators took to reach their final determinations. It thus provides the public with useful perspective for making informed decisions. Public Health is unable to substantiate some complaints related to hospice agencies simply because it is unable to gather sufficient evidence, which is different from those complaints that it is able to conclude that the allegations are untrue. We believe that Public Health should differentiate these outcomes into two categories on its website: unsubstantiated—indicating that the allegations have been proven untrue—and undetermined—indicating that there was not enough evidence to make a determination. Those who rely on the Cal Health Find website would be better informed and better protected if Public Health shared this specific detail, thus ensuring full disclosure and transparency.

Recommendation: To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022, to include the following:

- Specific identifiers to differentiate between complaints that were unsubstantiated based on a review of sufficient evidence and complaints that were undetermined because it could not reach a conclusion because of lack of evidence.

Status: Not Implemented.

Finding: The Cal Health Find website does not include indicators of performance quality. CMS's Care Compare website includes multiple measures of performance to help users make decisions about nursing homes. For example, it includes a facility rating system based on recent annual inspection results, staffing levels, and quality measures that take into consideration factors like the percentage of residents who have been injured in falls. Another indicator of facility quality on the Care Compare website is the abuse icon, which labels facilities that have been recently cited for abuse or neglect. This icon allows users to quickly identify potentially problematic facilities. Once the facility resolves the problem, the icon is removed at the next monthly update of the website, which gives facilities the incentive to quickly address conditions leading to abuse or neglect. By adopting a similar rating system and indicators into Cal Health Find, Public Health could ensure that members of the public have easy access to this critical information they need to select a hospice agency.

Recommendation: To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022, to include the following:

- A quality-of-care rating system for hospice agencies similar to the one that CMS uses for Care Compare. After all hospices have been inspected based on the new regulations, Public Health should begin reporting the quality-of-care ratings.

Status: Not Implemented.

Finding: The Cal Health Find website does not include indicators of performance quality. CMS's Care Compare website includes multiple measures of performance to help users make decisions about nursing homes. For example, it includes a facility rating system based on recent annual inspection results, staffing levels, and quality measures that take into consideration factors like the percentage of residents who have been injured in falls. Another indicator of facility quality on the Care Compare website is the abuse icon, which labels facilities that have been recently cited for abuse or neglect. This icon allows users to quickly identify potentially problematic facilities. Once the facility resolves the problem, the icon is removed at the next monthly update of the website, which gives facilities the incentive to quickly address conditions leading to abuse or neglect. By adopting a similar rating system and indicators into Cal Health Find, Public Health could ensure that members of the public have easy access to this critical information they need to select a hospice agency.

Recommendation: To ensure that the public has adequate information when selecting a hospice agency to provide care, the Legislature should require Public Health to revise its Cal Health Find website by October 2022, to include the following:

- An indicator or icon identifying a hospice agency that has received citations for abuse and neglect in the past year.

Status: Not Implemented.

California Department of Social Services and Counties

2020-109 *In-Home Supportive Services Program: It Is Not Providing Needed Services to All Californians Approved for the Program, Is Unprepared for Future Challenges, and Offers Low Pay to Caregivers* (February 2021)

Finding: Various groups have expressed concerns with the In-Home Supportive Services (IHSS) program, including concerns related to caregiver shortages, the effect that rapid growth in California's senior population could have on the program, and the negative financial impact low wages can have on most caregivers. Caregivers throughout the State earn far less than a living wage—defined as the salary necessary for a full-time worker to afford basic necessities without public assistance—and many likely qualify for public assistance. These low wages likely will affect the ability of counties to recruit caregivers to respond to current and future demand for their services.

Recommendation: To balance the need to attract a sufficient number of caregivers into the IHSS program with the need to maintain control over the State's costs, the Legislature should consider using the annual budget process to allocate additional funds to counties to enable counties to better afford increasing caregiver wages.

Status: Not Implemented.

Finding: Although counties can negotiate higher caregiver wages, state law creates disincentives for them to do so, as increases in provider wages have an outsized financial impact on the counties that provide them. Compounding these issues, caregivers in certain localities earn less than the local

minimum wage. In 2019 the Legislature increased the statewide minimum wage to be no less than $12 per hour, an amount equal to the local minimum wage. Between 2014 and 2019, localities in seven counties passed ordinances that raised local minimum wages by varying amounts; however, these localities declined to grant the increase to local IHSS caregivers.

Recommendation: To ensure that these offset funds are used to best address wage disparities, the Legislature should prioritize their availability to counties where caregivers earn the least, relative to a living wage, and should exempt these wage increases from Welfare and Institutions Code Section 12306.16, subdivision (d), so that the amounts allocated are not included in adjustments to the county contribution.

> **Status:** Partially Implemented. AB 135 (Chapter 85, Statutes of 2021), in part, deletes subsequent county IHSS Maintenance of Effort (MOE) adjustments that otherwise would have applied when the $15 minimum wage takes effect on January 1, 2022.

Finding: Due to the adjustments to the counties' contributions required by state law, counties that increase caregiver wages continue to pay the increased contribution, even when the State's minimum wage surpasses their locally negotiated wage. Generally, the amount a county contributes is based on the amount it paid in the prior fiscal year plus the current inflation factor. Counties that do not negotiate wage increases generally do not have their contribution changed when the state minimum wage increases, even if such an increase results in higher caregiver wages in those counties. However, when a county negotiates a local caregiver wage increase, a portion of the cost of that negotiated increase is added to the amount the county must pay each year. Thus, when a county contribution is raised for increased caregiver wages in one year, it is also increasing the amount the county must contribute in every future year, even if the state minimum wage increases.

Recommendation: To limit the disincentive for counties to provide caregiver wage increases, the Legislature should modify the State's cost-sharing system to eliminate the ongoing costs that counties pay for local wage increases that are nullified by increases to the State's minimum wage.

> **Status:** Implemented. AB 135 (Chapter 85, Statutes of 2021) expands the limitation for IHSS state-county sharing arrangements on the 10 percent state participation to allow no more than two three-year periods that commence before, and no more than two three-year periods that commence on or after, the date the state minimum wage reaches $15, and deletes subsequent county IHSS MOE adjustments that otherwise would have applied when the $15 minimum wage takes effect on January 1, 2022. Additionally, this statute deletes subsequent MOE adjustments that otherwise would have applied when the $15 minimum wage takes effect on January 1, 2022.

Finding: The State's decision in fiscal year 2012–13 to adjust the contribution each county pays toward the IHSS program by a set percentage—or inflation factor—each year rather than updating each county's contribution based on its proportion of the IHSS program's costs has resulted in some counties paying significantly more than their proportional share while others pay less. This approach has effectively increased the State's share of program costs and penalized counties whose programs did not expand as rapidly as others did. If the State incorporates more modest changes to the way that counties contribute to the IHSS program, it may be able to establish more equitable results.

Recommendation: To provide for more equitable financial participation by counties, the Legislature should revise the State's IHSS funding formula to include annual updates based on current program growth and costs and a review of specific funds available to counties. To the extent that some counties' revenues dedicated to IHSS are insufficient to cover their IHSS contributions, the Legislature should provide counties with assistance as it deems appropriate or designate additional funding sources in state law.

> **Status:** Not Implemented.

Homeless Coordinating and Financing Council

2020-112 *Homelessness in California: The State's Uncoordinated Approach to Addressing Homelessness Has Hampered the Effectiveness of Its Efforts* (February 2021)

Finding: The State currently does not have a comprehensive understanding of how it is spending state funds to address homelessness. At least nine state agencies provided funding through 41 programs to address homelessness in the State during the past three years. Furthermore, there is no single state entity that comprehensively tracks the sources of funding, the intended uses, or related expenditures for these programs. We would expect the Homeless Coordinating and Financing Council (homeless council) to do so to fulfill its statutory goal of coordinating existing state and federal funding and applications for competitive funding. However, the homeless council does not track how much funding is available or spent toward addressing homelessness statewide.

Recommendation: To ensure that the State effectively addresses the statewide issue of homelessness, the Legislature should require the homeless council, in collaboration with all state agencies that administer state and federal funding for homelessness, to collect and track funding data on all federal and state funded homelessness programs, including the amount of funding available and expended each year, the types of activities funded, and types of entities that received the funds.

> **Status:** Not Implemented. AB 1575 (Assembly Housing and Community Development Committee, 2021) would have required the homeless council, upon appropriation from the Legislature or receiving technical assistance from the U.S. Department of Housing and Urban Development (HUD), to conduct a homelessness statewide gaps and needs assessment by July 31, 2022. This bill died in the Assembly.

Finding: In 2017 the State established the homeless council—which includes representatives of state agencies, advocacy groups for the homeless, and other stakeholders. The statute that created the homeless council assigned it 18 goals, including coordinating existing funding, creating a statewide data system, and establishing partnerships with stakeholders to develop strategies to end homelessness. However, homeless council staff stated that the council has not set priorities or timelines for achieving all 18 statutory goals. Further, the homeless council still has not finalized an action plan that homeless council staff believe will serve as the council's strategic plan.

Recommendation: The Legislature should require the homeless council to prioritize its statutory goals with an emphasis on giving higher priority to coordination of statewide efforts to combat homelessness. To this end, the Legislature should require the homeless council to finalize its action plan and ensure that the plan documents the State's approach to addressing homelessness in California and that the action plan is updated regularly.

Status: Not Implemented. AB 827 (R. Rivas, 2021), in part, would have required the homeless council, on or before June 1, 2022, to develop and publish an action plan to implement statutory requirements for creating partnerships with specified entities, and identifying resources, benefits, and services that can be accessed to prevent and end homelessness in California. The bill also would have required the homeless council, on an annual basis, to review that action plan and hold a stakeholder meeting to determine whether the action plan's goals are being met. This bill died in the Assembly.

Finding: California does not currently have a statewide system to collect data on local or statewide efforts to combat homelessness. Federal regulations require continuums of care (CoCs) to capture certain information in their Homeless Management Information Systems (HMIS) about the number and demographics of people experiencing homelessness and the services they receive through different providers in their areas. These data include information about homelessness programs, such as their sources of funding and their inventory of available beds, and information about those experiencing homelessness, such as basic demographic characteristics, current living situations, sources of income, and health conditions. However, the State currently has no mechanism in place to collect, integrate, and analyze statewide data on individuals and families experiencing homelessness or on the services that programs provide. The State is making an effort to establish a statewide data warehouse by contracting with a firm to design, develop, implement, and support HDIS, the Homeless Data Integration System. Requiring data reporting into an HMIS as a condition of receiving state funding would ensure that data from the various homelessness programs that the State funds would be eventually captured into the HDIS, since the homeless council intends to pull its data from each CoC's HMIS.

Recommendation: To ensure that the State has access to comprehensive data about homelessness, the Legislature should require all state entities that administer state funding for homelessness to ensure that recipient service providers enter relevant data into their CoC's HMIS, as law allows, as a condition of state funding. The required information should include, at a minimum, the same or similar information that recipients of federal CoC program funding must enter.

Status: Implemented. AB 977 (Chapter 397, Statutes of 2021) requires, beginning January 1, 2023, that a grantee or entity operating specified state homelessness programs, as a condition of receiving state funds, to enter the Universal Data Elements and Common Data Elements, as defined in HUD's Homeless Management Information System Data Standards, on the individuals and families it serves into its local HMIS, unless otherwise exempted by state or federal law. These data entry requirements apply to all new state homelessness programs that commence on or after July 1, 2021. The homeless council is required to specify the format and disclosure frequency of the required data elements, and provide technical assistance and guidance to any grantee or entity that operates a program subject to these provisions, if the grantee or entity does not already collect and enter into HMIS the data elements required. Finally, the homeless council is required to provide the aggregate data summaries to specified state agencies or departments within 45 days of receipt.

Finding: The State falls short of providing CoCs with the necessary support and guidance to effectively address homelessness at the local level. In fact, the operations of CoCs are largely unsupervised by any state agency. Although state law assigned the homeless council the goals of creating partnerships among state agencies, local government agencies, recipients of federal CoC program funding, federal agencies, and homeless service providers, this goal is vague and lacks a

definite requirement or enforcement mechanism to develop minimum expectations or guidance and to disseminate best practices to CoCs. In the absence of detailed requirements, we found the five CoCs we reviewed do not always employ best practices or comply with federal regulations and expectations. We believe that the CoCs would benefit from the homeless council developing guidance and disseminating best practices for effectively addressing homelessness.

Recommendation: To ensure that CoCs are aware of processes and practices that can improve their efforts to combat homelessness at the local level and to provide CoCs with the necessary technical support, the Legislature should require the homeless council to develop statewide expectations and guidelines that CoCs and other local entities must follow as a condition of receiving state funding. These expectations and guidelines should consider best practices available from relevant local, state, and federal entities and should address, at a minimum, developing effective comprehensive plans, conducting point-in-time counts effectively and efficiently, increasing collaboration among service providers, conducting gaps analyses, and ensuring an effective coordinated entry process.

> **Status:** Not Implemented. AB 827 (R. Rivas, 2021) would have, in part, required the homeless council to collaborate with HUD to develop a statewide best practices guide that addresses and tackles homelessness to disseminate to local agencies and organizations that participate in HUD's CoC Program. The bill would have required those agencies and organizations to follow those practices as a condition of receiving state funding. This bill died in the Assembly.

Finding: By investing added responsibility and authority in the homeless council to coordinate the State's response to homelessness, the Legislature can ensure that decision makers have the ability to clearly assess the State's efforts, successes, and challenges and to make informed decisions in the fight to reduce homelessness.

Recommendation: To the extent that the homeless council believes it does not have sufficient resources to implement any new statutory requirements, the Legislature should require the homeless council to conduct an analysis to determine its budgetary needs for implementing any new statutory requirements.

> **Status:** Not Implemented.

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HIGHER EDUCATION

University of California

2021-047 *Native American Graves Protection and Repatriation Act: Despite Some Recent Improvements, the University of California Has Not Yet Taken Adequate Action to Ensure Its Timely Return of Native American Remains and Cultural Items* (November 2022)

Finding: More than 30 years after the passing of NAGPRA, many campuses still have large collections of Native American remains and cultural items because of their historical struggle to inventory and repatriate these collections. The University of California (UC) Office of the President has not ensured that campuses prioritize completing their plans to facilitate the return of their NAGPRA collections. Since July 2020, the Office of the President has required campuses to create repatriation implementation plans (repatriation plans) that include specific timelines and strategies. However, it did not set a deadline for completing these plans. The four campuses we reviewed have not yet completed their plans as of mid-October 2022, more than two years later. Without requiring campuses to develop their plans by a given deadline, the Office of the President is risking that campuses will not take a proactive, strategic, and timely approach to returning remains and cultural items to the tribes. Further, the size of these collections—as well as the limited resources the Office of the President and the campuses have dedicated to this responsibility—means that it will likely take many years of sustained effort before campuses have successfully repatriated their NAGPRA collections. In fact, at their present pace, some campuses will not fully complete the return of their collections for more than a decade.

Recommendation: To ensure that the UC continues its recent progress in returning remains and cultural items to tribes, the Legislature should amend state law to require the UC to periodically report its campuses' progress towards completing repatriation.

Status: Not Implemented. (Report issued in November 2022.)

Finding: Campuses have not planned for sustainable long-term funding of their repatriation efforts. The Office of the President provided funding to campuses for two years beginning in fiscal year 2021–22, but it expects campuses to use their own funding for repatriation after fiscal year 2022–23. To address the importance of NAGPRA and CalNAGPRA, along with the significant requirements these laws impose on the university, the Office of the President could dedicate funds to support campuses' repatriation activities. However, it has chosen not to do so following fiscal year 2022–23. In the absence of such an action, the funding that campuses have currently identified for repatriation is inadequate and will likely add years to the already delayed return of remains and cultural items to California tribes.

Recommendation: To ensure that campuses have adequate funding to fully repatriate their collections in a timely manner, the Legislature should amend state law to require the Office of the President to provide sufficient funding to support campuses' repatriation efforts.

Status: Not Implemented. (Report issued in November 2022.)

Finding: The Legislature amended CalNAGPRA in 2018 to require that the UC establish a systemwide NAGPRA committee, and it further amended CalNAGPRA in 2019 to require that this committee have an equal number of voting representatives from Native American tribes and

the UC. The 2018 amendment also required campuses with NAGPRA collections to establish similar committees. CalNAGPRA requires the California Native American Heritage Commission (NAHC) to nominate members to the systemwide and campus NAGPRA committees. The background and experience that state law requires for NAGPRA committee members from the UC include: a graduate degree in Archeology, Anthropology, Native American Studies, Ethnic Studies, Law, Sociology, Environmental Studies, or History; a minimum of five years working in the applicable field of study; at least one member of each campus committee must be affiliated with a Native American Studies Program; and at least two members of the systemwide committee must be affiliated with a Native American Studies Program. However, several university members on the campus committees, with the exception of the Los Angeles committee, do not meet these requirements. NAHC attributed this issue to the difficulty campuses have in meeting CalNAGPRA's requirements for committee members. All committee members from California tribes possess the qualifications required by state law. Although some committee members do not have the degrees specified in state law, we found that committee members generally have diverse backgrounds that likely strengthen the UC's committees. Our review found that all members of the campus NAGPRA committees who did not meet the background and education requirements in state law nonetheless had professional experiences that can make positive contributions to the committees. Additional flexibility in state law would better empower the NAHC to nominate those candidates best suited for the UC's NAGPRA committees. Providing for additional types of educational background and expertise for committee members in state law will allow for additional diversity and perspective on the university's NAGPRA committees. This change will also allow the NAHC flexibility in nominating those candidates it feels are best suited for committee membership.

Recommendation: To ensure that the systemwide and campus NAGPRA committees have members with diverse backgrounds, the Legislature should revise CalNAGPRA to allow individuals with more types of educational backgrounds to qualify for committee membership.

Status: Not Implemented. (Report issued in November 2022.)

University of California and California State University

2021-611 *Higher Education Emergency Relief Fund: Some University Campuses Did Not Maximize Available Federal Pandemic Funds, and They Prioritized Students Differently When Awarding Relief Funds* (November 2021)

Finding: In early 2020, the pandemic caused a global public health crisis. In March 2020, the president of the United States declared the pandemic a national emergency. In response to the pandemic, Congress provided economic assistance to institutions of higher education and their students through three laws enacted between March 2020 and March 2021. These laws allocated more than $76 billion in total to the Higher Education Emergency Relief Fund (HEERF) to help defray campuses' expenses associated with the pandemic and provide financial aid grants to students, among other uses. We found that most of the campuses we reviewed did not maximize available federal funds because they used HEERF funds to pay for some costs that could be reimbursed by the Federal Emergency Management Agency (FEMA) instead, thereby reducing the amount of HEERF funds available for other purposes.

Recommendation: If the CSU Chancellor's Office and the University of California Office of the President do not ensure that their respective campuses submit eligible expenses incurred in response to the pandemic to FEMA for reimbursement, the Legislature should direct the CSU Chancellor's Office and the University of California Office of the President to do so or explain why submitting these claims was not feasible.

Status: Not Implemented.

Calbright College

2020-104 *Calbright College: It Must Take Immediate Corrective Action to Accomplish Its Mission to Provide Underserved Californians With Access to Higher Education* (May 2021)

Finding: In recognition of a deficit in competency-based education in the community college system, in 2018 the Legislature created an online community college, now named Calbright College (Calbright), to provide high-quality, affordable, and self-paced educational programs. The Legislature created Calbright to provide working adults with access to flexible postsecondary education that will position them to obtain well-paying jobs. However, Calbright has failed to take critical steps necessary to achieve that mission. It has yet to adopt sufficient processes for selecting the educational programs it offers, and it has not worked with employers to ensure that the programs it selects adequately prepare its target student population to obtain jobs. In addition, Calbright has neither established a plan for helping its students obtain jobs after graduation, nor has it tracked whether its programs are effective in helping graduates secure jobs.

Recommendation: To ensure that Calbright provides educational and economic opportunities to Californians and is accountable for its performance, the Legislature should do the following:

- Require Calbright to demonstrate substantive compliance with our audit recommendations.
- Require the California State Auditor (State Auditor) to provide an update to the Legislature by no later than December 2022 about Calbright's progress in implementing those recommendations.
- Adopt a sunset provision that would eliminate Calbright as an independent community college district if the State Auditor determines that Calbright has not demonstrated substantive compliance with those recommendations by December 2022.
- If it eliminates Calbright, the Legislature should explore other options for providing competency-based education for California adults who face barriers to traditional postsecondary education.

Status: Not Implemented. AB 2820 (Medina and Quirk-Silva, 2022) would have made the California Online Community College Act inoperative on January 1, 2024, and would have appropriated CalBright's funding to other community college purposes. This bill died in the Senate in 2022.

AB 1432 (Low, 2021) would have made the California Online Community College Act inoperative at the end of the 2022–23 academic year. These provisions were removed from the bill in June 2022.

Previously, in the 2019–2020 Regular Session, SB 74 (Chapter 6, Statutes of 2020), the Budget Act of 2020, required, among other things, that the CalBright Board of Trustees close the college no later than December 31, 2020. Additionally, this bill required the CalBright Board of Trustees to submit a plan to the Joint Legislative Budget Committee and the Department of Finance identifying the timeline and steps it plans to take for closing the college, by September 1, 2020. However, this bill was amended by AB 89 (Chapter 7, Statutes of 2020), which deleted the above requirements. Therefore, the Legislature did not ultimately implement this recommendation during the 2019–2020 Regular Session.

HOUSING & COMMUNITY DEVELOPMENT

Department of Housing and Community Development and the Department of General Services

2021-114 *State Surplus Property: The State Should Use Its Available Property More Effectively to Help Alleviate the Affordable Housing Crisis* (March 2022)

Finding: The State's need for affordable housing is significantly outpacing its production, which is negatively affecting Californians. A lack of affordable housing correlates with a significant increase in the number of people experiencing homelessness, which negatively affects both adults and children. To help address this need for affordable housing, the Governor and the Legislature have turned to the use of excess public land for such housing. In January 2019, the Governor responded to the shortage of affordable housing in California in part by issuing an executive order that directed the Department of General Services (DGS) to conduct a comprehensive survey of all state‑owned land, identify properties not currently needed by the State, and offer those properties suitable for affordable housing for long‑term lease. The executive order set an aggressive schedule for DGS to complete its review. The Governor issued the order in mid‑January 2019 and required DGS to complete its review by the end of April 2019. However, the executive order did not establish a timeline for DGS to offer the properties it identified for affordable housing and, at its current rate, it will take DGS seven years to put forward all of the remaining properties. DGS's identification of all state properties suitable for development was likely hampered by the executive order's time constraints. To accomplish its review within three and a half months, DGS relied heavily on the professional judgment of its staff rather than on specified criteria. Given the time constraints, this reliance was not unreasonable; however, it led to some inconsistencies in DGS's decision‑making. Additionally, although the executive order did not create an ongoing process when it required DGS to identify state property and offer it for development, ensuring that efforts made under the executive order become a standard part of the State's property management system will further increase the State's ability to respond to the affordable housing crisis.

Recommendation: To ensure that the creation of affordable housing made available under the excess state property executive order continues, the Legislature should enact state laws to require that DGS and the California Department of Housing and Community Development (HCD) carry out the duties prescribed in Executive Order N‑06‑19. Further, the Legislature should require the following:

- By September 2022, DGS should develop a set of criteria to consistently evaluate state parcels for suitability as affordable housing sites.

- By July 2023 and every four years thereafter, DGS should conduct a review of all state‑owned property and identify parcels that are potentially viable for affordable housing based on the established criteria. Once this review is complete, follow up with all related agencies to determine property availability. After the completion of each review, DGS and HCD should prioritize the identified properties for development.

Status: Implemented. AB 2233 (Chapter 438, Statutes of 2022) and SB 561 (Chapter 446, Statutes of 2022) require DGS to develop, in consultation with HCD and no later than September 1, 2023, a set of criteria to consistently evaluate state‑owned parcels for suitability as affordable housing sites. These bills also require, on or before July 1, 2024, and every four years thereafter, DGS to conduct a review of all state‑owned property

and identify state-owned parcels that are potentially viable for affordable housing based on those criteria. Following each review, these bills require DGS to update, on or before January 1, 2024, a digitized inventory of all excess state land.

Further, AB 2233 also requires DGS on or before January 1, 2024, and annually thereafter, to report to the Legislature on the status of excess state properties.

This bill also requires DGS, and HCD, no later than June 1, 2023 and annually thereafter, to evaluate and update the screening tools jointly developed pursuant to Executive Order N-06-19. This bill requires all state agencies to respond to requests for information from the DGS, and to consider exchanging excess state land with local governments for other parcels for purposes of affordable housing development and preservation. This bill also requires all state agencies to use all existing legal and financial authority, subject to the direction of the Governor, to expedite and prioritize developments accepted pursuant to the request for proposal process described in AB 2233.

Finding: In January 2019, the Governor responded to the shortage of affordable housing in California in part by issuing an executive order that directed the Department of General Services (DGS) to conduct a comprehensive survey of all state-owned land, identify properties not currently needed by the State, and offer those properties suitable for affordable housing for long-term lease. The executive order set an aggressive schedule for DGS to identify state property suitable for development into affordable housing and required DGS to complete a comprehensive survey of all state-owned land by April 30, 2019—roughly three and a half months after the Governor issued the order. To meet this deadline, DGS had to review 44,000 parcels during the time available, gather additional information from the agencies that possessed the parcels it deemed potentially viable, and create a comprehensive map of the available properties it identified. Based on these efforts, DGS identified 690 potentially viable properties. After further review with state agencies, DGS reduced the number of these potentially viable properties to the 92 sites it identified for development under the executive order. Although the executive order has proven effective at generating affordable housing, without further action, the State's process for identifying excess property will return to its earlier, less active approach. The executive order required DGS to review state property, but it did not create a requirement that DGS supplement its initial review with periodic assessments. DGS completed its review in 2019 and continues to review all state properties identified as excess for suitability for the program. However, the deputy director indicated DGS has no plans to conduct additional periodic reviews similar to what was conducted in 2019. Without an ongoing process and the necessary resources for identifying such properties and offering them for affordable housing, the State may miss opportunities to further address the affordable housing crisis.

Recommendation: To facilitate a comprehensive review of state land for affordable housing uses, the Legislature should require DGS to issue, by July 2023 and every four years thereafter, a report on the results of its review of state property, including a determination as to which parcels are suitable for affordable housing and the results of DGS's contact with the possessing agencies.

Status: Implemented. AB 2233 (Chapter 438, Statutes of 2022) requires DGS to develop, in consultation with HCD and no later than September 1, 2023, a set of criteria to consistently evaluate state-owned parcels for suitability as affordable housing sites. The bill also requires, on or before July 1, 2024, and every four years thereafter, DGS to, among other things, conduct a review of all state-owned property and identify state-owned parcels that are

potentially viable for affordable housing based on those criteria. Following each review, this bill requires DGS to contact all related agencies to determine excess state land. On or before January 1, 2024, and annually thereafter, this bill requires DGS to report to the Legislature on the status of excess state properties.

Finding: The State Property Inventory (SPI) may not be accurate because not all agencies are meeting the reporting requirements and because DGS has identified mismatches between the SPI and county property data. State law requires each state agency to report to DGS on all real property it possesses by December 31 of each year. This reporting populates the SPI. The information must include a certification by the head of the agency that the information provided is correct. Despite these requirements, in fiscal year 2019–20, one of the 38 agencies that possess state property failed to report to the SPI, and seven agencies failed to report in a timely manner. In fiscal year 2020–21, three agencies failed to report on the property they possessed and four reported after the deadline. DGS indicated that, although it provides multiple reminders, the agencies did not communicate the rationale behind their late reporting or their failure to report. Further, the State's current SPI reporting process in state law does not require DGS to ensure the accuracy of the information it provides to the Legislature. State law generally requires state agencies to self-report and certify information on the land they possess, but we identified no law that expressly requires DGS to verify the submitted information. DGS indicated that it does not independently verify the information it receives because the volume of that review process would be significant and the law requires state agencies to submit and certify the information. However, without such verification, the State cannot ensure that state agencies are proactively identifying excess property that the State could use for affordable housing or for reducing state expenses.

Recommendation: To ensure that the SPI's reporting of state-owned property is accurate and supports the needs of the Legislature, the Legislature should require DGS to verify annually a sample of the responses agencies provide.

Status: Not Implemented. AB 2233 (Chapter 438, Statutes of 2022) would have required DGS to annually verify a sample of the responses provided by state agencies in response to the survey. This provision was removed prior to the bill's enactment.

Finding: California's existing surplus property process established in state law helps the State prepare for economic uncertainty but is of limited use in identifying affordable housing opportunities. State law generally requires that proceeds generated from the sale of surplus property support the State's budget stabilization account, known as the rainy day fund, which it uses to mitigate budget shortfalls. However, resolving complexities surrounding the properties possessed by the California Department of Transportation (Caltrans) may require legislative action. According to Caltrans, much of its property must be put to a transportation-related use and parcels are generally sold at fair market value, with limited exceptions.

Recommendation: To maximize the amount of affordable housing that can be created using state land, the Legislature should amend state law to allow Caltrans to sell available excess property to DGS at less than current fair market value if that property is to be used for the development of affordable housing.

Status: Not Implemented. AB 950 (Ward, 2021) would have authorized the Department of Transportation to sell its excess real property to the city, county, or city and county where the real property is located, if the city, county, or city and county agrees to use the real property for the sole purpose of implementing affordable housing, emergency shelters, or feeding programs, as specified. This bill died in the Senate on August 11, 2022.

Department of Housing and Community Development and Department of Finance

2021-125 *Regional Housing Needs Assessments: The Department of Housing and Community Development Must Improve Its Processes to Ensure That Communities Can Adequately Plan for Housing* (March 2022)

Finding: The Legislature recognizes that the availability of housing is of vital statewide importance and that the State and local governments have a responsibility to facilitate the development of adequate housing. State law requires HCD to conduct assessments to determine the housing needs (needs assessments) throughout regions in the State. The needs assessments rely on projections of future population and households developed by the Department of Finance (Finance). HCD is required to consider certain factors identified in state law and then can adjust the needs assessments for any of the factors. Regions use the needs assessments to plan for additional housing to accommodate population growth and address future housing needs. State law requires HCD to consider vacancy rates in existing housing and the vacancy rates for healthy housing markets when developing the needs assessments. A low supply of housing can result in low rental vacancy rates, which in turn can lead to housing price increases. Therefore, HCD adjusts its needs assessments so that housing markets can achieve a healthy vacancy rate. In some cases, that adjustment will add to the number of housing units HCD determines a region needs so that the region can obtain a healthy vacancy rate. State law specifies that the minimum vacancy rate for a healthy rental housing market is 5 percent, but the law does not define the healthy vacancy rate for owned housing. HCD concluded that its choice of a single healthy vacancy rate for the overall market instead of separate rates for owned and rental housing was appropriate. We are concerned that HCD has not completed a formal analysis to support its claim that a single healthy vacancy rate was appropriate.

Recommendation: To provide HCD additional clarity and guidance in conducting its vacancy rate adjustments, the Legislature should amend state law to clarify whether HCD should continue to use a healthy vacancy rate that includes both rental and owned housing or whether it should determine and use separate healthy vacancy rates for owned housing and rental housing.

Status: Not Implemented.

INSURANCE

Employment Development Department

2020-628.2 *Employment Development Department: Significant Weaknesses in EDD's Approach to Fraud Prevention Have Led to Billions of Dollars in Improper Benefit Payments* (January 2021)

Finding: Since the surge in pandemic-related California unemployment claims began in March 2020, individuals, news organizations, and law enforcement officials have reported many cases of potential and actual unemployment insurance (UI) fraud. Not surprisingly, the pandemic conditions increased the Employment Development Department's (EDD) UI workloads and also resulted in changes to federal UI benefit programs, both of which have created a greater risk of fraud. Additionally, EDD was unprepared to prevent payment for fraudulent claims filed under the names of incarcerated individuals—which it estimated to total about $810 million. EDD had told the Legislature for years that it was considering adopting a cross match between claim and incarceration data. However, because it had not developed the capacity to match data between its claims system and the data from state and local correctional facilities, it did not detect these fraudulent claims until after the fact.

Recommendation: To ensure that EDD prevents fraud associated with incarcerated individuals, the Legislature should amend state law to do the following:

- Require EDD to regularly cross match UI benefit claims against information about individuals incarcerated in state prisons and county jails to ensure that it does not issue payments to people who are ineligible for benefits. The Legislature should specify that EDD perform the cross matches as quickly as possible after individuals file claims and with as little disruption of legal and eligible claims as possible.
- Require the California Department of Corrections and Rehabilitation (CDCR) and any other necessary state or local government entities to securely share information about incarcerated individuals with EDD to enable EDD to prevent fraud.
- Require EDD to include, in its annual report to the Legislature about fraud, an assessment of the effectiveness of its system of cross matching claims against information about incarcerated individuals. The assessment should include how regularly EDD performs the cross matches, how successful the cross matches are in detecting and preventing fraud, and whether the cross matches negatively affect eligible claimants attempting to legally obtain benefits.

Status: Partially Implemented.

AB 110 (Chapter 511, Statutes of 2021) requires CDCR to provide the name, known aliases, birth date, Social Security number, booking date, and expected release date, if known, of a current inmate to EDD for the purposes of preventing payments on fraudulent claims for unemployment compensation benefits. This information must be provided to EDD on the first of every month and upon EDD's request. For purposes of preventing payments on fraudulent claims for unemployment compensation benefits, EDD's director is required to verify with the information provided by CDCR that the claimant is not an inmate currently incarcerated in the state prisons. EDD is required to complete necessary system programming or automation upgrades to allow electronic monitoring of CDCR inmate data to prevent payment on fraudulent claims for unemployment compensation benefits at the earliest possible date, but not later than September 1, 2023.

AB 56 (Chapter 510, Statutes of 2021), in part, requires EDD to assess the effectiveness of its system of cross matching claims against information about incarcerated individuals. The assessment shall include how regularly EDD performs the cross matches, how successful the cross matches are in detecting and preventing fraud, and whether the cross matches negatively affect eligible claimants attempting to legally obtain benefits. EDD is required to include this assessment in its annual report on fraud deterrence and detection activities. Details on fraud methods and tools may be generalized, excluded, or redacted to protect the department's fraud deterrence practices.

Finding: EDD's disjointed approach to fraud prevention has placed its UI program at a higher risk for fraudulent activity. It has not established a centralized unit to manage its fraud detection efforts, and it does not reliably track suspicious claims to ensure that it is taking appropriate action to resolve any issues, including those that suggest fraud has occurred. Further, EDD does not measure or monitor any of its fraud prevention or detection tools to determine how effectively each one detects fraud. As a result, it may be using ineffective fraud prevention and detection techniques that fail to prevent fraudulent payments or that delay payments to legitimate claimants.

Recommendation: To ensure that EDD effectively protects the integrity of the UI program, the Legislature should amend state law to require EDD to do the following:

- By January 2022 and biannually thereafter, assess the effectiveness of its fraud prevention and detection tools and determine the degree to which those tools overlap or duplicate one another without providing any additional benefit. EDD should then eliminate any fraud prevention and detection approach for which it lacks clear evidence of effectiveness. It should include this assessment in its annual report to the Legislature on fraud detection and deterrence efforts.

- By July 2021, provide the Legislature with an update on its progress in performing this analysis.

Status: Implemented. AB 138 (Chapter 78, Statutes of 2021), in part, requires EDD to provide to specified legislative committees a plan for assessing the effectiveness of its fraud prevention and detection tools by May 1, 2022, and to provide a report with an update on its progress on performing the assessment that the plan identified by July 1, 2022. On or before January 1, 2023, and annually thereafter, EDD is required to analyze and assess the effectiveness of its fraud prevention and detection tools and submit this analysis and assessment to the specified legislative committees.

Employment Development Department

2020-128/628.1 *Employment Development Department: EDD's Poor Planning and Ineffective Management Left It Unprepared to Assist Californians Unemployed by COVID 19 Shutdowns* (January 2021)

Finding: In March 2020, in response to the pandemic, the federal government passed legislation providing additional UI benefits to supplement California's existing UI program. The dramatic rise in unemployment and the expansion of unemployment benefits created a massive surge in claims (claim surge) after California's statewide stay-at-home order went into effect on March 19, 2020. Along with the claim surge came delays in the receipt of benefit payments, as EDD

was overwhelmed by the extraordinary number of claims. When a claimant has waited more than 21 days after submitting an application for either processing of payment or disqualification, EDD considers that claim as part of its backlog.

Although EDD has made improvements since the pandemic began to increase the number of claims it can process without manual intervention, it cannot rely in the long term on some of these adjustments. As a result, EDD remains at risk of its backlog of claims continuing or increasing. Additionally, EDD has failed to adequately plan for additional possible increases in UI claims when making staffing decisions. This failure to prepare leaves EDD vulnerable to future workload disruptions from spikes in claims caused by additional pandemic-related shutdowns or even predictable seasonal changes in employment levels.

Recommendation: To ensure that EDD's claims processing is as effective and efficient as possible, the Legislature should require EDD to convene a working group to assess the lessons learned from the claim surge and identify the processes that EDD can still improve. That working group should do to the following:

- Include representatives from EDD's UI branch, IT branch, and executive management. It should also include representatives from the strike team.
- Issue a report on the lessons learned from the claim surge by no later than January 2022. The report should identify any improvements that the working group recommends that EDD make and include a review of EDD's implementation of the strike team's recommendations.

> **Status:** Not Implemented. AB 360 (Patterson, 2021) would have, in part, required EDD to convene a working group to assess the lessons learned from claim surges, identify the processes that EDD can still improve, and issue a report by January 1, 2022. This bill died in the Assembly.

Finding: As claims began to surge in March 2020, EDD halted most of its work determining whether claimants were eligible for UI benefits. This action curbed the size of its claims backlog significantly and resulted in more timely payments to Californians. Although EDD's actions likely allowed it to pay benefits faster, EDD now faces an impending workload for which it has no clear plan to address and that could have significant consequences for claimants. As of mid-December 2020, the UI support division was in the process of drafting a plan for resuming all eligibility determinations and addressing deferred determinations. When it conducts these eligibility determinations, EDD will likely find that some of these claimants were in fact not eligible for the benefits they received.

The claim surge and corresponding delayed payment on claims has generated significant levels of interest from the public and the Legislature. EDD's claims processing has been the subject of many news reports and legislative hearings, and members of the Legislature report fielding numerous calls from constituents about their claims. It is almost certain that a similar level of interest will exist for information about how many Californians may be subject to overpayment notices and how far EDD has progressed in processing that workload.

Recommendation: To ensure transparency in EDD's operations and provide information to policymakers, the Legislature should require EDD to report on its website at least once every six months the amount of benefit payments for which it must assess potential overpayments, the

amount for which it has issued overpayment notices, the amount it has waived overpayment on, and the amount repaid related to those notices. The reports should encompass benefit payments EDD made from March 2020 until the time when it resumes all eligibility determinations. EDD should be required to publish these reports until the repayment period for all the notices has elapsed.

> **Status:** Implemented. AB 56 (Chapter 510, Statutes of 2021), in part, requires EDD to, upon appropriation by the Legislature, report at least once every six months on its website specified benefit overpayment information encompassing benefit payments made from March 1, 2020, through January 12, 2021, and continue to publish this information until the time when EDD resumes all eligibility determinations.

Finding: Before the claim surge, EDD did not adopt a comprehensive plan for how it would respond to economic downturns when its UI program is in higher demand. Having such a plan would have strengthened its poor response to the 2020 claim surge.

Recommendation: To ensure that EDD is better prepared to provide effective services and assistance to Californians during future economic downturns, the Legislature should amend state law to require EDD to develop a recession plan that takes into account the lessons learned from previous economic downturns, including the pandemic. At a minimum, the Legislature should require EDD's plan to include the following:

- The indicators EDD will monitor and use to project the likely upcoming workload that it will face.
- The steps EDD will take to address increases in its workload, such as cross-training non-UI staff, changing its staffing levels, prioritizing specific tasks, and adjusting the way it performs certain work.
- The altered policies or procedures that EDD will activate if a rise in UI claims becomes significant enough to warrant that step.

The Legislature should require EDD to develop the plan within 12 months of the effective date of the related change to state law. To address new developments in UI processes, programs, or other relevant conditions, the Legislature should require EDD to update its recession plan at least every three years thereafter.

> **Status:** Implemented. SB 390 (Chapter 543, Statutes of 2021) requires EDD to develop and, upon appropriation by the Legislature, implement a recession plan to prepare for an increase in unemployment insurance compensation benefits claims due to an economic recession. The plan shall detail how to respond to economic downturns with a predetermined strategy that has considered the full effect on EDD's operations and include, but not be limited to, identifying the lessons learned from previous economic downturns, identifying ways to improve self-serve services to avoid long wait times to speak to staff, and enhancing claims processing tools to ensure that the EDD's identity verification processes are as robust as possible. EDD is required to provide a copy of the recession plan to specified legislative committees and Finance by March 1, 2022, and to update the recession plan and provide a copy to specified legislative committees and Finance every second year thereafter.

JUDICIARY

State Bar of California

2022-030 *The State Bar of California's Attorney Discipline Process: Weak Policies Limit Its Ability to Protect the Public From Attorney Misconduct* (April 2022)

Finding: Weaknesses in the State Bar of California's (State Bar) monitoring processes diminish the value of those processes in ensuring that it is closing attorney discipline cases appropriately. It closes the majority of cases without discipline. The State Bar uses an external reviewer to conduct a semiannual review of a selection of its closed cases to identify errors and areas for staff improvement. However, several flaws in the design of the external review process limit its independence, such as not alternating among different reviewers; having the reviewer submit its report to State Bar management instead of directly to the Board of Trustees of the State Bar (board); and not having the external reviewer select cases for review. All of these factors increase the risk that the review is not objective.

Recommendation: To improve the independence and objectivity of the semiannual review of the State Bar case files, the Legislature should require the State Bar to do the following:

- Regularly change its external reviewer.
- Have its external reviewer present its findings and recommendations, with all confidential information redacted, directly to the Board of Trustees of the State Bar.
- Require the State Bar to report periodically to the board on the actions it takes to address the external reviewer's recommendations.

Status: Not Implemented.

Finding: The State Bar's executive director indicated that the State Bar has taken steps to address repeated misconduct, including issuing a new policy addressing alternatives to discipline and adding information to the closing letters for reportable actions that it sends to attorneys, but its efforts to reduce recidivism are centered around a redesign of its probation process for attorneys convicted of misconduct. The inconsistencies identified as a result of this audit led the State Bar to issue a policy directive in February 2022 clarifying how to proceed when a complainant withdraws the complaint or otherwise fails to cooperate in the investigation. In November 2021, the Office of Chief Trial Counsel of the State Bar (trial counsel's office) began a practice of presenting the findings and recommendations of the external reviewer to the board, and it formalized this practice in a January 2022 policy directive. In the January 2022 policy, the State Bar indicated that the external reviewer is responsible for summarizing the external review's findings and any recommendations. The trial counsel's office prepares a written response to the review that it provides to a board committee along with the reviewer's summary. Although this new policy represents an improvement in how information is shared, the external reviewer should still be provided the opportunity to present the results of his or her review directly to the board.

Recommendation: To ensure that the State Bar implements the policy and procedure changes identified in this audit, the Legislature should require an assessment by no later than December 2023 of the State Bar's compliance with those policies and procedures.

Status: Not Implemented.

State Bar of California

2020-030 *The State Bar of California: It Is Not Effectively Managing Its System for Investigating and Disciplining Attorneys Who Abuse the Public Trust* (April 2021)

Finding: Beginning in 2016, the State Bar reorganized the staffing for its discipline system, including reorganizing the structure of the trial counsel's office, which investigates and prosecutes cases of attorney misconduct. Following the reorganization, the State Bar has experienced longer case processing times and an increasing backlog of discipline cases. The State Bar's backlog is generally defined as *discipline cases that remain pending beyond six months from receipt as of every December 31*. The State Bar officials with whom we spoke were critical of using this measure. For instance, the chief of mission advancement and accountability explained that staff cannot control many aspects of case processing, such as the time that it takes a court to provide certified documents.

Although six months may be insufficient for resolving certain cases, the State Bar may take up to 12 months for more complicated cases. However, it has chosen not to take advantage of this option. State law sets a goal and policy of 12 months for the State Bar to reach specified outcomes regarding complaints that the chief trial counsel designates as *complicated matters*. Although in 2016 the State Bar identified criteria for designating an item as a complicated matter, the special assistant to the chief trial counsel explained that the State Bar discontinued use of this designation sometime before July 2017, because the state law allowing this designation conflicts with other parts of the law. As specified, one section of state law sets a goal and policy of resolving or forwarding a completed investigation to the State Bar Court within 12 months for complaints designated as complicated; however, two other sections of state law set a reporting requirement or goal of six months for certain outcomes regarding all complaints. In addition, these sections of law use differing language for cases that proceed to the State Bar Court, including "filing a notice of disciplinary charges" and "filing of formal charges."

Recommendation: To clarify state law and provide more transparency regarding the nature of the existing backlog of discipline cases, the Legislature should do the following:

- Revise state law to remove Business and Professions Code (B&PC) section 6140.2, which has similar requirements for the State Bar's goals and policies for timely case processing but omits the State Bar's authority to designate complicated matters.

- Revise B&PC section 6086.15, subdivision (a)(1), to require the State Bar to include in its discipline report the number of complicated matters as of the end of the reporting period that were pending beyond 12 months after receipt without dismissal, admonition, or the filing of formal charges by the trial counsel's office.

> **Status:** Implemented. SB 211 (Chapter 723, Statutes of 2021) revises the goal and policy of the State Bar as it relates to complaints alleging attorney misconduct and requires, among other things, the State Bar to propose, no later than October 31, 2022, case processing standards for competently, accurately, and timely resolution of cases within the trial counsel's office. This provision states that it is also the goal and policy of the State Bar, as to complaints designated as complicated matters by the trial counsel's office, to dismiss a complaint, admonish the attorney, or have the trial counsel's office file formal charges

within 12 months after it receives a complaint alleging attorney misconduct. The statute further requires the State Bar to include in its discipline report a description of its success in meeting these case processing goals.

Finding: State law requires the State Bar to issue a discipline report that enables key stakeholders—the Governor, the Chief Justice of California, and specified legislative members and committees—to evaluate certain aspects of its discipline system for the previous calendar year. The information in the discipline report is particularly important because it is the only comprehensive report that the State Bar submits to the Legislature describing the performance and condition of its entire discipline system. Information from multiple years is useful for determining how effectively the State Bar has used its resources over time and whether changes to the State Bar's fee bill are warranted. The deadline established in state law for submitting the annual discipline report limits the amount of time the Legislature has to assess the State Bar's performance before deliberating on the annual fee bill.

Recommendation: To provide itself sufficient time to review the discipline report before considering the annual fee bill, the Legislature should do the following:

- Amend state law to require the State Bar's discipline report to cover the 12 months from July 1 through June 30 of the previous year and to require that the State Bar submit the discipline report annually by October 31.

- In the year in which it amends the discipline report's time period, require the State Bar to report information for both the prior calendar year and the newly defined period to ensure that stakeholders can compare the information for the newly defined period to prior years.

Status: Implemented. SB 211 (Chapter 723, Statutes of 2021) requires the State Bar to provide its Annual Discipline Report by October 31, rather than April 30, of each year, and the report must cover the period from July 1 of the previous calendar year to June 30 of the year in which the report is issued. This statute also requires the Annual Discipline Report due on October 31, 2022, to include data from the prior fiscal and calendar year.

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PUBLIC SAFETY

County Probation Departments, Courts, and Batterer Intervention Program Providers

2021-113 *Batterer Intervention Programs: State Guidance and Oversight Are Needed to Effectively Reduce Domestic Violence* (October 2022)

Finding: Requiring probation departments to conduct initial assessments of all domestic violence offenders eligible for probation to identify underlying issues, such as substance abuse or mental health concerns, before courts order probation could have a significant impact on batterer intervention program completion. State law requires probation departments to conduct these assessments only on some offenders—those placed on formal probation—and only after the offender has been granted probation. However, we believe these assessments should occur before the court orders probation in both felony and misdemeanor cases, so that the court can consider each offender's underlying needs and risks when deciding whether to grant probation and when setting the terms and conditions of probation. The information collected from these assessments may also help the court determine whether it is more appropriate for the probation department or the court to supervise the offender. For example, if the initial assessment identifies a mental health or substance abuse concern, the probation department and court can ensure that the offender receives treatment and the court may consider delaying enrollment in a program until after the offender receives such treatment. Considering offenders' needs and risks is critical to setting them up for successful program completion. It would also benefit the courts and the probation departments if state law required more comprehensive assessments. For example, state law requires all offenders to pay a fee for their program unless the court waives the fee because the offender does not have the ability to pay. Although the batterer intervention law requires probation departments to assess the economic backgrounds of offenders on formal probation, it does not require probation departments to assess offenders' financial means to pay for a program. If the assessment identified that the offender does not have the financial means to pay, the court could approve a fee waiver or refer the offender to employment services. Further, the batterer intervention law requires offenders to attend ongoing same-gender group sessions, but it does not require probation departments to assess offenders' gender identities or sexual orientations. Transgender, gender-nonconforming, or not heterosexual individuals may not feel safe and welcome participating in a program that does not focus on LGBTQ relationships. Consequently, these offenders may not receive appropriate rehabilitation from a same-gender program.

Recommendation: To ensure that courts have vital information when sentencing offenders, the Legislature should require probation departments to assess all domestic violence offenders, rather than just those who are placed on formal probation, and to do so before the court sentences the offenders. In addition to the current requirements in state law, the initial assessments should determine an offender's sexual orientation, gender identity, and financial means to facilitate providing the offender with appropriate rehabilitative programs and services.

Status: Not Implemented.

Finding: Although the batterer intervention law allows program providers to grant no more than three excused absences for good cause, this law does not specify whether offenders must make up any such missed classes. When we reviewed a selection of program provider policies, we found

that some require offenders to make up missed classes and attend the full 52 weeks, whereas others allow offenders to attend only 49 classes, taking into consideration the three excused absences that state law allows. Further, the batterer intervention law does not provide direction on how program providers should address unexcused absences. Although we believe that an unexcused absence is a program violation that providers should prioritize reporting to probation departments and the courts, we found instances where some providers did not report these absences for months. It is critical for the Legislature to provide this additional direction to ensure that all offenders receive consistent rehabilitative programming and that the probation departments, courts, and program providers consistently enforce the conditions of probation.

Recommendation: To ensure that all program providers and probation departments require offenders to attend programs consistently, the Legislature should define unexcused absences and provide direction as to whether unexcused absences are allowed and whether offenders must make up missed classes.

Status: Not Implemented.

Finding: Although the batterer intervention law requires that program fees and fee waivers be based on the offender's ability to pay, it does not define ability to pay. Further, while the batterer intervention law allows indigent offenders to negotiate a deferred payment schedule for program fees, it does not provide a definition of indigence. Moreover, state law allows only the court to authorize fee waivers to certain offenders, but some probation departments did not identify or correct the practices of program providers who inappropriately waived program fees without the court's approval. We believe the law is clear as it is currently written. However, given that some probation departments and providers have not adhered to state law, we believe the Legislature could emphasize the requirements by expressly prohibiting probation departments and program providers from waiving offenders' program fees.

Recommendation: To ensure that all courts and program providers use a consistent approach to fee waivers and fee scales, the Legislature should define indigence and ability to pay as they pertain to the batterer intervention law (California Penal Code section 1203.097). It should also expressly prohibit probation departments and program providers from authorizing fee waivers.

Status: Not Implemented.

Finding: We found that probation departments generally do not maintain program fee information and therefore have likely not provided such information to the courts. As a result, probation departments and courts have not disclosed program fees to offenders when referring them to a program. The batterer intervention law does not require the probation departments or the courts to disclose program fees to offenders or to advise them of the availability of fee waivers. Without such disclosures, we question how offenders can fully understand program fees or the option to request a fee waiver from the court before agreeing to attend a program as a condition of their probation. Further, they may be unaware that they can also request a fee waiver at any time during their probation term, should their financial situation change. Additionally, the majority of program providers do not transparently disclose their fees on their websites. When we evaluated websites for 26 program providers across the five counties we reviewed, we found that the majority of them did not transparently or sufficiently disclose their fees or their sliding fee scales. Requiring program providers to disclose their fees clearly and transparently will allow offenders to obtain sufficient information to select a program that is most suitable to their financial situation.

Recommendation: To ensure that offenders have sufficient information when choosing a program provider, the Legislature should require program providers to publicly post a comprehensive description of their sliding fee scales, and it should require the courts to provide each offender with a selection of available program providers, including their standard fees and sliding fee scales, before the offender agrees to the conditions of probation. Further, the Legislature should require the courts to inform offenders of the availability of fee waivers for those who may not have the ability to pay for a program.

Status: Not Implemented.

Finding: The four probation departments' standards lack sufficient guidance about the timeliness with which program providers need to report certain information to the departments. The batterer intervention law does not include specific time frames for reporting this information; instead, it uses terms such as periodically and immediately. Consequently, we expected the probation departments to specify what they consider immediate reporting, such as the next business day or within two business days, and what they consider periodic reporting, such as every three months. However, none of the four departments' standards sufficiently specify the time frames for when program providers must submit all six of these reports. Without the framework for probation departments to oversee program providers, we observed instances when some program providers had not reported critical offender information for months. For example, because unallowed absences are a program violation, we expected the departments' standards to describe how soon program providers should report these absences, such as within two weeks. However, none of the probation departments' standards specified the time frame for reporting such absences, and state law requires program providers to report attendance only periodically to the probation department. When the program providers fail to report required offender information in a timely manner, probation departments and courts lack necessary information to supervise offenders effectively.

Recommendation: To ensure that probation departments and providers provide to the courts timely notification about offenders' program and probation violations, the Legislature should require immediate reporting of all program and probation violations. Further, the Legislature should define immediate as within a specified number of business days, such as two business days, after an entity learns of a violation.

Status: Not Implemented.

Finding: We believe that identifying a state oversight agency and implementing a collaborative statewide approach would allow California to strengthen its program administration and effectiveness. Specifically, the Legislature could task a single state agency with overseeing program providers to ensure their compliance with state law. That state agency could also monitor probation departments' supervision of offenders to ensure that the departments fulfill their responsibilities in a timely and consistent way. In addition, it could collaborate with the Judicial Council to ensure that it provides sufficient guidance to the courts regarding holding offenders accountable when they violate the conditions of their probation. Finally, the state agency could work with stakeholders—such as law enforcement officials, rehabilitative experts, and victim advocates—to establish statewide comprehensive standards as well as a system to track critical offender and program data, such as completion rates. We believe that the DOJ, under the direction of the Office of the Attorney General (Attorney General), is the state agency that is best positioned to oversee programs statewide. In 2003 the Attorney General convened a 26-member task force to learn how local criminal justice systems have carried out their responsibilities to, among other things, hold

offenders accountable for domestic violence crimes. In 2005 the task force reported that it found problematic practices related to program standards and program provider performance. Further, DOJ has a research center that is dedicated to applying a scientific approach to legal review, policy and data analysis, and empirical studies leading to data-driven decisions through collaboration. Because the Attorney General is the chief law enforcement officer of the State and because DOJ is already responsible for tracking criminal data, such as domestic violence crimes, we believe that DOJ is well positioned to lead statewide efforts to reduce domestic violence.

Recommendation: To ensure that probation departments, courts, and program providers comply with state law, the Legislature should designate DOJ as responsible for the oversight of the batterer intervention system. Its duties should include the following:

- Approving, monitoring, and renewing all program providers.
- Conducting periodic audits of probation departments and program providers.
- Establishing statewide comprehensive standards through regulations, including but not limited to, facilitators' educational requirements and a 52-week curriculum.
- Identifying or developing a comprehensive offender assessment tool.
- Collaborating with the Judicial Council and relevant stakeholders, such as law enforcement representatives, mental health professionals, rehabilitative experts, victims' advocates, and district attorneys, to set standards for programs.
- Tracking relevant offender and program data to analyze program effectiveness.

Status: Not Implemented.

Department of Justice

2021-112 *The Child Abuse Central Index: The Unreliability of This Database Puts Children at Risk and May Violate Individuals' Rights* (May 2022)

Finding: County social workers conduct investigations of suspected child abuse and document these investigations in the statewide Child Welfare Services Case Management System (CWS/CMS) maintained by Social Services. When social workers complete the associated investigations and substantiate allegations, CWS/CMS automatically populates a Child Abuse Central Index (CACI) report with the available data. Social workers then print, finalize, and mail the reports to the DOJ as DOJ requires. According to DOJ, if it determines that the reports are missing any required information, it mails the reports back to the county and requires the county to resend corrected reports. DOJ's staff manually enter complete reports into the CACI database. Then, a DOJ staff member reviews the data entry to ensure that it accurately reflects the reports before a separate DOJ unit scans and stores an electronic copy of the reports. In evaluating CWS/CMS data statewide, we identified more than 52,000 reports of substantiated child abuse that the counties generated during the four-year period ending June 2021. However, CACI contained only about 25,000 of these substantiated reports, meaning that it did not include more than half—about 27,000.

Additionally, although the problem is not nearly the same size or scope as the thousands of missing records in CACI, we identified 298 reports of child abuse in CACI during the same four-year period that did not have corresponding substantiated reports of child abuse in county records.

The State updates CACI using an outdated and inefficient process, which allows errors and omissions to persist undetected. Additionally, the process contains an inherent lag between when a county mails a report of child abuse to DOJ and when DOJ enters that suspect's information into CACI. In fact, we found that it typically takes 28 days from the date that counties complete a report of child abuse to the date that DOJ enters the report into CACI. As a result of this lag time, an authorized user could request a background check on an individual and DOJ could report that the individual is not in CACI even if a county had substantiated an allegation of child abuse against that individual. Legislative action could improve this process by amending state law to grant DOJ direct access to the CWS/CMS system that county CWS agencies use to record the results of their child abuse investigations.

Recommendation: To better protect children when an authorized user requests a child abuse background check, the Legislature should amend state law to require DOJ to directly access and review CWS/CMS data, which counties already use to record the results of their child abuse investigations. If the Legislature implements this change, it should no longer require counties to submit reports of child abuse to DOJ for inclusion in CACI, thus eliminating redundant efforts and reducing the risk of error.

Status: Not Implemented.

Finding: State law requires counties to report to DOJ all known allegations of child abuse for which the county has conducted an investigation and determined that the allegation is substantiated. At the same time, state law prohibits counties from sending a report to DOJ unless it has conducted an *active investigation* and determined that the allegation is substantiated. Social Services' guidance to counties defines active investigations as including, among many other items, interviews with the suspect and victim when appropriate and if they are available. This guidance directs counties to determine whether they have completed an active investigation on a case-by-case basis in coordination with the county legal counsel. However, the guidance states that, if a county substantiates an allegation relying on the results of a law enforcement or other investigation without conducting the county's own active investigation, the county may choose to substantiate the allegation but should not refer the suspect to CACI. Because counties can substantiate certain allegations of child abuse and not report the suspects to CACI, which state law currently permits, CACI's effectiveness in protecting children is limited. When a county substantiates an allegation of child abuse, the county has determined that it is more likely than not that the child abuse occurred. However, authorized users may be unaware of this determination if the suspect is not reported to CACI. As a result, authorized users may unknowingly allow individuals with a history of substantiated child abuse to have access to children.

Recommendation: To maximize the effectiveness of child abuse background checks in protecting children, the Legislature should amend state law to require all reports of substantiated child abuse to be included in DOJ's background checks. To protect the due process rights of individuals, the Legislature should continue to require a grievance hearing process.

Status: Not Implemented.

California Department of Corrections and Rehabilitation, Los Angeles County Sheriff's Department, San Bernardino Police Department, San José Police Department, and Stockton Police Department

2021-105 *Law Enforcement Departments Have Not Adequately Guarded Against Biased Conduct* (April 2022)

Finding: Strong hiring processes are critical to ensuring that law enforcement departments identify applicants' detectable biases. State law and POST regulations require local law enforcement departments to perform multiple hiring steps that may reveal that applicants hold biases that disqualify them from serving as officers (disqualifying biases). Only the Los Angeles County Sheriff's Department (Los Angeles Sheriff) and San José Police Department (San José Police) effectively leveraged hiring interviews to identify whether applicants had experience with or were capable of working with diverse groups of people. POST regulations require departments to hold a structured oral interview with applicants. These interviews involve asking applicants predetermined questions in a standardized fashion and evaluating their responses against predefined, job-relevant criteria. POST requires that the departments' structured interviews address, at minimum, experience, problem-solving ability, communication skills, interest and motivation, interpersonal skills, and community involvement and awareness. POST's interview guidance details that the community involvement and awareness factor includes elements that can aid departments in determining whether an applicant possesses disqualifying biases. These elements include an applicant's experience with and interest in community issues, freedom from social and ethnic prejudices, and sensitivity to and acceptance of differences based on demographic background. Despite the benefit that structured oral interviews can provide, neither Stockton Police nor CDCR conducted them. San Bernardino Police, San José Police, and Los Angeles Sheriff all conducted structured interviews of their applicants. However, only Los Angeles Sheriff's and San José Police's interviews regularly contained a question designed to determine whether the applicant could work effectively with a diverse community. Additionally, four of the five departments generally did not follow another key practice: contacting certain individuals who could provide valuable information about an applicant. POST regulations require departments to contact each applicant's relatives, neighbors, and other applicant-provided personal references. In the hiring decisions we reviewed, all of the departments contacted these individuals. However, the departments did not consistently contact additional individuals known as secondary references. State regulations describe secondary references as contacts provided to a department by the applicant's initial references and require that departments contact these individuals during the hiring process. POST's guidance also emphasizes the value of secondary references, stating that they are sometimes more candid than references the applicants provide. A final practice for identifying disqualifying biases that the departments did not adequately implement is a thorough review of the applicants' social media. Social media reviews can provide several benefits to departments, one of which is that they may reveal applicants who are affiliated with hate groups or hold biased views. Although each of the departments we reviewed incorporated some assessment of applicants' social media accounts into its hiring process, most reviews were limited and their rigor was unclear based on the records the departments kept. Additionally, none of the departments except CDCR had formalized guidance for their staff on how to conduct effective social media reviews. Although it regulates law enforcement hiring, POST has not conducted reviews to ensure that law enforcement departments are adequately performing the steps we describe above. State law requires POST to perform any inquiries necessary to determine whether

law enforcement departments are adhering to hiring standards, and POST conducts regular audits of local law enforcement departments' hiring practices. POST audited each of the four local departments at least once from January 2020 through January 2022. However, POST's audits do not include a review to ensure that departments have conducted structured oral interviews and that the interviews adequately address the six factors that regulations require. Further, although POST verifies during its audits that departments have contacted references, it does not determine whether departments have contacted secondary references.

Recommendation: To better align existing expectations in state law with best practices for addressing bias during the hiring of peace officers, the Legislature should do the following:

- Require that POST, in the course of its regular audits of local law enforcement departments' hiring processes, determine whether the departments conduct the following activities:
  - Oral interviews that incorporate assessments of officer applicants' ability to interact with a diverse community.
  - Interviews of secondary references to obtain information about officer applicants' characters.
- Require POST to develop guidance for local law enforcement departments on performing effective Internet and social media screenings of officer applicants. This guidance should include, at minimum, strategies for identifying applicant social media profiles and for searching for and identifying content indicative of potential biases, such as affiliation with hate groups.

Status: Not Implemented. AB 2547 (Nazarian, 2022) would have required POST to develop guidance for local law enforcement departments on performing effective Internet and social media screenings of officer applicants. The guidance would have to include, at a minimum, strategies for identifying applicant social media profiles and for searching for, and identifying, content indicative of potential biases, such as affiliation with hate groups. This bill died in the Senate on August 11, 2022.

Finding: One potential barrier to law enforcement departments performing in-depth reviews of applicants' social media is that state law prohibits employers from requiring or requesting that employees or applicants disclose their usernames or passwords for the purpose of accessing their personal social media. The statute does not clearly state whether that prohibition applies to employers that are state or local public departments, including law enforcement. Given the value that reviewing an applicant's public social media accounts provides in screening the applicants for a law enforcement position, an amendment to that statute to clarify that law enforcement departments are permitted to ask applicants to disclose their social media accounts for the purpose of employment screening would benefit those departments' screening practices.

Recommendation: To provide law enforcement departments hiring peace officers the ability to effectively screen for bias in applicants, the Legislature should amend state law to specify that law enforcement departments can request that officer applicants identify their public social media accounts so departments are aware of the accounts and can review them to identify content indicative of potential biases, such as affiliation with hate groups.

Status: Not Implemented.

Finding: Multiple authorities on law enforcement practices have indicated that training officers about bias is a key strategy for mitigating its effects. An effective training program reinforces expectations regarding fair and impartial law enforcement, improves officers' understanding of the effects of bias and ways to mitigate those effects, and strengthens officers' ability to interact effectively and respectfully with the diverse individuals in their community. The US DOJ, IACP, and other law enforcement experts have published best practices for the frequency with which officers should receive training about bias, as well as the content and approaches departments should include to ensure that those trainings are effective. Despite the importance of effective training, the departments we reviewed have not required that training as frequently as recommended. For example, multiple sources recommend that departments provide officers with frequent training related to bias. Frequent training on bias can reinforce key principles and ensure that officers are up to date on current circumstances, applications, and methods for bias-free policing. However, rather than following this guidance, the departments we reviewed have generally required officers to meet the lower threshold set in state law. This threshold requires officers to participate in training about racial and identity profiling and bias only once every five years, although it allows departments to provide that training more frequently if needed. In contrast, POST's regulations require certain officers to receive 24 hours of training every two years on other important topics, such as driving, making arrests, and communication. Three of the departments we reviewed—Los Angeles Sheriff, San José Police, and Stockton Police—have made additional trainings available to their officers, but none of those departments require the additional trainings at regular intervals. Most of the local departments agreed that more frequent trainings on bias would be beneficial, but would be cost-prohibitive. Local law enforcement departments are unlikely to offer training about bias more frequently without change at the state level. The Legislature could address this issue by aligning the requirements for training about bias with those that already exist for training on other vital subjects. This new requirement would likely represent an increased cost for the State. However, bias has the potential to negatively affect many of the activities in which officers engage on a daily basis. For this reason, we believe the additional cost is worthwhile. The US DOJ notes that law enforcement departments should educate their officers regarding the various cultures within their communities so that officers are better prepared to engage with and respond to residents in a manner that is situationally appropriate. However, the law enforcement departments do not consistently provide this type of training. Without sufficient training to improve officers' understanding of different cultures, they may lack critical knowledge, leading to misperceptions and miscommunications that negatively affect their interactions with individuals from different cultures.

Recommendation: To ensure that peace officers are properly trained about bias and its effects, the Legislature should amend state law to require that officers—including those at CDCR—receive training on the following topics at least every other year, and should require POST to monitor to ensure that local departments comply with this requirement:

- Explanations of implicit and explicit bias, including how bias can influence behavior.
- Community engagement strategies, including the benefits of effective community engagement and the means to achieve that engagement.
- Cultural awareness and sensitivity, including regarding the various cultures within the communities they serve.

- Reporting obligations, including how officers should respond after observing biased behavior by peers.

Status: Not Implemented.

Finding: Alongside their other efforts to mitigate the effects of bias, law enforcement departments can proactively monitor key information about officer conduct to identify trends or signals that indicate an officer may need support. One recommended approach for this type of monitoring is the use of an early intervention system. In general, these systems entail collecting information about officers' behavior; analyzing that information to identify patterns, both positive and negative; assessing whether those patterns indicate a need to intervene; and providing supports or corrective actions when necessary. These systems address a wide range of conduct, including behaviors that may be the product of officers' biases. Early intervention systems are an important component of departments' efforts to monitor and improve officer performance. Departments that do not proactively identify and correct officers' behavior can miss opportunities to provide important supports, coaching, and training to improve officers' performance before it harms members of the public or the officers themselves. In fact, some research has shown that these systems can reduce negative outcomes, such as complaints about an officer as well as officers' use of force against members of the public. Despite the benefits, none of the departments we reviewed have established early intervention systems that are fully aligned with best practices. The Legislature could take action to ensure that local departments statewide are making use of stops data, given that doing so is an effective means of proactively identifying indications of bias. Departments must already collect stops data and report them to DOJ. The Racial and Identity Profiling Advisory Board (RIPA Board), which performs analyses of the stops data and issues public reports detailing the results, has recommended that departments annually review information about officers' individualized stops data and that departments identify officers with outlier trends regarding stops and searches, in conjunction with other performance metrics. However, it has not yet published technical guidance about how departments should incorporate stops data into an early intervention system. Such guidance could be useful given the nuances and complexities of using stops data to identify trends indicative of potential bias. The Legislature could require the RIPA Board to develop and publish that guidance and could require the RIPA Board to provide oversight of departments' implementation of early intervention systems that effectively incorporate analysis of stops data.

Recommendation: To aid law enforcement departments in effectively leveraging data on officers' stops as part of their early intervention systems, the Legislature should require the RIPA Board to develop and disseminate technical guidance for how best to analyze stops data to reveal potential indications of bias at the officer level.

Status: Not Implemented.

Finding: Proper identification of and response to biased conduct demonstrates that, in practice as well as in principle, departments are committed to mitigating the effects of bias and building relationships of trust with the communities they serve. Each of the departments we reviewed has complaint and investigation processes that serve as its primary means for responding to instances of biased conduct. In accordance with state law, which requires departments to have processes for handling and reporting complaints by members of the public, each department has established

ways that its employees or members of the public can submit complaints regarding misconduct, including biased conduct. The four departments' investigations often overlooked or dismissed more subtle indicators of possible bias, suggesting that the departments were focused on only the most direct signs of bias—such as the use of racial slurs or other overt demonstrations of bias. When examined as a whole, the deficiencies we describe in the four local departments' investigations of bias demonstrate that these departments lack a sufficient framework for investigating such issues. Sufficient guidance for conducting investigations would necessarily include a uniform definition for what constitutes biased conduct by officers and factors that investigators should weigh in making their assessments. Because biases are not always demonstrated in clear and simple ways and are not always consciously held, one approach to determining whether they have influenced an officer's behavior is considering how a reasonable third party would perceive that behavior. This approach allows a department to evaluate the presence of bias in a way that incorporates the likely perspective of the community a department serves. It is already a best practice for identifying and mitigating bias related to hate crimes, workplace discrimination, and legal proceedings. In several of the cases we reviewed, the local departments failed to reach conclusions that incorporated the reasonable appearance of officers' conduct. Instead, their conclusions reflected much narrower thresholds for determining whether the officers' behavior was problematic. A statewide definition of biased conduct and a requirement that law enforcement departments apply it during their investigations would clarify expectations regarding what constitutes biased conduct. The definition of racial or identity profiling in state law provides a useful starting point for such a definition. However, the definition is limited to specific police activity and does not address other conduct, such as officers expressing biased or prejudiced viewpoints on social media. Poor investigation practices of Los Angeles Sheriff, San Bernardino Police, and Stockton Police not only have impaired their identification of individual instances of biased conduct but have also hindered their ability to monitor the prevalence of biased conduct by their officers. These three departments' failures to formally determine whether biased conduct has occurred and to properly label their investigations has left them unable to effectively track such incidents. Another issue with some of the investigations we reviewed was investigators' reliance on officers' after-the-fact statements about the intent behind their conduct. We identified this problem at Los Angeles Sheriff, San José Police, and Stockton Police. For example, in two investigations we reviewed, Stockton Police asked officers whether their behavior was motivated by bias but did not document any additional analysis about whether the officers had acted in a biased manner. Additionally, because Los Angeles Sheriff, San Bernardino Police, and Stockton Police do not reliably make formal findings specific to bias or track the investigations that include allegations of bias, they are at increased risk of failing to disclose records made public under recent changes to state law. Recently, state law effective January 2022 requires departments to disclose certain records related to investigations of biased conduct that result in sustained findings. However, if departments do not properly make sustained findings for, or track investigations of, biased conduct, they may not be able to adhere to the intent of this law.

Recommendation: To ensure that law enforcement departments properly identify and respond to possibly biased conduct by their officers, the Legislature should amend state law to do the following:

- Create a definition of biased conduct that law enforcement departments must use when investigating any bias-related complaint or any incident that involves possible indications of officer bias. At a minimum, the definition should specify that biased conduct can include conduct

resulting from implicit as well as explicit biases; that conduct is biased if a reasonable person would conclude so using the facts at hand; that an officer need not admit biased or prejudiced intent for conduct to reasonably appear biased; and that biased conduct may occur in an encounter with the public, with other officers, or online, such as conduct on social media.

- Require law enforcement departments that analyze officer conduct based on this definition to reach one of the existing formal determinations in state law about whether an allegation is true, and to document a rationale for reaching the determination.
- Require DOJ to develop standard investigative protocols that law enforcement departments must follow when evaluating whether an officer has engaged in biased conduct.
- Require POST, in consultation with DOJ, to develop training on how to properly conduct investigations of biased conduct. State law should require officers who handle complaints or other misconduct investigations to attend the training at least once every two years.

Status: Partially Implemented. AB 655 (Chapter 854, Statutes of 2022) requires, among other things, the Department of Justice to adopt and promulgate guidelines for the investigation and adjudication of complaints of a peace officer being engaged in membership in a hate group or participation in any hate group, by local agencies.

AB 2547 (Nazarian, 2022) would have required POST to establish a definition of biased conduct, and included minimum descriptions for that definition. The bill would have also required that POST use this definition in any investigation into a bias-related complaint or incident. Additionally, the bill would have required POST to develop guidance for local law enforcement departments on performing effective social media screenings for officer applicants. The bill died in the Senate on August 11, 2022.

Finding: To promote greater transparency and accountability around local law enforcement efforts to address bias, the Legislature could require departments to regularly report whether they are adhering to a standardized set of best practices. In performing our audit, we found a large volume of information about the best approaches that law enforcement departments can take to address bias. However, we found little information about how widespread the use of these practices is throughout the State. Increased transparency could incentivize local departments to adopt policies or practices that they would not have otherwise. Additionally, more visibility into local department practices would provide the public and policymakers with information that would assist them in holding local departments accountable. For a statewide reporting effort to work optimally, the RIPA Board would need to establish a uniform expectation of the policies and practices that departments should use to combat bias. This guidance would help departments ensure that they are being comprehensive in their efforts. In addition, to ensure that the departments' responses to the RIPA Board are accurate, the Legislature could require that departments provide the board with copies of any of the policies, procedures, or plans that they attest align with the best practices. By establishing the expected components of a department's approach to combating bias, verifying a selection of department practices, and publicly reporting on each department's adherence to those best practices, the RIPA Board would add a layer of accountability and transparency that is missing from the State's current approach to addressing bias in law enforcement.

Recommendation: To increase the adoption of best practices for addressing officer bias in law enforcement departments statewide, the Legislature should do the following:

- Require the RIPA Board to outline specific best practices for addressing bias within law enforcement in at least the areas of recruiting, hiring, training, community engagement, early intervention systems and related monitoring, and misconduct investigations. The Legislature should require local law enforcement departments to report to the RIPA Board the extent to which they have implemented those best practices, and should further require that departments provide the board with copies of any of the policies, procedures, or plans that they attest align with the best practices if the RIPA Board requests they do so. Finally, the Legislature should require the RIPA Board to publish annually through a scorecard, interactive dashboard, or similar means, each department's progress.

Status: Not Implemented.

Finding: DOJ could more regularly perform in-depth reviews of individual law enforcement departments and recommend improvements. Currently, DOJ's Civil Rights Enforcement Section is responsible for addressing a broad array of civil rights violations including hate crimes, failure to provide disability access, and police misconduct. This section conducts reviews of many areas of law enforcement departments' operations, including hiring, training, community engagement, early intervention systems, complaint investigations, and discipline. Despite the benefits that these reviews offer, DOJ has performed them infrequently. From 1999 until March 2022, it had completed only six reviews of city or county departments that examined their broader policing practices, with another four ongoing. Given the value that these reviews provide to both law enforcement departments and the public, we believe that DOJ should complete them on a more regular basis. Additionally, to ensure that DOJ performs these reviews for the departments that will benefit most, it should be required to develop selection criteria.

Recommendation: To increase the adoption of best practices for addressing officer bias in law enforcement departments statewide, the Legislature should do the following:

- Establish a required frequency with which DOJ must complete best practice reviews of law enforcement departments to assess their efforts to combat bias. Local departments should be required to cooperate with DOJ, and DOJ should issue public reports about the results of those reviews. The Legislature should further establish the minimum required areas that DOJ should evaluate during these reviews, including the best practices described in this report, and require DOJ to establish criteria for selecting the law enforcement departments it reviews.

Status: Not Implemented.

Finding: In 2019 US DOJ recommended that law enforcement departments consider instituting routine, third-party audits of internal affairs investigations to increase the public's trust in the departments' decisions. Because our review focused on investigations of possible biased conduct, we do not know whether the departments we reviewed regularly fail to adequately investigate other types of officer misconduct. However, it is reasonable to assume that external oversight would incentivize better performance of those investigations as well. The goals and principles of effective independent oversight, as described by US DOJ and the National Association for Civilian Oversight of Law Enforcement (NACOLE), relate to departments' investigations more broadly,

rather than just bias-related investigations. We recommend the State adopt a framework for misconduct investigations. Under this approach, DOJ would be responsible for establishing criteria for successful local oversight of law enforcement investigations. For local governments that do not provide oversight that meets these criteria, state law would require DOJ—which already conducts broader reviews of some departments and collects departments' data on bias-related complaints—to audit the associated law enforcement departments' investigations of possible biased conduct.

Recommendation: To increase the adoption of best practices for addressing officer bias in law enforcement departments statewide, the Legislature should do the following:

- Require that DOJ establish guidelines for local independent review of law enforcement departments' misconduct investigations, such as specifying that an effective independent review entity should have full access to the relevant records and should review all of the department's bias-related investigations. For any law enforcement department that does not have a process for independent review that aligns with DOJ's guidelines, the Legislature should require DOJ to conduct periodic audits of the department's misconduct investigations to identify whether it has appropriately handled investigations of possible biased conduct.

Status: Not Implemented.

Board of State and Community Corrections and County Sheriff's Departments

2021-109 *San Diego County Sheriff's Department: It Has Failed to Adequately Prevent and Respond to the Deaths of Individuals in Its Custody* (February 2022)

Finding: The California Constitution designates the Attorney General as the chief law officer of the State. Further, state law requires sheriffs' departments to report to the Attorney General all facts concerning the death of an individual while in its custody within 10 days of that death. However, in our review of four counties, we found that sheriff's departments did not report some deaths that occurred after incidents in jails because the individuals were released before their deaths. For example, we found instances in which the coroner or medical examiner's offices described individuals dying in hospitals after incidents in the county jails, such as attempted suicide or medical emergencies. However, the respective counties did not report these deaths to the Attorney General because the state law requiring reporting of in custody deaths requires sheriff's departments to report only those individuals who died while in custody at the time of death and not individuals who died after having been released.

Recommendation: To ensure that all sheriff's departments accurately report deaths that occur from incidents or conditions in county jails, the Legislature should amend state law to require sheriff's departments to report to the Attorney General individuals who are released from custody after being transported directly to a hospital or similar medical facility and subsequently die in the facility. It should also amend state law to require sheriff's departments to provide the Attorney General with all facts concerning the death, such as the cause and manner. The DOJ should annually publish this information on its website.

Status: Not Implemented.

Finding: Studies on health care at correctional facilities have demonstrated that identifying individuals' medical and mental health needs at intake—the initial screening process—is critical to ensuring their safety in custody. Nonetheless, our review of 30 individuals' deaths from 2006 through 2020 found that some of these individuals had serious medical or mental health needs that the San Diego Sheriff's Department's health staff did not identify during the intake process. Some of these individuals died within four days of their arrest. When we evaluated the intake practices of three comparable counties, we found that the counties had procedures that are more comprehensive. For example, the San Diego Sheriff's Department relies on registered nurses to perform the mental health portion of its intake screening, even though these nurses may not specialize in mental health care. In contrast, the Riverside County Sheriff's Department's policy requires that a mental health clinician evaluate every individual at intake. Implementing similar policies could help the San Diego Sheriff's Department to more effectively identify mental health needs early.

Recommendation: To ensure that the San Diego Sheriff's Department identifies individuals' medical and mental health needs at intake, the Legislature should require it to revise its policies to better align with best practices, as follows:

- Revise its intake screening policy to require mental health professionals to perform its mental health evaluations. These evaluations should include a mental health acuity level rating scale to better inform individuals' housing assignments and service needs while in custody. The San Diego Sheriff's Department should communicate the acuity level rating it assigns to individuals to all detention staff overseeing them.
- Create a policy requiring health staff to review and consider each individual's medical and mental health history from the county health system during the intake screening process.

Status: Not Implemented.

Finding: Our case review found that the San Diego Sheriff's Department staff did not always follow up after individuals previously received or requested medical or mental health services, even though these individuals often had serious needs that, when unmet, may have contributed to their deaths. Best practices stress that timely treatment and follow up are important components of any health care system. In some of the cases we reviewed, individuals reported to health staff that they were experiencing persistent symptoms, yet they did not receive timely evaluations from a physician. Moreover, although the San Diego Sheriff's Department's policy indicates that a nurse should conduct a face-to-face appraisal with an incarcerated individual within 24 hours of a mental health care request to determine the urgency of that request, it only requires this appraisal for mental health requests, not medical health care requests. Therefore, inmates with urgent medical needs may not get prompt care. Best practices indicate that a face-to-face appraisal should apply to all nonemergency health care requests. Finally, our review found that all three comparable counties have stronger policies for instances when incarcerated individuals refuse medical or mental health care. The San Diego Sheriff's Department and the three comparable counties have policies that require detention staff to witness and document an individual's refusal to accept medical treatment or care. However, the Alameda Sheriff's Office, Orange Sheriff's Department, and Riverside Sheriff's Department also require a health staff member to witness and sign the refusal. In contrast, San Diego allows a single sworn staff member to be the only signer if health staff are unavailable to serve as the second witness to the verbal refusal of care.

Recommendation: To ensure that the San Diego Sheriff's Department provides the necessary medical and mental health care to individuals incarcerated in its facilities, the Legislature should require it to do the following:

- Revise its policy to require that nurses schedule an individual for an appointment with a doctor if that individual has reported to the nurse for evaluation more than twice for the same complaint.
- Revise its policy to require that a nurse perform and document a face-to-face appraisal with an individual within 24 hours of receipt of a request for medical services to determine the urgency of that request.
- Revise its policy to require more frequent psychological follow-up after release from the inmate safety program, including at least monthly check-ins.
- Revise its policy to require that a member of its health staff witness and sign the refusal form when an individual declines to accept necessary health care.

Status: Not Implemented.

Finding: In addition to providing adequate health care, performing safety checks is a key component of ensuring the well being of individuals in detention facilities. Conducting these checks—which state law requires hourly through direct visual observation—is the San Diego Sheriff's Department's most consistent means of monitoring for medical distress and criminal activity. Nonetheless, in our review of 30 in custody deaths, we found instances in which deputies performed these checks inadequately. For example, based on our review of video recordings, we observed multiple instances in which staff spent no more than one second glancing into the individuals' cells, sometimes without breaking stride, as they walked through the housing module. When staff members eventually checked more closely, they found that some of these individuals showed signs of having been dead for several hours. Although the San Diego Sheriff's Department's assistant sheriff of detentions indicated that the San Diego Sheriff's Department has a process for periodically monitoring whether staff members adequately perform safety checks, it is not documented in policy. In contrast, the Riverside County Sheriff's Department has a formal policy that requires supervising staff to regularly review videos of safety checks being performed, and it is thus in a better position to assess the quality of safety checks. Establishing a similar process could help the San Diego Sheriff's Department to identify sworn staff who do not consistently conform to policy when conducting their checks so that it can designate them for further action, such as additional training or disciplinary measures. Until it strengthens its safety check policy and formalizes a process for ensuring that sworn staff adhere to this policy, the San Diego Sheriff's Department risks further instances of delayed responses to medical emergencies or other crises.

Recommendation: To ensure that sworn staff properly perform safety checks, the Legislature should require the San Diego Sheriff's Department to do the following:

- Revise the safety check policy to include the requirement for staff to check that an individual is still alive without disrupting the individual's sleep.
- Develop and implement a policy requiring that designated supervising sworn staff conduct audits of at least two randomly selected safety checks from each prior shift. These audits should include a review of the applicable safety check logs and video footage to determine whether the safety

checks were performed adequately. In addition, the policy should require higher-ranking sworn staff to conduct weekly and monthly audits of safety checks. The policy should also require each facility to maintain a record of the safety check audits that staff members perform.

Status: Not Implemented.

Finding: In slightly less than a third of the 30 cases we reviewed, issues with the response time of sworn staff or medical staff may have resulted in unnecessary delays in performing lifesaving measures. The early moments in a medical emergency are critical. A 2020 study found that one of the top five predictors of survival in a cardiac arrest occurring away from a hospital was someone performing cardiopulmonary resuscitation (CPR) immediately. In addition, a 2021 study found that for each five minute delay in calling emergency medical services, the odds of surviving a cardiac arrest decreased by 41 percent. Nonetheless, in some of the cases we reviewed, sworn staff failed to begin CPR immediately or before the arrival of medical staff, or were slow to respond to the scene of the medical emergency. The Sheriff's Department needs to take action to ensure that it promptly responds to emergencies. Specifically, sworn staff need additional training for immediately starting CPR and how to properly alert medical staff. Until it strengthens its safety check policy and formalizes its process, the San Diego Sheriff's Department risks further instances of delayed responses to medical emergencies.

Recommendation: To ensure that San Diego Sheriff's Department staff promptly respond to unresponsive individuals, the Legislature should require the San Diego Sheriff's Department to revise its policies to require that sworn staff members immediately start CPR without waiting for medical approval, as safety procedures allow. The Legislature should also require that the San Diego Sheriff's Department provide sworn staff with additional training for starting CPR immediately and how to properly alert medical staff.

Status: Not Implemented.

Finding: One of the San Diego Sheriff's Department's reviews—the 30 day medical review—involves reviewing the circumstances surrounding the incident and pertinent medical and mental health services and reports. According to state law, the San Diego Sheriff's Department must review every in custody death within 30 days to determine the appropriateness of clinical care; to assess whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study. To fulfill this requirement, San Diego Sheriff's Department policy states that the medical services administrator, in consultation with the chief medical officer, is responsible for reviewing all in custody deaths within 30 days. In practice, the chief medical officer—who is a licensed physician—indicated that he currently conducts the reviews with input from other health staff regarding the individuals' clinical histories. Although the chief medical officer is also required to review suicide deaths, the San Diego Sheriff's Department's policy has specified since late 2018 that the chief mental health officer will also present findings on suicides. However, the San Diego Sheriff's Department did not sufficiently document the results or recommendations from its 30 day medical reviews. For 22 of the 30 cases we reviewed, the San Diego Sheriff's Department was unable to provide us with documentation from these reviews that detailed any findings or conclusions about the clinical care given; identified whether any concerns required further study; or stated whether changes to policies, procedures, or practices were warranted. We believe that if the

San Diego Sheriff's Department properly documented the 30 day medical reviews, it could better identify and track instances when it did not provide sufficient medical and mental health follow up care before an individual's death.

Recommendation: To ensure that the San Diego Sheriff's Department properly assesses the reasons for each in-custody death and makes prompt changes as necessary in response, the Legislature should require it to revise its policy to specify the following:

- Staff will provide a written report of each 30-day medical review to its management.
- When warranted, the report should specify recommendations for changes to prevent further deaths.
- The 30-day medical review should determine the appropriateness of clinical care; assess whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

Status: Not Implemented.

Finding: The Critical Incident Review Board—the San Diego Sheriff's Department's internal review committee—generally does not review natural deaths. Instead, it primarily reviews suicides, homicides, and accidental in-custody deaths. According to the San Diego Sheriff's Department's chief legal advisor, the Critical Incident Review Board does not review natural deaths in part because the risk of legal liability in those incidents is low. He further stated that, because the Medical Examiner's Office has made a determination that an individual's death was from natural causes, it rules out other human factors. However, we found in our review of 30 case files that the Medical Examiner's Office typically reviews events preceding individuals' deaths and their medical records, but it does not make conclusions about the appropriateness of care provided by the San Diego Sheriff's Department. We find the San Diego Sheriff's Department's decision not to hold critical incident reviews for natural deaths concerning given that these deaths accounted for nearly 50 percent of all deaths in the San Diego Sheriff's Department's facilities in the period of our review. Further, we identified significant deficiencies in the San Diego Sheriff's Department's handling of care leading to all types of deaths, including natural deaths. By not requiring the Critical Incident Review Board to review these cases, the San Diego Sheriff's Department is not doing everything it can to protect incarcerated individuals.

Recommendation: To improve oversight of in-custody deaths and encourage meaningful action to prevent future deaths, the Legislature should require the San Diego Sheriff's Department to revise its policy to require that the Critical Incident Review Board review natural deaths.

Status: Not Implemented.

Finding: The San Diego Sheriff's Department has not consistently taken meaningful action in response when in custody deaths have occurred. Specifically, its reviews of in custody deaths have been insufficient and have lacked transparency. As a result, the San Diego Sheriff's Department risks conveying to the public that it is not taking these deaths seriously and making every effort possible to prevent similar deaths in the future. The Critical Incident Review Board does not make its reports and investigations public. The Critical Incident Review Board's reports are classified as attorney-client privileged, meaning that they are confidential and cannot be disclosed without the San Diego Sheriff's

Department's consent. The purpose of attorney-client privilege is to ensure that clients can fully disclose information to their lawyer without fear that it will be revealed to others, enabling them to receive competent legal advice. Although we do not disagree with having a confidential forum to discuss potential litigation matters, we are concerned that the San Diego Sheriff's Department does not have a separate public process to demonstrate that it is addressing deficiencies in its policies, procedures, and practices after in custody deaths occur. By keeping its findings and recommendations confidential, the San Diego Sheriff's Department risks conveying to the public that it is not taking these deaths seriously, investigating them thoroughly, or acting to prevent future incidents.

Recommendation: To increase the transparency of the San Diego Sheriff's Department's reviews of in-custody deaths, the Legislature should require the San Diego Sheriff's Department to either make public the facts it discusses and recommendations it decides upon in the relevant Critical Incident Review Board meetings or to establish a separate public process for internally reviewing deaths and making necessary changes.

Status: Not Implemented.

Finding: To restore public confidence in county law enforcement, San Diego County voters approved the Citizens' Law Enforcement Review Board (CLERB) in 1990, a citizen-governed board. CLERB is responsible for reviewing complaints of misconduct and investigating deaths arising in connection with the actions of officers employed by the Sheriff's Department or Probation Department. CLERB did not investigate four other in custody deaths—two that were classified as accidental, one as homicide by law enforcement, and one as suicide—from 2009 through 2011. CLERB's executive officer said that it did not investigate these deaths because the Sheriff's Department failed to inform CLERB of their occurrence. Although the Sheriff's Department indicated that it did not have information on notifications for this period, we find the lack of review of these cases concerning. In 2011 CLERB made a policy recommendation requesting that the Sheriff's Department include it in all in custody death notifications. Although the Sheriff's Department declined to modify its policies to include CLERB in its initial death notifications, which includes the county district attorney and Medical Examiner's Office, it did direct a specific unit to inform CLERB of all in custody deaths, usually within a few days of their occurrence. However, when the Sheriff's Department does not notify CLERB of deaths immediately, CLERB investigators do not have the opportunity to visit the initial scenes of the incidents shortly after the death occurred. Moreover, although the Sheriff's Department generally notifies CLERB of in custody deaths, it does not do so until after various department entities have processed the scene. As a result, CLERB investigators are not able to be present at the initial scene of the death. Instead, shortly after receiving notification of an in custody death, CLERB issues a subpoena to the Sheriff's Department for the homicide unit's investigation file. The Sheriff's Department forwards it to CLERB once it has completed its criminal investigation, usually about two to eight months after the death occurs. As a result, CLERB's investigators generally do not learn about potential witnesses or have the opportunity to visit the scene until months after the death of an incarcerated individual, severely limiting their ability to conduct an independent and thorough investigation. In fact, when we reviewed a selection of CLERB's investigations, we found that its investigators either did not visit the scenes of the deaths at all or did not do so until more than a year after the death occurred. Without the ability to independently interview witnesses or the opportunity to visit the initial scenes of the deaths, CLERB must conduct its investigation based primarily on information that the Sheriff's Department's internal investigators provide, such as photographs

and videos. For the cases we reviewed, CLERB's investigators' only other sources of evidence were statements from the decedents' families, reports from the medical examiner, and—in only one case—a direct interview with an incarcerated individual who was a witness. CLERB's nearly exclusive reliance on evidence provided by the department precludes its investigators from reaching independent conclusions on in custody deaths and providing truly external oversight of county law enforcement. For CLERB to carry out this function, its processes must change and the Sheriff's Department must fully cooperate.

Recommendation: To ensure that the San Diego Sheriff's Department provides complete and prompt assistance to CLERB's investigations, the Legislature should require the Sheriff's Department to do the following:

- Revise its policy to include CLERB in its immediate death notification process.
- Revise its policy to allow a CLERB investigator to be present at the initial death scene.
- Revise its policy to encourage its staff to cooperate with CLERB's investigations, including participating in interviews with CLERB's investigators.

Status: Not Implemented.

Finding: Although the Sheriff's Department's policies generally align with BSCC's standards related to health, safety, and personnel training, those standards are not specific enough in certain areas to ensure inmate safety. For example, BSCC's standards do not explicitly require that a mental health professional should perform mental health screenings. As a result, the San Diego Sheriff's Department's, Alameda Sheriff's Office's, and Orange Sheriff's Department's policies allow medical nurses and health clinicians rather than mental health professionals to perform mental health screenings at intake. In these counties, the health staff generally will refer an incarcerated individual for a mental health evaluation if they observe general signs necessitating the referral or if the individual self reports mental health concerns. In contrast, the Riverside Sheriff's Department's policy requires a mental health professional to conduct the mental health screening in all instances, which is a best practice. In another example, BSCC's standards do not describe the actions that constitute an adequate safety check. Instead, the standards simply state that safety checks must be conducted at least hourly through direct visual observation of all inmates and that observation through a video camera alone is not sufficient. The four counties we reviewed based their policies on different interpretations of this standard. Moreover, CDCR requires its staff to count living, breathing individuals whom they see in person. This count is an hourly check that is the equivalent to what BSCC's standards refer to as a safety check. Although BSCC is currently revising the safety check standard, its proposed revision still does not specify that a safety check must include verifying that an individual is alive, which is essential to ensuring the safety of incarcerated individuals across the State.

Recommendation: To ensure that standards of care for incarcerated individuals are adequate and consistent across the State, the Legislature should amend state law to require BSCC to amend certain regulations to address the following:

- County sheriff's departments with jails that have an average daily population of more than 1,000 must have a mental health professional perform mental health evaluations at intake.
- Safety checks must include a procedure for checking to see that each individual is alive.

> **Status:** Not Implemented. AB 2343 (Weber, Atkins, 2022) would have required the BSCC to adopt regulations setting minimum standards for mental health care at local correctional facilities, including safety checks of incarcerated persons that are sufficiently detailed to determine that the inmate is alive. The Governor vetoed this bill on September 29, 2022.

Finding: State law does not require that BSCC have medical or mental health professionals on its board, despite its responsibility for creating standards in these areas. The qualifications for almost all of the board member positions are related to law enforcement in a detention setting. State law requires BSCC to seek the advice of medical and mental health professionals when establishing minimum standards and when reviewing and making revisions every two years. However, because the standards have so much impact on the lives of incarcerated individuals, we believe that having medical and mental health representation on the board is critical. Similar boards in other states, such as the New York City Board of Corrections and the Texas Commission on Jail Standards, have medical experts serving as members.

Recommendation: To ensure the involvement of experts in the areas of medical and mental health care in approving BSCC's regulations and training standards related to the health and safety of incarcerated individuals, the Legislature should change the composition of BSCC to include a medical professional and a mental health professional.

> **Status:** Not Implemented. AB 2343 (Weber, Atkins, 2022) would have changed the composition of the BSCC to include additional members effective July 1, 2023, including a licensed health care provider and a licensed mental health professional, both appointed by the Governor. The Governor vetoed this bill on September 29, 2022.

Finding: State law does not require that BSCC have medical or mental health professionals on its board, despite its responsibility for creating standards in these areas. The qualifications for almost all of the board member positions are related to law enforcement in a detention setting. State law requires BSCC to seek the advice of medical and mental health professionals when establishing minimum standards and when reviewing and making revisions every two years. However, because the standards have so much impact on the lives of incarcerated individuals, we believe that having medical and mental health representation on the board is critical. Similar boards in other states, such as the New York City Board of Corrections and the Texas Commission on Jail Standards, have medical experts serving as members.

Recommendation: To ensure that BSCC's regulations, guidance, and training align with medical and mental health care best practices, the Legislature should require BSCC to evaluate and update all of its regulations and training as needed once its composition includes a medical professional and a mental health professional.

> **Status:** Not Implemented.

Finding: BSCC's required training hours for sworn staff working in local detention facilities do not align with their standards for similar positions. BSCC's regulations require only 24 hours annually of continuing professional education training for adult correctional officers, supervisors, and managers, even though it requires 40 hours of continuing training for probation officers and juvenile correctional supervisors and managers. Requiring fewer hours for adult corrections

personnel does not make sense when thousands of individuals are incarcerated in these facilities and the number of individuals who have died has increased over the past 15 years. Based on our review of how San Diego Sheriff's Department's sworn staff responded to medical, mental health, and safety needs, we recommend increasing the number of training hours to align with similar professions to allow sheriff's departments to better protect and keep incarcerated individuals safe. Further, BSCC does not require that any of the 24 hours of training cover topics pertaining to mental health, even though best practices suggest staff should receive at least four hours of mental health training annually. Without such a requirement, law enforcement staff may not be sufficiently prepared to provide care to and properly monitor individuals with mental health needs.

Recommendation: To ensure that all local correctional officers in the State receive sufficient continuing professional education, the Legislature should require BSCC to amend its regulations to require that local correctional officers working in local detention systems with an average daily population of more than 1,000, complete 40 hours of training annually and that at least four of those hours relate to mental and behavioral health.

> **Status:** Not Implemented. AB 2343 (Weber, Atkins, 2022) would have required the BSCC to adopt regulations setting minimum standards for mental health care at local correctional facilities, including in-service training of correctional officers to include no fewer than four hours of training on mental and behavioral health annually. The Governor vetoed this bill on September 29, 2022.

Board of State and Community Corrections and Counties

2020-102 *Public Safety Realignment: Weak State and County Oversight Does Not Ensure That Funds Are Spent Effectively* (March 2021)

Finding: To reduce state prison overcrowding and help lower the State's incarceration costs, beginning in 2011, the Legislature transferred the responsibility for managing certain offenders sentenced for nonviolent, nonserious offenses from the State to counties—a change in responsibility commonly referred to as *realignment*. Along with housing the influx of inmates that resulted from realignment, state law also intended for county jails to make educational, rehabilitative, and exercise opportunities available to all inmates; however, the counties we reviewed struggled to do so. Counties generally built their jail facilities before realignment, and the jails were only intended to house inmates for sentences up to one year. As a result, officials at the three counties we reviewed stated that they lack the facilities and resources to provide a number of vocational trade programs to prepare inmates for reentry to the community. Further, these three counties' jails often lack adequate outdoor facilities for inmates to engage in physical activities or exercise sufficiently. These facility limitations are of particular concern because county jails may house some realigned inmates for significantly longer than three years and in some cases longer than 10 years.

Recommendation: To ensure that inmates serving lengthy terms in county jails have adequate educational and exercise opportunities, the Legislature should amend state law to limit the time inmates can spend in county jail to terms of no more than three years. In the event that the total sentence exceeds three years, it should require that the person serve the sentence in state prison.

> **Status:** Not Implemented.

Finding: As part of the realignment legislation, the State created the State Revenue Fund 2011 to receive the sales tax revenue and vehicle license fees that the State allocates to the counties for public safety realignment. That fund includes a Mental Health account. In turn, state law required each county to create a Local Revenue Fund 2011 to receive allocations from the State and to divide its Local Revenue Fund 2011 into eight specified accounts. However, in establishing the county accounts, the Legislature did not require counties to create a Mental Health account to receive the funds the State allocated for this purpose for public safety. In total, the State paid $1.1 billion to counties for this mental health funding in fiscal year 2019–20. The other funds the State provides to the counties for mental health are associated with a previous social services realignment dating back to 1991. State law restricts the 1991 mental health funding for mental health services that serve specific targeted populations, such as seriously emotionally disturbed children and adults who have serious mental disorders. In contrast, counties must use the 2011 realignment funding for public safety purposes, including providing mental health services to reduce student failure in schools, harm to self and others, homelessness, and preventable incarceration or institutionalization.

Recommendation: To ensure consistency between state allocations and county accounting records, the Legislature should amend state law to require counties to separate mental health funding for public safety realignment from previously enacted mental health funding.

Status: Not Implemented.

Finding: As a part of their responsibilities, Community Corrections Partnership committees (Partnership Committees) are required to recommend plans for how their respective counties will implement public safety realignment programs and services. This plan could also include recommendations to the county to maximize the effective investment of criminal justice resources, which includes realignment funds for the 10 public safety realignment accounts we identified. Additionally, state law requires the Board of State and Community Corrections (Community Corrections) to—among other things—provide an annual report to the Legislature regarding the implementation of realignment, inspect and report on county jail facilities' compliance with state standards, collect best practices and make them available to counties, and define key realignment terms. However, we found that Community Corrections has, at best, minimally met these requirements and needs to improve its oversight of counties.

Recommendation: To ensure that the counties and Community Corrections are aware of their oversight responsibilities and resolve inconsistencies we identified from county to county, the Legislature should amend state law to clearly identify the specific accounts in the Local Revenue Fund 2011 it requires county Partnership Committees to plan for and oversee and Community Corrections to include in its annual reports to the Legislature.

Status: Not Implemented.

Appendix

Legislation Chaptered or Vetoed During the Second Year of the 2021–22 Regular Legislative Session

The table below briefly describes bills that were chaptered or vetoed during the second year of the 2021–22 Regular Legislative Session and relate to a report issued by the California State Auditor (State Auditor) in the past ten years. These bills either address audit recommendations or the subject matter of the bill relates to findings in a State Auditor report.

Legislation Chaptered or Vetoed in the 2021–22 Regular Session

BILL NUMBER (CHAPTERED/VETOED)	REPORT (ABBREVIATED TITLE)	SUMMARY OF LEGISLATION
Education		
AB 2158 Ch. 279, Stats. 2022	2018-131 *Alum Rock Union Elementary School District* (May 2019)	Includes within the definition of "local agency," a school district, county office of education, and charter school for purposes of certain ethics training requirements and includes in the definition of "local agency official" a member of the governing board of a school district, a county board of education, or the governing body of a charter school, whether or not the member receives any type of compensation, salary, or stipend or reimbursement for actual and necessary expenses incurred in the performance of official duties. Requires each of those members in service as of January 1, 2025, except for members whose term of office ends before January 1, 2026, to receive ethics training before January 1, 2026, and at least once every 2 years thereafter.
Environmental Quality		
AB 2083 Ch. 689, Stats. 2022	2021-117 *Electrical System Safety* (March 2022)	Prohibits an electrical or gas corporation from recovering, through a rate approved by the California Public Utilities Commission (CPUC), costs arising directly from new or additional activities expressly agreed to by the corporation, or any payment, fine, or penalty paid by the corporation, in a settlement agreement resolving a criminal or civil inquiry, investigation, or prosecution, except when the CPUC determines that those costs were just and reasonably incurred.
SB 884 Ch. 819, Stats. 2022	2021-117 *Electrical System Safety* (March 2022)	Requires the CPUC to establish an expedited utility distribution infrastructure undergrounding program and would authorize only those electrical corporations with 250,000 or more customer accounts within the State to participate in the program. Requires a large electrical corporation, in order to participate in the program, to submit a distribution infrastructure undergrounding plan, including the undergrounding projects located in tier 2 or 3 high fire-threat districts, or rebuild areas that it will construct as part of the program, to the Office of Energy Infrastructure Safety (Energy Safety Office), which would be required to approve or deny the plan within 9 months. Requires the large electrical corporation, if the Energy Safety Office approves the plan, to submit to the CPUC a copy of the plan and an application requesting review and conditional approval of the plan's costs and requires the CPUC to approve or deny the plan within 9 months. If the plan is approved by the Energy Safety Office and the CPUC, requires the large electrical corporation to file specified progress reports, include additional information in its wildfire mitigation plans, hire an independent monitor to review and assess its compliance with its plan, apply for available federal, state, and other nonratepayer moneys throughout the duration of the approved plan, and use those nonratepayer moneys to reduce the program's costs on its ratepayers, as specified. Authorizes the CPUC to assess penalties on a large electrical corporation that fails to substantially comply with the CPUC decision approving its plan.
SB 1145 Ch. 366, Stats. 2022	2020-114 *California Air Resources Board Climate Change Goals* (February 2021)	Requires the California Air Resources Board (CARB) to create and maintain on its Internet website a greenhouse gas emissions dashboard that provides updated publicly available information regarding how the State is progressing toward meeting its statewide climate change goals.

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BILL NUMBER (CHAPTERED/VETOED)	REPORT (ABBREVIATED TITLE)	SUMMARY OF LEGISLATION
SB 1230 Ch. 371, Stats. 2022	2020-114 *California Air Resources Board* (February 2021)	Requires, among other things, CARB, with respect to the various zero-emission and near-zero-emission vehicle incentive programs administered or funded by CARB, to adopt certain revisions to those programs if CARB finds those revisions to be feasible. Requires CARB, if it finds that the adoption of the revisions is infeasible, to prepare a report describing the rationale for the finding, to post the report on its Internet website, and to provide a notice of the report to the relevant policy and fiscal committees of the Legislature.
Governmental Organization		
AB 1804 **VETOED**	2018-039 *Fi$Cal Status* (January 2019)	Would have required, on and after January 1, 2024 and until January 1, 2028, the Financial Information System for California (FI$Cal) project office to include certain information in its annual report to the Legislature, including the number and length of unplanned outages that occurred during normal business hours, the total number of users' service requests by priority level, the number of service requests successfully resolved, and the number of resolutions that took longer than the service level objectives defined by the project.
Health & Human Services		
AB 2144 **VETOED**	2019-119 *Lanterman-Petris-Short Act* (July 2020)	Would have required the California Department of Justice (DOJ) to, on a quarterly basis, provide to the Department of Health Care Services (DHCS) a copy of certain reports related to the detention of persons pursuant to the Lanterman-Petris-Short Act for the purpose of determining the eligibility of the person to own, possess, control, receive, or purchase a firearm. Would have also required the DHCS to share the information it receives from the DOJ and designated facilities with county mental health or behavioral health departments on a quarterly basis. Would have required a designated facility to submit a quarterly report to the DHCS that identified people admitted to a facility pursuant to the Lanterman-Petris-Short Act because the person is gravely disabled and minors younger than 13 years of age admitted pursuant to the Children's Civil Commitment and Mental Health Treatment Act of 1988. Would have required the designated facility to include in the report the same information required to be reported to the DOJ for individuals who are subject to firearms restrictions.
AB 2242 Ch. 867, Stats. 2022	2019-119 *Lanterman-Petris-Short Act* (July 2020)	Requires, on or before December 1, 2023, DHCS to convene a stakeholder group of entities, including the County Behavioral Health Directors Association of California and the California Hospital Association, among others, to create a model care coordination plan to be followed when discharging those held under temporary holds or a conservatorship. Requires the model care coordination plan and process to outline who would be on the care team and how the communication would occur to coordinate care. Among other components, requires the model care coordination plan to require that an individual exiting a temporary hold or a conservatorship be provided with a detailed plan that includes a scheduled first appointment with the health plan, the mental health plan, a primary care provider, or another appropriate provider to whom the person has been referred. Requires facilities designated by the counties for evaluation and treatment of involuntarily committed patients to implement the care coordination plan by August 1, 2024. Requires a care coordination plan to be developed and provided to an individual before being discharged from a hold or released after being detained for evaluation and treatment. Requires a care coordination plan to be developed and provided to a conservatee prior to their release. Requires the county behavioral health department, among others, to participate in designing an individual's care coordination plan. To the extent permitted under state and federal law and consistent with the Mental Health Services Act and for the purposes of the Lanterman-Petris-Short Act, clarifies that counties may pay for the services authorized in those provisions using funds from the Mental Health Services Fund when included in county plans, as specified, and authorizes counties to pay for those services with specified funds from the Local Revenue Fund and the Local Revenue Fund 2011.

BILL NUMBER (CHAPTERED/VETOED)	REPORT (ABBREVIATED TITLE)	SUMMARY OF LEGISLATION
SB 929 Ch. 539, Stats. 2022	2019-119 *Lanterman-Petris-Short Act* (July 2020)	Requires, in part, DHCS to collect data quarterly and publish, on or before May 1 of each year, a report including quantitative, de-identified information relating to, among other things, the number of persons in designated and approved facilities admitted or detained for 72-hour evaluation and treatment, clinical outcomes and services for certain individuals, waiting periods prior to receiving an evaluation or treatment services in a designated and approved facility, demographic data of those receiving care, the number of all county-contracted beds, and an assessment of the disproportionate use of detentions and conservatorships on various groups. Specifies that the information be from each county for some of those data. Requires the Judicial Council of California (Judicial Council) to provide DHCS, by October 1 of each year, with data from each superior court to complete the report, including, among other things, the number and outcomes of certification review hearings, petitions for writs of habeas corpus, and judicial review hearings. Beginning with the report due May 1, 2025, requires the report to also include the progress that has been made on implementing recommendations from prior reports. Requires DHCS to make the report publicly available on DHCS's Internet website. Requires each county behavioral health director or other entity involved in implementing the provisions relating to detention, assessment, evaluation, or treatment for up to 72 hours to provide data as prescribed by DHCS. Authorizes DHCS to impose a plan of correction against a facility or county that fails to submit data timely or as required.
SB 1035 Ch. 828, Stats. 2022	2019-119 *Lanterman-Petris-Short Act* (July 2020)	Authorizes the court to conduct status hearings with the person who is the subject of a petition to obtain assisted outpatient treatment and the treatment team to receive information regarding progress related to the categories of treatment listed in the treatment plan and authorizes the court to inquire about medication adherence. Requires the director of the outpatient treatment program to also report to the court on adherence to prescribed medication when making the affidavit that affirms that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.
AB 2684 Ch. 413, Stats. 2022	2019-120 *Board of Registered Nursing* (July 2020)	Among other things, creates within the Board of Registered Nurses (BRN) a Nursing Education and Workforce Advisory Committee, which is required to solicit input from approved nursing programs and members of the nursing and health care profession to study and recommend to the board, nursing education standards, simulated clinical experiences, and solutions to workforce issues. Provides that BRN's executive officer is required to develop a uniform method for evaluating the approval of school of nursing and nursing program requests and granting approvals pursuant to certain provisions and requires the executive officer to post the uniform method and any revisions on BRN's website. Prohibits an institution of higher education or a private postsecondary school of nursing subject to certain provisions from paying any clinical agency or facility for clinical experience placements for students enrolled in a nursing program offered by that school of nursing. Additionally, requires an approved school of nursing or nursing program to meet a minimum of 500 direct patient care clinical hours and authorizes an approved school of nursing or nursing program to cover fewer than two academic years if approved to providing a course of instruction that prepares a licensed vocational nurse. For approved schools of nursing actively accredited, requires BRN to accept continuing approval decisions from the accreditor, approve substantive change requests if approved by the accreditor, and consider limited factors when considering a request to increase enrollment, among other things.
AB 2326 Ch. 528, Stats. 2022	2019-105 *Childhood Lead Levels* (January 2020)	Requires, in part, that, beginning on July 1, 2023, a laboratory that performs a blood lead analysis to report to the California Department of Public Health (CDPH) the person's Medi-Cal client identification number (CIN) or, for other health plans, the name of the health plan and the medical plan identification number unless the health care provider cannot, or will not, provide the requested information.

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BILL NUMBER (CHAPTERED/VETOED)	REPORT (ABBREVIATED TITLE)	SUMMARY OF LEGISLATION
AB 408 Ch. 904, Stats. 2022	2019-104 *Youth Experiencing Homelessness* (November 2019)	Requires, in part, a local educational agency (LEA) liaison for homeless children and youths and unaccompanied youths to offer training annually to classified and certificated employees of the LEA who work with pupils experiencing homelessness, including teachers, support staff, and other school staff who work with pupils. Requires the training to cover the LEA's homeless education program policies and recognition of signs that pupils are experiencing, or are at risk of experiencing, homelessness. Requires the California Department of Education (CDE) to develop and implement a plan for monitoring the compliance of LEAs with state laws relating to youth experiencing homelessness. The implementation of this monitoring plan is required to include reviews of the LEAs, including schoolsite inspections to ensure that the State is not underestimating the number of youth experiencing homelessness.
AB 2375 Ch. 912, Stats. 2022	2019-104 *Youth Experiencing Homelessness* (November 2019)	Requires an LEA, regardless of the receipt of certain funds, to ensure, by the end of the 2021–2022 school year, that a specific housing questionnaire is based on best practices developed by the California Department of Education.
AB 1502 Ch. 578, Stats. 2022	2017-109 *Skilled Nursing Facilities* (May 2018)	Prohibits a person or an applicant that submits an application for a license to operate a health facility after July 1, 2023 from establishing, acquiring, or operating a freestanding skilled nursing facility without first obtaining a license from the CDPH. Applies the licensure requirement to a change of ownership or management of such a facility. Requires the application to include certain information, including evidence that the applicant is reputable and responsible to assume the facility's license or management and evidence of specified financial capacity, and, if the applicant is part of a chain, providing a diagram indicating the relationship between the applicant and the persons or entities that are part of the chain. Requires an applicant for a skilled nursing facility to report certain changes in information in an application 30 days prior to that change. Authorizes CDPH to take certain actions, including imposing civil penalties, if an applicant establishes, acquires, or operates a freestanding skilled nursing facility before CDPH acts on its application or following the denial of its application, or if the person does not first apply to and obtain a license from CDPH. Requires CDPH to ensure a facility's operation is transitioned to a qualified operator, following the denial of an application. Authorizes CDPH, subsequent to licensure, to assess a civil penalty of $10,000 for a material violation of these provisions.
AB 1907 Ch. 277, Stats. 2022	2017-109 *Skilled Nursing Facilities* (May 2018)	Extends from 2 years to 30 months the maximum time period between inspections that are required to be conducted by CDPH of a skilled nursing facility.
AB 2079 **VETOED**	2017-109 *Skilled Nursing Facilities* (May 2018)	Would have, among other things, required the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, no later than July 1, 2023, and would have required that a minimum of 85 percent of a facility's total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents' direct patient-related services. Would have also required a facility to report total revenues collected from all revenue sources, along with the portion of revenues that are expended on all direct patient-related services and nondirect patient-related services, to DHCS by June 30 of each calendar year, with certification signed by a duly authorized official. If a skilled nursing facility failed to comply with the direct patient-related services spending requirement, the bill would have required the facility to issue a pro rata dividend or credit to the state and to all individuals and entities making non-Medicare payments to the facility for resident services, as specified. Would have required the DHCS to ensure that those payments were made and to impose sanctions, as specified. Would also have authorized the DHCS to withhold certain payments from a skilled nursing facility licensee for failure to fully disclose information, as specified.
AB 1720 Ch. 581, Stats. 2022	2016-126 *California Department of Social Services* (March 2017)	Authorizes, in part, the California Department of Social Services (CDSS) to grant a simplified criminal record exemption to an applicant for a license or special permit to operate or manage various types of facilities, including community care facilities, and the specified individuals connected with these facilities, if certain criteria is met. Prohibits CDSS from requiring an applicant for a license to disclose their criminal history information prior to receipt of live scan results.

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Higher Education		
SB 1364 **VETOED**	2016-125.1 *University of California Office of the President* (August 2017)	Would have, among other things, made it unlawful for any vendor, as defined, to accept payment above a specified threshold from the University of California pursuant to a contract for prescribed services if the vendor is performing services or supplying the University of California with employees to perform services who are paid less than the higher of the total compensation rate specified in the vendor's contract with the University of California or as required by university policy.
Housing & Community Development		
AB 2592 Ch. 439, Stats. 2022	2021-114 *State Surplus Property* (March 2022)	Requires, by January 1, 2024, the Department of General Services (DGS) to prepare and report to the Legislature a streamlined plan to transition underutilized multistory state buildings into housing for the purpose of expanding affordable housing development and adaptive reuse opportunities of multistory state office buildings.
AB 1288 **VETOED**	2020-108 *California's Housing Agencies* (November 2020)	Would have, in part, authorized the California Debt Limit Allocation Committee (Debt Limit Committee), until January 1, 2028, to adopt, amend, or repeal its rules and regulations without complying with the procedural requirements of the Administrative Procedures Act and made the rules and regulations adopted, amended, or repealed by the Debt Limit Committee effective immediately upon adoption.
AB 1978 Ch. 644, Stats. 2022	2020-108 *California's Housing Agencies* (November 2020)	Requires, in part, the California Department of Housing and Community Development (HCD) to establish and publish on its Internet website a tracking system for all the programs it administers, including the deadlines for each step of a program application.
SB 1307 Ch. 669, Stats. 2022	2019-111 *Mobile Home Park Inspections* (July 2020)	Requires, among other things, the HCD to post an explanation of the process for a city, county, or city and county to assume the enforcement responsibilities pursuant to Mobilehome Parks Act and Special Occupancy Parks Act, on its Internet website, in multiple languages.
Insurance		
AB 2129 Ch. 119, Stats. 2022	2020-128/628.1 Employment Development Department: *Unemployment Insurance Claim Surge* (January 2021) and 2020-628.2 Employment Development Department: *Unemployment Insurance Fraud* (January 2021)	Requires the Employment Development Department's (EDD) recession plan to include a summary of the actions taken by EDD to implement recommendations contained in the recession plan previously provided to specified legislative committees and the Department of Finance.
Public Safety		
AB 731 **VETOED**	2020-102 *Public Safety Realignment* (March 2021)	Would have required the sheriff in each county to compile and submit to the Board of State and Community Corrections (Community Corrections) data that include a list of all the educational opportunities, rehabilitative opportunities, and exercise opportunities at the county jail, as well as the number of participants and the cost of administering those opportunities, and the overall recidivism rates for each county jail. Would have required Community Corrections to compile a report based upon those findings and to submit the report to the Legislature by July 1, 2023.
SB 903 Ch. 821, Stats. 2022	2020-103 *California Department of Corrections and Rehabilitation* (August 2020)	Requires the California Rehabilitation Oversight Board to examine the California Department of Corrections and Rehabilitation's efforts to address the housing needs of incarcerated persons, including those who are identified as having serious mental health needs, who are released to the community as parolees and to include specified data on homelessness in its reports.

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BILL NUMBER (CHAPTERED/VETOED)	REPORT (ABBREVIATED TITLE)	SUMMARY OF LEGISLATION
AB 2645 Ch. 247, Stats. 2022	2019-103 *Emergency Planning* (December 2019)	Requires a county, pursuant to the existing requirement to integrate access and functional needs into its emergency plan upon the plan's next update, to address specific additional plan elements. Requires the plan, with regard to emergency evacuation, to also integrate evacuation and transportation plans to account for local community resilience centers, to ensure that local community resilience centers, as defined, are prepared to serve as communitywide assets during extreme heat events and other disasters, to designate available locations that may be necessary to provide respite to individuals during certain environmental emergencies, and to integrate evacuation plans to account for specified state grant programs relating to community resilience. Requires the plan, with regard to emergency sheltering, to also integrate sheltering and transportation plans to account for transportation between community resilience centers and shelters.
AB 485 Ch. 852, Stats. 2022	2017-131 *Hate Crimes* (May 2018)	Requires local law enforcement agencies to post to their internet websites, on a monthly basis, the hate crime information that they are required to send to the California Department of Justice.
AB 557 Ch. 853, Stats. 2022	2017-131 *Hate Crimes* (May 2018)	Requires the DOJ to establish a grant program for the purpose of creating, supporting, or expanding vertical prosecution units for the prosecutions of hate crimes. Requires the units to be primarily focused on better serving hate crime victims and achieving just, equitable, and appropriate resolutions to hate crime cases. Authorizes the DOJ to provide one-time grants, upon appropriation by the Legislature, on a competitive basis, to selected prosecutorial agencies in a manner and in an amount determined by the DOJ. Requires grant recipients to report specified information to the DOJ by no later than July 1, 2028, and requires the DOJ to compile that information and report to the Legislature by no later than July 1, 2029.