Implementation of State Auditor's Recommendations

Audits Released in January 2006 Through December 2007

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

February 2008 Report 2008-406 S3

CALIFORNIA STATE AUDITOR

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Elaine M. Howle
State Auditor
Doug Cordiner
Chief Deputy

CALIFORNIA STATE AUDITOR
Bureau of State Audits

555 Capitol Mall, Suite 300 Sacramento, CA 95814 916.445.0255 916.327.0019 fax www.bsa.ca.gov

February 21, 2008 2008-406 S3

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

Dear Governor and Legislative Leaders:

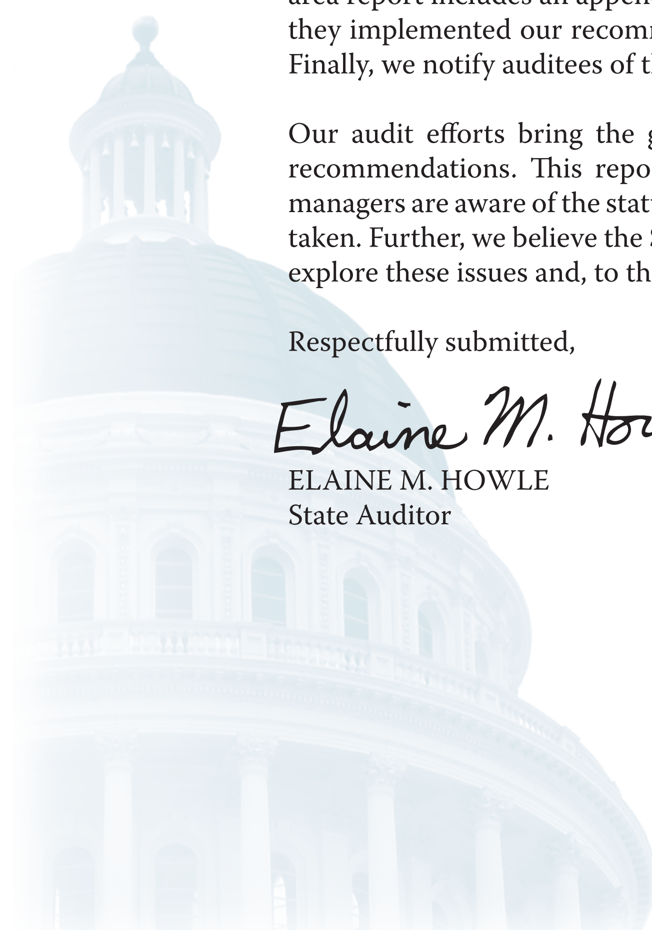
The Bureau of State Audits presents its special report for the Senate Budget and Fiscal Review Subcommittee No. 3—Health, Human Services, Labor and Veterans Affairs. This report summarizes the audits and investigations we issued during the previous two years that are within this subcommittee's purview. This report includes the major findings and recommendations, along with the corrective actions auditees reportedly have taken to implement our recommendations.

This information is also available in a special report that is organized by policy areas that generally correspond to the Assembly and Senate standing committees. This special policy area report includes an appendix that identifies monetary benefits that auditees could realize if they implemented our recommendations, and is available on our Web site at www.bsa.ca.gov. Finally, we notify auditees of the release of these special reports.

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

Respectfully submitted,

ELAINE M. HOWLE
State Auditor



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Introduction

This report summarizes the major findings and recommendations from audit reports we issued from January 2006 through December 2007, that relate to agencies and departments under the purview of the Senate Budget and Fiscal Review Subcommittee No. 3—Health, Human Services, Labor and Veterans Affairs. The purpose of this report is to identify what actions, if any, these auditees have taken in response to our findings and recommendations. We have placed this symbol ➲ in the margin of the auditee action to identify areas of concern or issues that we believe an auditee has not adequately addressed.

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

We report all instances of substantiated improper governmental activities resulting from our investigative activities to the cognizant state department for corrective action. These departments are required to report the status of their corrective actions every 30 days until all such actions are complete.

Unless otherwise noted, we have not performed any type of review or validation of the corrective actions reported by the auditees. All corrective actions noted in this report were based on responses received by our office as of January 2008.

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California Children and Families Commission

Its Poor Contracting Practices Resulted in Questionable and Inappropriate Payments to Contractors and Violations of State Law and Policies

REPORT NUMBER 2006-114, OCTOBER 2006

California Children and Families Commission's response as of October 2007

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits (bureau) review the California Children and Families Commission's (state commission) spending practices, planning efforts, and contracting procedures.

Audit Highlights . . .

Our review of the California Children and Families Commission's spending practices and contracting procedures revealed that it:

- ***Allowed one of its media contractors to circumvent the payment provisions of a contract by paying invoices totaling $673,000 for fees and expenses of some of the contractor's employees that were prohibited under the terms of the contract.***
- ***Did not fully use the tools available to it to ensure its contractors provided appropriate services.***
- ***Could not always demonstrate it had reviewed and approved final written subcontracts and subcontractors' conflict-of-interest certificates.***
- ***Did not always follow state policy when it used a competitive process to award three contracts valued at more than $47.7 million and failed to provide sufficient justification for awarding one $3 million contract and six amendments totaling $27.6 million using the noncompetitive process.***

Finding #1: The state commission did not enforce contract terms for one contractor, resulting in overpayments totaling more than $673,000.

The state commission, in paying invoices totaling $623,000 in fees and expenses submitted by one of its media contractors, allowed the contractor to circumvent the payment provisions of a contract. The contractor claimed the expenses by representing some of its employees as subcontractors. In addition, the state commission paid the media contractor an added $50,000 fee that was unallowable per the contract. These payments violated the terms of the contract, which allowed for payments based only on the contractor's own services, in the form of commissions applied to the cost of the advertising it placed; no other services or fees were to be charged.

We recommended that the state commission ensure that both it and its contractors comply with all contract terms.

State Commission's Action: Corrective action taken.

The state commission stated in its 90-day response to our audit that its most concerted efforts have been on staff training to ensure that all staff with any contract management responsibility understand the state's contracting procedures. In its one-year response, the state commission provided a schedule of the training courses that its staff attended between December 2006 and September 2007. It also stated that now that it has completed the Procurement Policy and Procedure Manual (manual), key staff will attend formal, internal training courses during November and December 2007 on topics such as contract concepts and timeline development, contract monitoring, invoice review and approval, and conducting and documenting solicitations. In its 90-day response, the state commission also had indicated that it appointed a specific staff member to track the training status of staff with contract responsibility. Finally, in its one-year response, the state commission pointed to a specific section of the new manual that discusses procedures its staff should follow when contractors do not appear to be complying with contract terms.

Finding #2: The state commission did not fully use the tools available to it to ensure that its contractors promptly provided appropriate services.

The state commission did not always include certain important elements when developing some of the contracts we reviewed. Specifically, the state commission's contracts did not always include a clear description of work to be performed, schedules for the progress and completion of the work, and a reasonably detailed cost proposal. Further, it did not always ensure that its contractors submitted adequate work plans, that it received all required work plans, and that it promptly approved them. As a result, the state commission cannot ensure that the resulting contracts clearly established what was expected from the contractor, that the contracts provided the best value, and that its contractors provided the agreed-upon services within established timelines and budgets.

We recommended that the state commission ensure that it fully develops its contracts by including clear descriptions of work, schedules for progress and completion of work, reasonably detailed cost proposals, a requirement for adequate supporting documentation for expenses, and clearly defined types of allowable expenses. We also recommended that it consistently enforce contract provisions requiring contractors to submit complete and detailed work plans before they perform services and incur expenses and to ensure that it promptly reviews and approves work plans.

State Commission's Action: Corrective action taken.

Again, the state commission referred to its 90-day response, which stated that it was sending all staff with any contract management responsibility to various training courses. In that same response, it also indicated that it had developed standard language for all new contracts, which addresses allowable out-of-pocket expenses and requires the contractor to obtain clarification from the state commission in advance of incurring an expense when it is unclear under the terms of the contract whether the expense is authorized. The state commission also stated that it redesigned the work plans it requires its public relations contractors to provide to include a detailed description of services and to identify the deliverables, target audience, and proposed completion timeline, as well as other information. Finally, in its one-year response, the state commission pointed to various sections of its new manual that describes the processes and procedures staff must follow related to the scope of work for a contract, schedules for progress and completion of work, contract budgets, and work plans.

Finding #3: The state commission did not document its oversight of subcontractor agreements and conflict-of-interest certificates.

The state commission could not demonstrate that it had reviewed and approved the final written subcontracts and subcontractors' conflict-of-interest certificates as required. Specifically, our review of a sample of nine contracts and 28 invoices associated with those contracts found that under each contract, the contractors charged for services provided by at least one and sometimes as many as six subcontractors. When we requested these subcontracts and conflict-of-interest certificates, the state commission had to forward our request to its contractors because it did not maintain copies of these documents in its files. Ultimately, it was only able to obtain 19 of a total of 22 requested subcontract agreements. Furthermore, the state commission was only able to obtain either the conflict-of-interest certificate or the conflict-of-interest language embedded within the subcontract for 14 of the 19 subcontracts it obtained. However, it was unable to locate the remaining five certificates. Because the state commission did not maintain these documents in its files, we question whether it reviewed and approved these documents as required before authorizing the use of subcontractors.

Additionally, subcontractors may be unaware of their obligation to preserve records that could be the subject of future audits. The state contracting manual requires contractors to include a provision in subcontracts indicating that the State has the right to audit records and interview staff in any subcontract related to the performance of the agreement. Our review of 19 subcontractor agreements found that five did not contain this language.

We recommended that the state commission establish a process to ensure that it obtains and reviews final written subcontracts and conflict-of-interest certificates before it authorizes the use of subcontractors. Additionally, it should ensure that its contractors include in all their subcontracts a provision indicating that the State has the right to audit records and interview staff in any subcontract related to the performance of the agreement.

State Commission's Action: Corrective action taken.

The state commission's 90-day response indicated that it is ensuring all staff with any contract management responsibility understand contracting procedures by requiring them to attend various training courses. Moreover, in its one-year response, it also pointed out a section in its new manual, which clearly indicates that the state commission must approve in advance final written subcontracts and conflict-of-interest certificates before the subcontractor performs any work. Further, in its 90-day response, the state commission indicated that it uses a Department of General Services' (General Services) form that contains general terms and conditions as a standard part of its contracts. One of the clauses in that document indicates the State's right to audit records and interview staff in any subcontract related to the performance of the agreement.

Finding #4: The state commission sometimes paid unsupported and inappropriate contractor expenses.

Although prudent business practices and some of its contracts include provisions requiring its contractors to include documentation necessary to support the expenses claimed, our review found that the state commission did not always enforce these provisions. Although generally the state commission received documentation to support the expenses claimed in our sample of 62 payments made to its contractors, we found both significant and minor instances in which this was not the case. Even when contractors included supporting documentation, the state commission did not always adequately review it before approving payment.

We recommended that the state commission consistently enforce contract provisions requiring contractors to submit supporting documentation for expenses claimed. Further, it should ensure that it performs an adequate review of such documentation before approving expenses for payment.

State Commission's Action: Corrective action taken.

The state commission's 90-day response indicated that it is ensuring all staff with any contract management responsibility understand contracting procedures by requiring them to attend training courses. In its one-year response, it also referred to a section in its new manual that discusses its invoice review and approval process, including a process for comparing the invoice to various documents, such as the contract and work plans, before approving them for payment.

Finding #5: The state commission inappropriately advanced funds to three contractors.

The state commission provided advance payments to three contractors even though it does not have the authority to do so. According to the state contracting manual, the State is permitted to make advance payments only when specifically authorized by statute, and such payments are to be made only when necessary. In addition, state laws are designed to ensure that public money is invested in and accounted for in the state treasury. Further, other state laws prohibit making a payment until services have been provided under a contract.

However, the state commission inappropriately advanced $2.5 million to a public relations contractor for the administration of the state commission's regional community-based organization program. The public relations contractor then took between 30 days and six months to disburse the funds to the selected community-based organizations. Our review of 13 other invoices from the same public relations contractor showed that the state commission advanced it funds for the regional community-based organization program totaling $6.8 million on three other occasions—invoices dated

July 2003, February 2004, and September 2004. Further, the state commission made advance payments in December 2005 and March 2006 to two county commissions totaling more than $91,500 under memorandums of understanding. When the state commission makes advance payments without the proper authority, it loses the interest it would otherwise earn on these public funds.

We recommended that the state commission ensure it does not make advance payments to its contractors unless it has authority to do so.

State Commission's Action: Corrective action taken.

According to the state commission's 90-day response, the community-based organization program for which it made advances was completed before the bureau raised its concern about these advances. Additionally, the state commission indicated that based on the bureau's recommendation, it cancelled a similar program that was in the pre-disbursement phase. It further stated that it has no current plans to pursue other programs requiring advance payments absent sufficient legal authority to do so. Finally, in its one-year response, it pointed to the section of its new manual that prohibits advance payments unless specifically authorized by statute.

Finding #6: Although it held strategic planning sessions annually, the state commission has not updated its written strategic plan since 2004.

The state commission poorly managed its process for updating its strategic plan, which outlines the current progress of its initiatives and future plans to advance its vision of school readiness. According to the executive director, the state commission annually either develops a draft plan or updates the prior year's plan, and presents it to the commissioners for their review and approval. However, it last updated its strategic plan in 2004. According to the executive director, although the strategic plan was presented and discussed with the commissioners in January 2004 and January 2005, the state commission did not request their formal approval.

In October 2006 the executive director provided us with a draft copy of a commission proceedings manual. The manual includes an annual commission calendar that lists recurring issues the commissioners are required to consider, such as adopting the strategic plan. The executive director hopes to begin using the manual in January 2007 if the commissioners adopt it.

We recommended that the state commission ensure that it updates its strategic plan annually and presents it to the commissioners for review and approval.

State Commission's Action: Corrective action taken.

In its 90-day response, the state commission indicated that the commissioners reviewed and approved the strategic plan in October 2006, which was effective until June 30, 2007. Additionally, in its one-year response, the state commission stated that it had developed and the commissioners adopted the most recent plan in September 2007.

Findings #7: The state commission did not always follow state requirements when awarding competitive contracts and it provided insufficient justification for awarding two contracts and six amendments using the noncompetitive process.

The state commission did not always follow state policies during its process of competitively awarding contracts. For instance, it did not fully justify its reason for awarding three contracts, totaling more than $47.7 million, when it received fewer than the minimum required number of three bids. Also, the state commission was unable to demonstrate that it had advertised a $90 million contract in the state contracts register as required by state policy.

Moreover, when awarding some of its contracts and amendments using the State's noncompetitively bid (noncompetitive) contract process, the state commission did not provide reasonable and complete justifications for using the process or for the costs of the contracts awarded. Two of the five noncompetitive contracts we reviewed had insufficient justification of the costs of the contract. For one of these contracts, as well as for six of eight amendments to contracts originally awarded using either a competitive bid or the noncompetitive process, the state commission cited insufficient staff resources or time limitations as its reason for using the noncompetitive process. We do not believe that these circumstances are compelling reasons for avoiding a competitive bidding process.

To ensure that it protects the State's interests and receives the best products and services at the most competitive prices, we recommended that the state commission follow the State's competitive bid process for all contracts it awards, unless it can provide reasonable and complete justification for not doing so. Further, it should plan its contracting activities to allow adequate time to use the competitive bid process.

We also recommended that the state commission fully justify the reasonableness of its contract costs when it receives fewer than three bids or when it chooses to follow a noncompetitive bid process. It should also advertise all nonexempted contracts in the state contracts register.

State Commission's Action: Corrective action taken.

The state commission's 90-day response indicated that it is ensuring all staff with any contract management responsibility understand contracting procedures by requiring them to attend training courses. The state commission also referred to several sections of its new manual—acquisition planning, ensuring a full and open competitive process for formal competitive procurements, noncompetitively bid contracts, and competitive contracts receiving less than three bids, as well as others—where it has addressed some of the issues related to these recommendations. For example, the manual specifically identifies the documentation that staff must prepare when three bids are not received. It also provides guidance to staff related to noncompetitively bid contracts and justification as to the reasonableness of the contract costs.

Finding #8: Documentation for the scoring of competitive proposals was inconsistent.

Inconsistencies in its documentation of the scoring process for contract bids may leave the state commission open to criticism and challenges to its decisions. It uses a consensus method to score proposals it receives on competitively bid contracts. For the nine competitively bid contracts we reviewed, the state commission retained only the consensus score sheet for each proposal submitted in six of the competitive contracts. Without all the individual scoring materials used in discussing and selecting a winning proposal, it is not possible for us or others to independently replicate the results.

To ensure that it promotes fair and open competition when it awards contracts using a competitive bid process, we recommended that the state commission ensure that it fully documents its process for scoring proposals, and that it retains the documentation.

State Commission's Action: Corrective action taken.

The state commission's 90-day response indicated that it is ensuring all staff with any contract management responsibility understand contracting procedures by requiring them to attend training courses. In its one-year response, the state commission also referred to several sections of it new manual that outline its competitive bid process including requirements that all RFPs include the evaluation criteria and selection process and all evaluation and scoring sheets be available for public inspection at the conclusion of the scoring process.

Finding #9: The state commission did not always follow state policies when allowing subcontractors under its interagency agreements and contracts with government agencies.

Of the 24 interagency agreements and four contracts with other government agencies we reviewed, 25 included the services of subcontractors, for a total of at least $64.6 million. This represents 53.6 percent of the total of $120.6 million for these agreements and contracts. For 17 of 25 interagency agreements and contracts with other government agencies, the state commission did not always comply with state policies when justifying the use of subcontractors. Three of the 17 appear to have included subcontractors, but the amount of funds subcontractors are to receive is not clear. We also question the justification for the remaining 14 subcontracts totaling $38.3 million.

To ensure that it follows state policies and protects the State's interest when using interagency agreements and contracts with government agencies, we recommended that the state commission obtain full justification for the use of subcontractors when required and, if unable to do so, deny the use of subcontractors.

State Commission's Action: Corrective action taken.

The state commission indicated that its new manual addresses this recommendation. Our review of the new manual found that it provides guidance related to interagency agreements and contracts with governmental agencies, but more specifically, it states that work performed under a government contract generally must be performed by the contractor agency, not subcontractors. However, it also provides staff the specific provisions that apply if subcontractors are used under these types of contracts.

Finding #10: The state commission agreed to reimburse contractors for indirect costs at higher rates than state policy allows.

The state commission did not always comply with state policies limiting the amount of administrative overhead fees paid to contractors for each subcontract. In fact, the state commission, in its interagency agreements, approved budgets to reimburse its contractors for over $1.2 million more than the state contracting manual allows.

To ensure that it follows state policies and protects the State's interests when using interagency agreements and contracts with government agencies, we recommended that the state commission limit the amount that it will reimburse its contractors for overhead costs to the rates established in the state contracting manual.

State Commission's Action: Corrective action taken.

The state commission indicated that its new manual addresses this recommendation. Our review of the new manual found that it contains a section that appears to provide appropriate guidance to staff on overhead fees and indirect costs, including establishing limits.

Finding #11: The state commission circumvented contracting law when it used memorandums of understanding to obtain services.

In fiscal years 2004–05 and 2005–06, the state commission awarded five memorandums of understanding (MOUs) and two amendments totaling more than $595,000. It appears to have intentionally used some of these to avoid having to comply with state contracting requirements, and for at least two MOUs and one amendment the intention was explicit. Although state contracting law allows agencies to enter into contracts with local government entities without competitive bidding, it strictly prohibits agencies from using these contracts to circumvent competitive bidding requirements.

To ensure that MOUs it awards allow for fair and competitive contracting and protect the State's best interests, we recommended that the state commission follow laws and policies applying to contracts when awarding and administering MOUs.

State Commission's Action: Corrective action taken.

Although in its 90-day response the state commission indicated that it had suspended its MOU program pending further review, its new manual provides specific guidance as to those few instances when an MOU can be used.

Finding #12: The state commission consistently failed to obtain approvals for its contracts and amendments on time.

According to state law, all contracts entered into by agencies, except those meeting criteria for exemptions, are not in effect unless and until approved by General Services. The state commission failed to obtain the required approvals before the beginning of the contract term for 43 of 45 of the contracts we reviewed. Similarly, it did not obtain the required approvals for 22 of the 44 amendments we reviewed until after the related contract or prior amendment had ended. Although we did not review all of the contracts to determine whether work began before approval, we noted three instances in which the contractor provided services totaling more than $7 million before the state commission obtained final approval of the contracts. The state commission also failed to obtain the required approvals altogether on three amendments.

To ensure that it does not expose the State to potential financial liability for work performed before the contract is approved, we recommended that the state commission ensure that it obtains General Services' approval of its contracts and amendments before the start of the contract period and before contractors begin work.

State Commission's Action: Corrective action taken.

The state commission's 90-day response stated that it is ensuring all staff with any contract management responsibility attend training courses related to contracting procedures. In its one-year response, it also referred to several sections in its new manual, one of which clearly states that staff are not authorized to instruct contractors to begin work before a signed copy of the contract is received.

Finding #13: The commissioners may have improperly delegated authority to award contracts.

State law authorizes the state commissioners to enter into contracts on behalf of the state commission. The commissioners adopted a formal resolution in May 2001 delegating their contracting authority to enter into and amend contracts to state commission staff. In this same resolution, the commissioners took action to ratify all prior contracts. It is our understanding that although the commissioners meet in public session to authorize expenditure authority and specify amounts of money for particular purposes, the ultimate decision to enter into contracts and the selection of providers of goods and services is performed by state commission staff. Our legal counsel advised us that it is a well-accepted principle of law that a power given to a public official that involves the exercise of judgment or discretion may not be delegated to others without statutory authority. In this case, no statute authorizes the commissioners to delegate their contracting authority.

To ensure that the state commission staff may lawfully enter into or amend contracts on behalf of the commissioners, we recommended that the state commission seek appropriate legal counsel.

State Commission's Action: Corrective action taken.

The state commission has hired a chief counsel. In its one-year response, the state commission did not address whether the chief counsel had reviewed the bureau's recommendation and advised commission staff regarding the legality of delegating the authority for taking certain actions regarding contracts. However, in a separate letter dated December 5, 2007, the state commission indicated that its chief counsel reviewed this issue beginning in May 2007 and continuing through July 2007, when she rendered her legal opinion to the commission and its staff. However, when we requested a copy of the legal opinion, the chief counsel told us that it was an oral opinion and that she could not provide us any information related to her opinion, asserting attorney-client privilege.

She did, however, provide us with the state commission's current policy related to the approval of contracts and it remains as it was during our audit. Accordingly, it is the continued practice of the state commission to authorize all expenditures in excess of $150,000, and to delegate to the executive director and his or her designee the authority to award and enter into any contracts that expend those funds.

California Institute for Regenerative Medicine

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

REPORT NUMBER 2006-108, FEBRUARY 2007

California Institute for Regenerative Medicine's response as of September and December 2007

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

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

Audit Highlights . . .

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

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

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

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

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

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

Institute's Action: Partial corrective action taken.

At the October 3, 2007, committee meeting, the institute presented the grants management system software and services provider recommended by institute staff and the process staff used to select the provider. The committee granted the institute approval to contract with the provider for a grants management system.

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

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

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

Further, the intellectual property policies for nonprofit entities and for-profit entities do not describe how prices will be discounted for therapies that result from institute-funded research. During the December 2006 committee meeting, the vice chair explained that the task force had difficulty finding practical benchmarks for the lowest available prices. He further stated that the portions of the policies for both nonprofit entities and for-profit entities that address discounted prices for therapies are works in progress. The committee agreed that once a practical benchmark is identified, it will apply the benchmark as a standard for discounted prices for therapies resulting from institute-funded research to the policies for both nonprofit and for-profit organizations.

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

Institute's Action: Partial corrective action taken.

The institute reports that it remains committed to ensuring that therapies developed through institute-funded research projects are accessible to uninsured patients and discounted prices for California patients whose drugs and non-drug therapies are purchased with public funds. The institute states that it held public meetings to allow interested parties to review and consider relevant regulatory issues and standards in both issues and is continuing to develop the appropriate regulations governing both nonprofit and for-profit grantees.

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

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

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

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

Institute's Action: Pending.

As part of its grants management process, the institute states that it will monitor compliance with its regulations regarding access to institute-funded patented inventions by requiring grantees to submit annual reports that identify licensed patented inventions, as well as any requests for access by other scientists for noncommercial research purposes.

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

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

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

Institute's Action: Partial corrective action taken.

The institute began drafting a grants administration policy targeted toward for-profit organizations in December 2006 and held meetings for interested parties in fall 2007 to discuss issues related to the policy. The proposed policy was included in the agenda for the December 12, 2007, committee meeting for its consideration.

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

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

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

Institute's Action: Corrective action taken.

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

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

Although the committee has approved a policy for administering nonprofit grants, the institute still is developing procedures to monitor grantees' compliance with the terms of the grants. For example, the act requires the grants review working group to conduct oversight reviews of grantees and to recommend standards to the committee to ensure that grantees comply with the terms of

awards. Although the grants review working group and the institute, through the nonprofit grants administration policy, developed these standards, the institute has not yet implemented a strategy to conduct the reviews.

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

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

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

Institute's Action: Partial corrective action taken.

The institute's grants administration policy for nonprofit organizations requires an administrative review prior to issuing a formal notice of grant award and before funds are released. According to the institute, for research grants it has developed a coding system to monitor the types of research that it funds. For facilities grants, the institute's interim grants administration policy states that requests for grant applications will detail the milestones and amounts for progress payments. The institute states that it continues to develop a web-based reporting system for grantees to facilitate the grants monitoring process.

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

The Political Reform Act requires that the institute submit its conflict-of-interest code to the Fair Political Practices Commission (FPPC) for review and approval. The FPPC must review the code to determine if it provides reasonable assurance that all foreseeable conflicts of interest will be disclosed or prevented, all affected persons have clear and specific statements of their duties under the code, and the code differentiates between designated employees with different powers and responsibilities. The institute submitted its code to the FPPC in July 2005, and after an exchange of correspondence between the FPPC and the institute, the FPPC approved the institute's code in May 2006. Subsequent to FPPC approval, the institute submitted the conflict-of-interest code to the Office of Administrative Law for its review and inclusion in state regulations. The Office of Administrative Law approved the institute's code in September 2006.

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

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

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

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

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

Institute's Action: None.

➲ The institute states that it has given careful consideration to our recommendation and has decided that it is not appropriate to implement it at this time. The institute states that in almost three years of operation and approval of four rounds of grants, the committee has never routinely or regularly adopted the recommendations of the institute's working groups. Until the time that such a pattern is detected, the institute believes the question we raise is hypothetical and not appropriate for submission to the attorney general. However, the institute states that it will continue to monitor the committee approvals for such a pattern and will reconsider our recommendation if such a pattern emerges.

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

Although, during our review, the institute implemented some improvements in its conflict-of-interest policies, it had not yet amended its policy for working groups to include specialists it might enlist to assist in evaluating grant applications. The institute recruited 32 out-of-state specialists in November 2006 to assist in reviewing innovation grant applications because it believed that the number of reviewers, which the act limits to 15, is not large enough for the number of grant applications it received. In the future, the institute intends to use specialists as needed. Specialists are individuals with scientific expertise on a particular issue who do not have a voting privilege and whose presence is not counted toward a quorum. According to the director of scientific activities, they are contacted through teleconference during the review meeting, act as secondary reviewers, and do not score or vote on any application. The institute's process is for specialists to disclose conflicts of interest before the review meeting and file confidential financial disclosure statements. When we made the institute aware that these specialists were not addressed in the conflict-of-interest policy for the grants review working group, it agreed to propose an amendment that it intended to present to the committee at its February 2007 meeting.

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

Institute's Action: Corrective action taken.

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

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

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

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

Institute's Action: Corrective action taken.

The institute's conflict-of-interest procedure for institute employees now incorporates a mechanism that identifies all entities that have applied for funding pursuant to a particular request for applications. Employees are to review a list of applicants to note any conflicts and disqualify themselves from reviewing any application with which they may have a conflict of interest.

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

The institute's procedures to avoid conflicts of interest in grants review working group activities require it to review the confidential financial interest disclosure statements of noncommittee members of the working group, but not the Statements of Economic Interest of the committee members of the working group. Therefore, the institute could overlook a conflict of interest. After we shared our concern with the institute, it agreed in December 2006 to revise its procedures to require a review of Statements of Economic Interest to identify potential conflicts of interest before each grants review meeting. Our examination of the Statements of Economic Interest revealed nothing to indicate such a conflict of interest existed during the review of training grants in August 2005—the only grants awarded at the time of our review.

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

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

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

Institute's Action: Corrective action taken.

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

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

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

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

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

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

Institute's Action: Partial corrective action taken.

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

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

On April 5, 2007, the committee's governance subcommittee adopted a recommendation to the full committee that it adopt for its members the policies and procedures for travel for institute staff and working group members. The committee did not adopt the policy for its members in its April 10, 2007, meeting. However, according to the institute in September 2007, the committee chair has asked that reimbursements to committee members conform to the proposed policy, assuming adoption in October or December 2007.

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

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

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

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

Institute's Action: Partial corrective action taken.

The institute reports that it has hired Mercer Human Resources Consulting to review and survey all institute salaries and, as of September 2007, expected a report within the next few weeks that will be discussed with the committee.

Batterer Intervention Programs

County Probation Departments Could Improve Their Compliance With State Law, but Progress in Batterer Accountability Also Depends on the Courts

REPORT NUMBER 2005-130, NOVEMBER 2006

Five county probation departments' responses as of November and December 2007

State law requires an individual who is placed on probation for a crime of domestic violence to complete a 52-week batterer intervention program (program) approved by a county probation department (department). The programs are structured courses designed to stop the use of physical, psychological, or sexual abuse to gain or maintain control over a person such as a spouse or cohabitant. The Joint Legislative Audit Committee requested that the Bureau of State Audits examine the extent to which the various entities involved in batterer intervention—including programs, departments, and courts—hold convicted batterers accountable. Specifically, we were asked to review how the departments and courts responded to a sample of progress reports, allegations, or other information from the programs. We were also asked to determine how well a sample of departments oversee programs.

Audit Highlights . . .

Our review of batterer intervention programs (programs) in California revealed the following:

- ***Only about half of batterers complete a program as required by state law.***
- ***Only two batterers in our sample of 125 ever completed a program after committing three or more violations of their program or probation terms.***
- ***The county probation departments (departments) we visited had various attendance policies, and all were more lenient than statutory provisions, which allow for only three absences for good cause.***
- ***Rather than notifying the courts as required by state law, some departments are counseling and referring batterers back to programs after they have been terminated for violations.***
- ***Courts sometimes do not impose any consequences on batterers, even those with multiple prior violations.***
- ***On-site program reviews required by statute are not being performed consistently.***

Finding #1: Many batterers do not complete their required programs, and the extent to which they are held accountable varies.

Based on statistics provided by the departments and our review of a sample of 125 batterers, only about half of the batterers required to complete a program actually do so. In reviewing department responses to violations committed by the 125 batterers, we found that some departments we visited counseled and referred batterers back to programs after they had been terminated for violations, rather than notifying the courts as required by state law. Because only two batterers in our sample ever completed a program after committing three or more violations, we questioned whether this practice only delays the inevitable court-imposed consequences of jail time or probation revocation. Further, some courts notified of violations simply returned batterers to programs without imposing any additional jail time, even though at times the batterer had multiple prior violations. We questioned whether this practice may be sending the unintentional message to batterers that they can avoid the program requirement without any significant penalty for doing so.

Although the most frequent violation involved noncompliance with attendance policies, the departments we reviewed had various policies regarding program attendance, and all were more lenient than statutory provisions, which allow for only three absences for good cause. In discussing their policies, departments cited the need for greater flexibility in attendance policies to allow as many batterers as possible to complete their assigned programs. In addition, the counties of some of the departments we visited have implemented a practice of having batterers make regular appearances to have their progress reviewed by the court. This appears to provide for better batterer accountability and may improve program outcomes.

We recommended that the departments, in conjunction with the courts and other interested county entities, jointly consider taking the following actions:

- Establish and clearly notify batterers of a set of graduated consequences that specify minimum penalties for violations of program requirements or probation terms. The nature of the violation, as well as the number of previous violations, should be taken into consideration when establishing the consequences.
- As part of these graduated consequences, establish a limit to the number of violations they allow before a batterer's probation is revoked and he or she is sentenced to jail or prison.
- Eliminate the practice of having probation officers counsel and direct batterers back to programs in which they failed to enroll or from which they have been terminated for excessive absences, and establish a consistent practice of notifying the court of such violations, allowing the court to set the consequence for the violations.
- If they have not already done so, implement a practice of regular court appearances in which batterers receive both negative and positive feedback on program compliance.
- Require programs to submit progress reports to the courts at the frequency specified by law.

We also recommended that the Legislature consider revising the attendance provisions included in the law to more closely align with what departments and courts indicate is a more reasonable standard and assess whether probation and the program requirement are an effective deterrent for future acts of domestic violence for individuals who commit acts of domestic violence while in programs or after completing a program.

Butte County Probation Department's Action: Corrective action taken.

After consideration of the report recommendations, the Butte department stated that it believes weekly pre-court and quarterly roundtable discussions among the judge, deputy district attorney, defense counsel, probation officers, and treatment program representatives help develop the consistency of consequences the audit report recommends. The Butte department indicated that its batterers are brought before the court for any failure to abide by the treatment program. Recommendations related to progress reports and regular court appearances were not directed to the department in Butte County because we did not discover any deficiencies related to these areas at this department during the audit.

Los Angeles County Probation Department's Action: Partial corrective action taken.

In its original response to the audit, the department in Los Angeles County, in consultation with the court in the county, indicated that it believes that the recommendation related to graduated consequences interferes with the discretion of individual judges and that regular court appearances would only be necessary for court-supervised probationers, not batterers on formal probation. We have not received any further communications from the county on this matter. Recommendations related to progress reports and court notifications of violations were not directed to the department in Los Angeles County because we did not discover any deficiencies related to these areas at this department during the audit.

Riverside County Probation Department's Action: Corrective action taken.

The Riverside department provided us with an outline of the graduated consequences the court in the county has established to guide its bench officers in their handling of treatment program attendance and enrollment violations for misdemeanor domestic violence cases in the county. Among other things, the outline indicates that on the fourth violation, probation will be terminated and the individual will serve extensive jail time.

The Riverside department explained that, because of an overburdened court system, the court is not able to have regular court appearances for all batterers and expects the probation department to attempt to resolve minor violations before returning the case to the court. Consequently, the department explained that it is in the process of implementing a policy in which probation officers could reinstate batterers into a program after a first-time attendance or enrollment violation but would provide written notification to the court of this action. The court could then choose to set the matter for further hearing if need be. The recommendation related to progress reports was not directed to the department in Riverside County because we did not discover any deficiencies related to this area at this department during the audit.

San Joaquin County Probation Department's Action: Corrective action taken.

The San Joaquin department stated that, although it was not able to obtain consensus from the court on a set of graduated consequences for batterers, it did develop a set of graduated consequences for its probation officers to follow in making recommendations to the court following violations of probation. These consequences include a recommendation that a batterer's probation be terminated, with all remaining jail time imposed, for the fourth violation of probation.

The San Joaquin department stated that it has directed probation officers to refer batterers back to programs only after a violation of probation has been filed with the court and the court has directed the batterer back to the probation department. Due to the limited resources of the court, the department indicated that regular court appearances are not feasible at this time. Additionally, the San Joaquin department stated that the courts have requested that required progress reports from the programs be sent to the department and the department has assumed the responsibility of notifying the court of any required action.

San Mateo County Probation Department's Action: None.

The original and subsequent responses from the San Mateo department did not indicate that it jointly considered the report's recommendations with the court and other interested county entities. Rather, the department responded that to its knowledge the court has not established a set of graduated consequences but that it is confident that all probationers are consistently held accountable for probation violations. The department then added that its current practices related to notifying the court of violations and referring batterers back to programs will continue as they are until they are changed. Recommendations related to progress reports and regular court appearances were not directed to the department in San Mateo County because we did not discover any deficiencies related to these areas at this department during the audit.

Legislative Action: Unknown.

Finding #2: Some courts appear to be inappropriately sentencing batterers to anger management programs that do not last 52 weeks and may not address domestic violence issues.

During the course of our audit, department officials told us, and evidence we found at one county we visited confirmed, that courts were directing individuals placed on probation for crimes of domestic violence to 16-week anger management programs, rather than the required 52-week batterer intervention programs. We also found one instance in Los Angeles County where the court delayed sentencing on an individual it found guilty of battery (the victim met the statutory definition of domestic violence contained in Family Code 6211) until 26 court-ordered program sessions could be completed. Then, after six months of delayed sentencing, it dismissed the charges "in the furtherance of justice."

We recommended that the courts consistently sentence, and the departments consistently direct, individuals granted probation for a crime of domestic violence—when the victim is a person specified in Section 6211 of the Family Code—to a 52-week batterer intervention program approved by the department. Courts should not substitute any other type of program, such as a 16-week anger management program, for a 52-week batterer intervention program.

If it is the Legislature's intent that individuals who commit domestic violence be consistently sentenced to 52 weeks of batterer intervention, it should consider enacting statutory provisions that would not allow the courts to delay sentencing so that batterers can complete a lesser number of program sessions.

Los Angeles County Probation Department's Action: None.

➲ In its original and subsequent responses, the department in Los Angeles County provided no specific information from the court on this recommendation.

Riverside County Probation Department's Action: Corrective action taken.

The department in Riverside County indicated that the vast majority of domestic violence defendants are ordered into a 52-week batterer intervention program and that the court has attempted to correct any sentencing variation through training and ongoing communication. Additionally, the department stated that the court established countywide guidelines for sentencing all domestic violence clients, including the 52-week program requirement.

San Joaquin County Probation Department's Action: Partial corrective action taken.

The department in San Joaquin explained that, although it has requested otherwise, the court continues to give the department discretion on the type of treatment program batterers attend. However, the department has provided written guidance to its probation officers that, when making program referrals, they must consider the arresting offense and the nature of the relationship between the offender and the victim, not just the charge to which the batterer was convicted.

Legislative Action: Unknown.

Finding #3: County probation departments could improve their monitoring of programs by more closely adhering to state law and by implementing performance measures.

Although state law requires departments to design and implement a program approval process, we found that none of the five departments we visited had written procedures to guide staff in analyzing and approving applications or application renewals. Additionally, we found that two departments we visited could not provide documentation of their reviews of the applications they had approved in the last five years. However, the applications approved in the last five years that we were able to review generally conformed to statutory requirements.

State law requires the departments to conduct annual on-site reviews of their programs, including monitoring sessions, to determine whether they are adhering to statutory requirements. To ensure that the programs are complying with statutory requirements, the departments would also need to perform on site reviews of program administration, such as the use of sliding fee schedules to assess the program fees batterers pay. However, based on our interviews with staff at all 58 departments and our review of selected programs at five departments, on-site reviews are not performed consistently. For example, the five departments we visited skipped years and programs in their on-site review efforts. Among the examples of programs straying from state requirements, we found one program that used an unqualified facilitator to oversee counseling sessions that were not single gender, as called for by law, and sessions that sometimes consisted only of movies that were not even related to domestic violence.

Further, while some departments have implemented program-monitoring practices beyond those required by law, such as meeting regularly with program directors; implementing performance measures, such as tracking program completion percentages and batterer recidivism, could improve program effectiveness. Another untapped measure of program effectiveness is the systematic collection of feedback from program participants.

We recommended that each department adopt clear, written policies and procedures for approving and renewing the approval of programs, including a description of how department personnel will document reviews of program applications.

We also recommended that each department consistently perform the on-site reviews required by state law. Specifically, a department should annually perform at least one administrative review and at least one program session review for each program. Further, the departments should document their reviews, inform programs of the results in writing, and follow up on areas that require correction.

Finally, we recommended that each department consider developing and using program performance measures, such as program completion and recidivism rates, and developing a mechanism to receive feedback from batterers on program effectiveness.

Butte County Probation Department's Action: Corrective action taken.

The Butte department indicated that, in addition to developing a program application checklist and conducting comprehensive recertification reviews on its two programs, it has begun conducting biannual administrative reviews and quarterly program session visits. Further, the department stated that, although it faces information gaps because some batterers are court-supervised, it attempts to gather relevant statistical information from the programs on enrollments, successes, and program failures. The department commented that it is working on closing the information gaps to provide more relevant measures.

Los Angeles County Probation Department's Action: Corrective action taken.

The Los Angeles department indicated that, although it does not anticipate adding new programs, it has developed a checklist to review a program application should the need arise. In its original response to the audit, the Los Angeles department indicated that it conducts program site visits at least annually, and usually semiannually. These visits are to include sitting in on an actual program session and a review of a random sample of administrative files. The department stated that it considered the feasibility of conducting a customer service evaluation for batterers who complete a program but determined that it did not have the resources to undertake this process. The department also indicated in its original response to the audit that it is developing the means to track recidivism data for batterers on formal probation.

Riverside County Probation Department's Action: Corrective action taken.

The Riverside department indicates that it uses the penal code and a manual developed by the California Institute of Human Resources at Sonoma State University to approve and renew the approval of programs. The department stated that all of its programs now receive at least one administrative review and at least one program session review, as required. Finally, the Riverside department responded that it has considered a number of avenues for collecting relevant program statistics and is currently pursuing statistics from the program on the number of referrals and completions, as well as a client survey upon completion of the program.

San Joaquin County Probation Department's Action: Corrective action taken.

The San Joaquin department has developed written procedures for approving and renewing provider applications. The department indicates that it continues to conduct administrative and program session reviews as required. Finally, the department indicates that it has developed a system that allows program providers to submit information, such as enrollments, attendance, terminations, completions, and quarterly progress reports directly to the department in electronic format. The department stated that, in addition to creating "to do" action items for providers and probation officers, it will also allow the department to track outcome measures by individual provider.

San Mateo County Probation Department's Action: Partial corrective action taken.

To the recommendation regarding written policies and procedures for approving and renewing program applications, the San Mateo department responded, "This is our current practice," without providing any additional information indicating what it has done to correct the deficiencies we found when we visited the department. In regards to on-site program reviews, the department responded that it was not in compliance at the time of the audit but has now installed an annual review process as required. In regards to developing program measures, the department stated there are customer service forms available to all probationers and other members of the public.

Department of Health Services

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

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

Department of Health Services' response as of December 2007

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

Investigative Highlight . . .

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

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

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

Health Services' Action: Partial corrective action taken.

Health Services reported that it initiated content filtering of Internet sites, making certain sites—such as modeling Web sites and Internet-based e-mail—inaccessible to its employees. It further stated that it modified the employee's building access to normal business days and hours only and suspended his Internet access.

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

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

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

Finding #2: The employee misused state resources.

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

Health Services' Action: Corrective action taken.

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

Department of Health Services

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

REPORT NUMBER 2006-110, APRIL 2007

Department of Health Services' response as of October 2007

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

Audit Highlights . . .

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

- ***Because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives; however, the branch does not process some applications within the time periods specified in statute.***
- ***Branch staff continue to enter data incorrectly into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to track the status of applications effectively.***
- ***Some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could.***
- ***Given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.***
- ***The branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals.***

continued on next page . . .

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

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

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

The branch reports that it has developed a letter and implemented a process to immediately notify applicants who have been automatically enrolled. Further, the branch states that it is in the process of updating its procedure manual with formal written procedures regarding the immediate notification of applicants who have been automatically enrolled. In addition, the branch states that it has modified the PETS and created a policy denial report and will soon have the ability to track applications referred to

the policy section. Further, the branch reports that managers are currently monitoring staff work to ensure that staff are accurately entering dates into PETS and asserts that formal procedures are scheduled for completion in mid-October, with updates to its procedure manual scheduled shortly thereafter. Finally, the branch states that the training and testing data was removed from PETS in August 2007.

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

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

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

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

Department's Action: Corrective action taken.

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

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

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

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

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

Department's Action: Corrective action taken.

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

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

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

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

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

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

Department's Action: Partial corrective action taken.

The branch reports that it is working collaboratively with the Medical Review Branch to evaluate the fraud indicator checklists on a quarterly basis using findings from the ongoing risk assessment analyses and the annual Medi-Cal Payment Error Study. The branch states that it established a workgroup, consisting of branch and Medical Review Branch staff, which has reviewed the current list of high-risk indicators and identified changes that need to be made to PETS. The branch reports that the next phase will entail updating the reasons applications are referred in the PETS to accurately reflect the referral indicators, which it asserts will be completed by November 1, 2007. Finally, the branch indicates that new procedures will be finalized and implemented by mid-October to ensure that applications referred for comprehensive review are processed within 60 days of receipt of the onsite report from the Medical Review Branch.

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

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

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

the effectiveness of these two initiatives, it could be worthwhile for the department to periodically assess Medicare's progress and the benefits the department could derive from this centralized source of information.

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

Department's Action: Partial corrective action taken.

The branch indicates that it continues to monitor Medicare's implementation of its revalidation process to identify opportunities for streamlining its application and verification procedures as appropriate, with a specific focus on the implementation of Medicare's federal regulations governing its accreditation and competitive bidding process for furnishing durable medical equipment, prosthetics, orthotics, and medical supplies. Further, the branch reports that it is nearing completion of four reenrollment phases of physicians, physician groups, and optometrists in Los Angeles County. The branch states that it continues to evaluate workload and available staff resources in carrying out reenrollment efforts.

Department of Health Services

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

REPORT NUMBER 2006-106, APRIL 2007

Department of Health Services' response as of October 2007

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

Audit Highlights . . .

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

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

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

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

Health Services' Action: Partial corrective action taken.

In its 60-day response, Health Services indicated that it continued to facilitate the deployment of staff from one district office to another for the purpose of addressing survey deadlines and the investigation of complaints. As of October 2007 Health Services

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

reports that only 19 of the 1,925 complaints it has received since April 17, 2007, were initiated beyond the 10 working-day requirement. However, Health Services provided no comparable information related to its efforts to close complaints promptly.

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

this determination either because of missing investigation reports or reports that were completed after Health Services notified the facility about the results. We saw similar documentation problems regarding Health Services' efforts to provide timely notifications to complainants. Specifically, Health Services could not provide evidence that it acknowledged receipt of a complaint for four of the 35 complaints we reviewed, while similarly being unable to produce evidence that it informed complainants of the results of investigations in seven instances.

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

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

Health Services' Action: None.

Although Health Services' initial response to the audit indicated that it would revise its policy and procedures manual to include "clearly established timeframes and expectations for work products to be completed, reviewed, and processed," its more recent 60-day and six-month responses were less committal on this issue. Specifically, Health Services' 60-day response simply indicated that it would "consider development of target timeframes for staff to complete key stages of the complaint process." Its six-month response indicated that the recommendation had been met; however, Health Services' response was silent on whether these target time frames had been established in its revised policies and procedures. Our review of Health Services' revised policies and procedures manual indicated that it has not developed these time frames. As noted above, without these timelines for individual steps in the complaint investigation process, Health Services' cannot insure that its objectives are being met and will have difficulty holding staff accountable for the completion of their work. Although Health Services' new quality assurance process reviews various aspects of the complaint investigation process, including whether complaints were correctly prioritized and investigated, it does not review how long it takes to complete complaint investigations and the cause for any delays beyond its stated policy of 40 days.

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

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

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

Health Services' Action: Corrective action taken.

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

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

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

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

Health Services' Action: Partial corrective action taken.

In September 2007 Health Services entered into a contract with a vendor for the design, development, and implementation of the "Health Facilities Consumer Information System." It expects this system will provide the public with access to long-term care facility information. Health Services expects to deploy the first phase of this system between February and March 2008, which will include information regarding long-term care facilities. The system will subsequently include information regarding hospitals. To address data reliability concerns, Health Services reports that 95 percent of all district office management and support staff have attended training regarding data processing and entry practices for its current systems.

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

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

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

Health Services' Action: Partial corrective action taken.

Health Services indicated that it has been working aggressively with CMS to enhance the ASPEN system. For example, Health Services reports that it met with the director of CMS' survey and certification division in April 2007 to discuss the results of our audit and to emphasize the need for "hard edits" in the ASPEN system. In addition, Health Services indicated that on May 22, 2007, program managers discussed the data accuracy problems identified by CMS during its annual "State Agency Evaluation of Performance Review." As part of its corrective action measures in response to this annual review, Health Services was required to develop written procedures for data entry and that staff would receive training on these procedures. Further, Health Services indicated that its managers would be responsible for pulling complaint and survey files throughout the year to check data entry accuracy with paper files. In its most recent response to the audit in October 2007, Health Services reported that in September 2007 it had reminded its managers to conduct these random reviews. Finally, Health Services reviews data accuracy in ASPEN through its new quality assurance program.

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

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

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

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

Health Services' Action: Pending.

Health Services reports that it plans to use CMS' ASPEN system to help schedule recertification surveys in a way that will reduce their predictability. In preparation for using ASPEN in this way, Health Services indicated that it has provided training to its staff on the use of ASPEN's Scheduling and Tracking System (AST). Health Services expects to implement AST in January 2008.

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

We generally found that Health Services' controls over the expenditure of funds from the citation account were weak. Allowable uses of citation account funds are prescribed within state law and include paying for the costs of ensuring the continued operation of a skilled nursing facility pending its correction of cited deficiencies or closure, including the appointment of temporary management or receivership, in the event that revenues form the facility are insufficient. Our review of citation account expenditures revealed that Health Services relied on high-level forecasts of expected revenues and expenses submitted in e-mails by temporary management companies as a basis to request funding. Given the magnitude of some of these payments—we noted one instance in which a single payment exceeded $700,000—we would have expected Health Services to eventually request evidence beyond the e-mails to gain some assurance that the payments made were necessary.

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

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

Health Services' Action: Pending.

Health Services reports that it has drafted new policies and procedures regarding the appointment of temporary managers. These draft policies define the roles and responsibilities of Health Services' staff and the temporary management company, as well as include the reporting responsibilities and financial process including requesting payment for services. Health Services indicates that it is now developing a solicitation of applications aimed at increasing the pool of eligible temporary managers.

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

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

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

Health Services' Action: Pending.

Health Services reports that it formed a workgroup to draft new classification specifications for its health facility evaluator employees. With the draft specifications complete, Health Services has come to an agreement with a vendor to validate the new classification specifications and develop the necessary documents for submission to the DPA. As of December 2007 Health Services reports that General Services is still reviewing the contract and that it has not been fully executed. Health Services plans to submit the classification package to DPA in June 2008. In addition, Health Services indicated that it has temporarily redirected staff on a voluntary basis to those district offices that are overburdened with workload due to difficulty in recruiting qualified staff.

Department of Health Care Services

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

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

Department of Health Care Services' response as of November 2007

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

Investigative Highlight . . .

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

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

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

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

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

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

Health Care Services' Action: Partial corrective action taken.

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

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

Department of Health Services

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

REPORT NUMBER 2006-035, FEBRUARY 2007

Department of Health Services' response as of August 2007

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

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

Audit Highlights . . .

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

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

continued on next page . . .

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

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

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

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

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

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

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

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

Health Services' Action: Corrective action taken.

Health Services reported that it has implemented a system that provides an audit trail for any facility rate change. It further stated that it has developed and implemented procedure changes in the system's programming language.

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

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

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

Health Services' Action: None.

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

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

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

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

Health Services' Action: Partial corrective action taken.

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

Health Services stated that it expects to recover the duplicate payments by issuing two Erroneous Payment Corrections (EPC). Health Services stated that the first EPC will recover approximately $5.3 million in duplicate Long Term Care payments and an additional $780,000 for duplicate or overlapping payments made to one or more different provider entities. The second EPC will recover funds for the Medical, Outpatient and Vision claims by October 2007. However, Health Services stated that it does not yet know the total dollar overpayment for that EPC.

Department of Industrial Relations

Investigations of Improper Activities by State Employees, January 2006 Through June 2006

INVESTIGATION I2006-0708 (I2006-2), SEPTEMBER 2006

Department of Industrial Relations' response as of September 2006

We investigated and substantiated an allegation that a Department of Industrial Relations (Industrial Relations) employee improperly used bereavement leave.

Investigative Highlight . . .

A Department of Industrial Relations employee improperly used bereavement leave for work missed while incarcerated.

Finding: An Industrial Relations' employee used bereavement leave while she was in jail.

An employee charged and received payment for 16 hours of bereavement leave on her official time report and cited the death of her aunt as the reason for her absence. However, public records show that the employee was incarcerated in a Los Angeles County jail for those two days. By charging bereavement leave for hours she missed due to her incarceration, the employee improperly claimed and received $282 for 16 hours she did not work, in violation of state law.

Industrial Relations' Action: Corrective action taken.

Industrial Relations served the employee with a five-day suspension without pay. In addition, Industrial Relations set up an accounts receivable to recover the 16 hours of pay that was improperly charged as bereavement leave.

Department of Industrial Relations

Its Division of Apprenticeship Standards Inadequately Oversees Apprenticeship Programs

REPORT NUMBER 2005-108, SEPTEMBER 2006

Labor and Workforce Development Agency's response as of August 2007

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the apprenticeship programs (programs) regulated by the Division of Apprenticeship Standards (division) and the California Apprenticeship Council. Specifically, the audit committee asked us to review and evaluate the laws and regulations significant to the programs and to identify the roles and responsibilities of the various agencies involved in them. It also asked us to determine the type of data collected by the division for oversight purposes and the extent to which it uses the data to measure the success of the programs and to evaluate the division's performance/accountability measures. In addition, the audit committee asked us to examine data for the last five fiscal years regarding the programs' application, acceptance, enrollment, dropout, and graduation rates, including the rates for female and minority students, and the programs' graduation timetables. Further, the audit committee asked us to review the extent and adequacy of the division's efforts related to recruitment into state-approved programs, and to identify any potential barriers to student acceptance into the programs. The audit committee wanted to know whether the division's management and monitoring practices have complied with relevant statutory requirements and whether the division has taken action against programs that do not meet regulatory or statutory requirements. Finally, the audit committee asked us to review the program's funding structure to determine whether employer contributions to programs reasonably relate to the costs of providing training. In our review, we noted the following findings:

Audit Highlights . . .

Our review of the Department of Industrial Relations' (department) Division of Apprenticeship Standards' (division) oversight of apprenticeship programs (programs) found that:

- ***The division suspended program audits in 2004 and did not follow up on corrective action related to audits it had started.***
- ***The division has not resolved apprentice complaints in a timely manner, taking over four years in some cases to investigate the facts of complaints.***
- ***The division has not adequately monitored the apprentice recruitment and selection process. In particular, it has not conducted Cal Plan reviews since 1998.***
- ***Division consultants did not consistently provide oversight through attendance at committee meetings.***
- ***The division's staffing levels have not increased in step with legal obligations, and it has failed to document priorities for meeting these obligations for existing staff.***
- ***The division did not report annually to the Legislature for calendar years 2003 through 2005, and the annual reports contain grossly inaccurate information about program completion.***

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Finding #1: The division suspended program audits in 2004 and did not follow up on corrective action related to audits it had started.

Although state law required it to begin randomly auditing approved programs during each five-year period beginning January 1, 2000, the division did not complete the audits it started, and it stopped conducting audits in February 2004. Program audits are the means by which the division can ensure that the committees, which sponsor the programs, are following their state-approved standards and they allow the division to measure programs' success.[1] The division chief, appointed in 2006, said he was told there had been insufficient staff to complete the audits, however, he indicated that the division planned to resume audits consistently in October 2006.

[1] Apprenticeship program sponsors—joint apprenticeship committees, unilateral labor or management committees, or individual employer programs—submit to the division an application for approval of their programs, along with proposed program standards and other relevant information. Because committees were the program sponsors for more than 97 percent of all active apprentices as of December 31, 2005, we refer to program sponsors as committees throughout the report.

» *The department is slow to distribute apprenticeship training contribution funds. Only $1.1 million of the roughly $15.1 million that had been deposited into the training fund by June 30, 2005, has been distributed as grants.*

» *The division does not properly maintain its data on the status of apprentices.*

A comprehensive audit plan that subjects all programs to possible random audits, gives priority to auditing programs with known deficiencies, and targets programs with a high risk profile would maximize the use of the division's limited audit resources. Until the division resumes its audits and ensures that the committees correct any weaknesses in their programs, it will have difficulty measuring the success of the programs and the quality of the training apprentices receive.

We recommended that the division follow through on its planned resumption of audits of programs and ensure that recommendations are implemented and that audits are closed in a timely manner. Additionally, the division should request that the Legislature amend auditing requirements to allow it to select programs for audit using a risk-based approach.

Division's Action: Partial corrective action taken on the first recommendation; no action taken on the second recommendation.

The division stated that it filled its consultant and field support vacancies and that for fiscal year 2007–08 it received a staffing augmentation of four new consultants who will specifically focus on audits. It also indicated that by late August 2007 it had completed 13 audits and had six more audits in process or scheduled to begin by the end of September 2007. The division says it is proceeding with audits as currently required by statute and regulations, and has not developed revised legislation to clarify audit requirements and the selection process.

Finding #2: The division has not resolved apprentice complaints in a timely manner or adequately monitored the apprentice recruitment and selection process.

State regulations require the director of the Department of Industrial Relations (department) to receive, investigate, and decide on complaints filed by apprentices. However, until recently the division did not consistently track these complaints. As a result, it did not review, investigate, and issue decisions in a timely fashion. Although there is no regulatory or statutory time limit for the division to investigate and resolve apprentice complaints, a time period of more than two years—and more than four years in some cases—to investigate the facts of a complaint seems excessive. Most of the complaints we reviewed that remained open in June 2006 related to allegations of unfair cancellation or suspension of an apprentice from a program. In these situations, a timely determination is critical because apprentices who were unfairly canceled are unable to become journeymen in their chosen field.

Furthermore, the division has not conducted adequate oversight of the committees' apprentice selection procedures to ensure that they promote equality of opportunity in state-approved apprenticeship programs. State regulations require committees to submit their apprenticeship selection standards to the division for approval. Among other things, the standards include provisions the committees use for determining the qualifications of apprentice applicants and uniform procedures for assuring the fair and impartial selection of applicants.

State regulations also require the State of California Plan for Equal Opportunity in Apprenticeship (Cal Plan) to be incorporated into the standards. However, the division exercises limited oversight over the implementation of the committees' selection procedures. Its division chief stated that the division has not conducted systematic reviews of apprenticeship programs, also known as Cal Plan reviews, since 1998 due to insufficient staff. Consequently, the division cannot determine the extent to which committees comply with their Cal Plans. Finally, state law requires the division to coordinate the exchange of information on available minorities and women who may serve as apprentices. The division's failure to monitor selection processes makes it nearly impossible to determine whether committees are adhering to equal opportunity requirements or to identify potential barriers for women and minorities.

We recommend that the division work with the department's legal division to establish time frames for resolving complaints and develop a method for ensuring that complaints are resolved within the time frames. Also, the division should require committees and their associated third-party organizations to maintain documentation of their recruitment and selection processes for a time period consistent with Cal Plan requirements and should conduct systematic audits and reviews of apprenticeship recruitment and selection to ensure compliance with Cal Plan requirements and state law. Finally, the division should develop a process for coordinating the exchange of information on available minority and female apprentices.

Division's Action: Corrective action taken on the first and second recommendations; no corrective action taken on the third recommendation.

The division said that complaints have been assigned to one individual at its headquarters, and that the status of complaint processing is reviewed each week during standing meetings with the division chief. Further, the division and the department's legal division have developed a communications process to ensure that complaints are processed timely. The agency indicates that the complaints backlog has been mostly cleared with only 10 pre-2007 complaints still open, all in the hearing phase.

The division says that the U.S. Department of Labor does not recognize California's authority to approve apprenticeship programs for federal purposes in March 2007. As such, it has suspended federally required Cal Plan audits. Instead, the division has implemented reviews of programs' selection procedures during regular visits and during audits of programs. These reviews have led to the revision of several program standards in order to bring the standards into sync with the actual practice of the programs. The division did not address the recommendation related to coordinating the exchange of information on available minority and female apprentices.

Finding #3: Division field offices can improve their oversight of the committees and the division has not documented priorities for existing staff.

Consultants working in the division's field offices can improve their oversight of the committees. A key role of the division's consultants, each of whom oversees an assigned group of committees, is to attend committee meetings, especially if an apprentice is to appear before a committee. Despite the stated importance of the consultants' attendance at committee meetings, our review of files at six field offices found that consultants did not consistently attend these meetings. The field offices also lack a formal, centralized process for tracking the resolution of issues or questions that may arise at committee meetings or during the normal course of business. Further, the consultants do not consistently enforce regulations requiring committees to complete self-assessment reviews and program improvement plans. Finally, although state regulations allow the division chief to cancel programs that have had no active apprentices for two years, until recently the consultants had not consistently identified inactive programs. Maintaining an up-to-date list of apprenticeship programs is important because the division can use it to more evenly prioritize and distribute the number of committees each of its consultants is responsible for, improving their ability to monitor their committees.

The division chief indicated that a lack of staff has prevented the division from completing its monitoring requirements. His priority for 2006 was to focus on customer service and to improve the division's processes to enable staff to meet requirements in a timely and accurate manner; his priorities for 2007 are to focus on promotion and expansion of apprenticeship into trades not typically associated with apprenticeship, and to ensure the quality of programs through consistent implementation of oversight activities.

We recommended that the division document specific priorities and goals for its staff both to maximize the use of existing staff and to identify additional staffing needs. We also recommended that the division require its consultants to enforce regulations that call for committees to submit self-assessment reviews and program improvement plans.

Division's Action: Corrective action taken.

The division stated that it has established goals, strategies, and standards, which have been communicated to staff. In addition, it has developed performance measurements for the standards and has set priorities related to oversight activities. The division also indicated that compliance with annual self-assessment reviews is very high and that staff are now working with programs to improve the quality of the self-reviews.

Finding #4: The division does not adequately track and disseminate information to the Legislature as state law requires and the department is slow to distribute apprenticeship training contribution funds.

State law requires the division chief and the California Apprenticeship Council to report annually to the Legislature and the public on their activities. According to its chief, the division did not do so for calendar years 2003, 2004, and 2005, thus missing the opportunity to make the Legislature aware of the apprenticeship programs and gain valuable feedback on the direction of the programs. The annual reports that have been prepared also contain grossly inaccurate information about the number of apprentices that complete the program due to a programming error.

Furthermore, although state law mandated the department to begin distributing grants to programs from the apprenticeship training contribution fund (training fund) in 2003, it did not distribute its first grants until May 2006. The department has had the authority to spend $1.2 million on grants in each of the last three fiscal years. Its budget officer attributes part of this delay to a lack of regulatory authority on how to calculate the grant amounts.

While the department has distributed $1.1 million in grants as of June 2006, it has spent significantly more on division operations. As of June 30, 2005, about $15.1 million had been deposited into the training fund. During fiscal years 2001–02 through 2004–05, the division used a total of $4 million from this fund to pay for salaries, benefits, and other costs. Additionally, during fiscal years 2002–03 and 2003–04, a total of $2.8 million was transferred from the training fund to the State's General Fund. Consequently, the June 30, 2005, fund balance was $8.3 million. Clearly, the use of $4 million primarily for general division expenses prior to the distribution of grants adversely affects the division's ability to fund grants to committees because less cash is available to support increases in spending authority for grants and subsequent grant distributions.

We recommended that the division ensure that it submits annual reports to the Legislature that are accurate, timely, and consistent with state law. We also recommended that the department request increased budgetary authority as necessary to distribute apprenticeship training contribution money received each fiscal year and the training fund balance as grants to applicable programs. If the department believes that amounts collected from employers for deposit into the training fund should be used to fund division expenses at the same priority level as grants to apprenticeship programs, the department should seek statutory changes that clearly reflect that employers are also funding general expenses.

Department's Action: Corrective action taken on the first and second recommendations; no corrective action taken on the third recommendation.

The division stated that the Legislature has received reports for 2003 through 2006. In addition, it says it has created an annual calendar that includes a task for submitting the report by April 1st of each year.

The division said that $1.2 million in grants for fiscal year 2006–07 were distributed in December 2006. Further it stated that the fiscal year 2007–08 budget includes an increase in the distribution authority to $3 million, which should be distributed by mid-September 2007. The department believes that it has the legal authority to use the money deposited in the training fund for purposes beyond the cost of administering the processing of checks and the distribution of grants. Therefore, it does not believe that additional statutory changes are necessary.

Finding #5: Information in the division's database could be used to oversee programs, if better maintained.

Because the division does not properly maintain its data on the status of apprentices, it cannot determine actual program performance, such as the rate at which apprentices cancel or complete their apprenticeships. Field office staff are responsible for updating and verifying the information entered in the database; however, according to a few of the consultants, staffing limitations prevent them from performing this function on a regular basis. Thus, the division's deputy chief, on a case-by-case basis, sends committees an electronic listing of active apprentices in their programs and asks them to update the information, which he then uses to update the database. A standardized process for updating the database on a regular basis could help increase the accuracy of the information it contains. If accurate, the division could use this information to set performance goals, pinpoint program successes and failures, and focus its monitoring efforts.

We recommended that the division establish a process for regularly reconciling information on the current status of apprentices with information maintained by committees and use data to set performance goals and to pinpoint program successes and failures.

Division's Action: Partial corrective action taken.

The division stated that consultants have been aggressively working with programs to synchronize program and division records. It also says that its roll-out of the electronic transmission of apprentice registration and drop forms has been moving more slowly than planned, but about 30 percent of apprentices are now being reported electronically. The division did not mention any effort it had made to use data to set performance goals or to pinpoint program successes or failures.

San Francisco-Oakland Bay Bridge Worker Safety

Better State Oversight Is Needed to Ensure That Injuries Are Reported Properly and That Safety Issues Are Addressed

REPORT NUMBER 2005-119, FEBRUARY 2006

Department of Industrial Relations' and the California Department of Transportation's responses as of April 2007

The Joint Legislative Audit Committee (audit committee) asked the Bureau of State Audits to evaluate the Department of Industrial Relations' (department) Division of Occupational Safety and Health's (division) enforcement of worker safety and health laws and the California Department of Transportation's (Caltrans) oversight practices on construction of the East Span of the San Francisco-Oakland Bay Bridge (East Span).

In addition, the audit committee asked us to compare the number of injuries reported by workers on the East Span with the number reported on other large construction projects. The audit committee also asked us to evaluate the workplace safety policies, including any safety bonus programs of companies contracted to work on the East Span, and determine whether any disciplinary action has been taken against workers complaining of injuries or health issues. We focused our review on the safety of workers involved in construction of the Skyway project because it is the largest, most expensive component of the East Span currently being constructed and was at the center of certain media allegations. The Skyway is a section of the new East Span stretching most of the distance from Oakland to Yerba Buena Island.

Audit Highlights . . .

Our review of safety oversight on the Skyway project of the San Francisco-Oakland Bay Bridge East Span replacement revealed the following:

- *The Division of Occupational Safety and Health (division) of the Department of Industrial Relations did not discover the potential underreporting of alleged workplace injuries and an alleged illness on the Skyway because it lacks procedures to ensure the reasonable accuracy of employer's annual injury reports.*
- *The division failed to adequately follow up on three of the six complaints received from Skyway workers, including an April 2004 complaint in which it found two alleged serious violations but did not issue citations to the contractor.*
- *The California Department of Transportation's safety oversight of the Skyway appears sufficient but improvements, such as increasing safety training and meeting attendance, could be made.*

Finding #1: The division does not exercise sufficient control over the injury reporting process to ensure that employers properly report injuries.

Although the reported injury rate of the prime contractor for the Skyway project is one-fourth that of the injury rate of similar projects, we question whether relying upon these statistics as an indication of project safety conditions is justified. The federal Occupational Safety and Health Administration's (federal OSHA) Form 300: Log of Work-Related Injuries and Illnesses (annual injury report), which employers are required to complete, summarizes the workplace injuries as defined in regulations, occurring during the year and is the basis for the calculation of injury rates. The acting chief of the division explained that division investigators review annual injury reports and may ask employees about injuries as part of on-site inspections, but the division does not collect these reports and it does not have a systematic process to detect injuries that go unrecorded. In addition, the acting chief stated that because the resources of the division are finite, a decision to invest resources into the policing of the recording of injuries in the annual injury reports necessarily means that other resource-dependent activities will suffer. Consequently, the division was not aware of a number of alleged workplace injuries and an alleged illness that potentially meet recording requirements but were not included in annual injury reports of the Skyway's prime contractor.

To identify the underreporting of workplace injuries and to help ensure the reasonable accuracy of annual injury reports, we recommended that the division develop a mechanism to obtain employers' annual injury reports and design procedures to detect the underreporting of workplace injuries. If the division believes it does not have the resources necessary to undertake this task in light of its other priorities, it should seek additional funding from the Legislature for this effort. In designing these procedures, the division should take into account conditions that may attribute to the underreporting of injuries.

Division's Action: None.

The division has concluded that developing a mechanism to obtain and review employers' annual injury reports to detect the underreporting of workplace injuries is impractical without having an electronic information management system. Further, it believes that the site investigation needed to establish a violation based on such a review would be time consuming. Using its recent investigation of the Skyway's prime contractor, Kiewit/FCI/Manson, a joint venture (KFM) as an example, the division indicates the investigation required over 400 hours of an inspector's time as well as ➲ managerial and legal review to find evidence that violations occurred. The division also states that stakeholders at an April 2006 meeting of the Cal/OSHA Advisory Committee (advisory committee) concluded that reviewing employers' annual injury reports for the underreporting of workplace injuries would not be in the best interest of the division. Rather, the division indicates it is working with another division within the department on the feasibility of electronically receiving employer's reports of injury and possibly physician's reports of injury, which would facilitate an automated review of these reports for targeting workplaces most likely to cause death or serious injury to workers.

Finding #2: The division did not follow up adequately on all Skyway complaints.

The division did not adequately follow up on three of the six complaints received from Skyway workers. In one instance, it chose to review an April 2004 complaint from former KFM employees, using the compliance assistance approach outlined by its informal partnership agreement with KFM. Because the agreement precluded issuing citations if KFM promptly abated hazardous conditions, the division did not issue citations that otherwise are required when it found two alleged serious violations of health and safety regulations while investigating this complaint. In another instance, because of internal miscommunication, the division failed to investigate a complaint at all. Finally, despite state law requiring it to conduct on-site investigations for employee complaints having a reasonable basis, the division decided to use its nonemployee complaint procedure to handle a complaint it received from a KFM employee.

We recommended that if the division believes it will use the partnership model in the future, it should create a plan for how it will operate under the model so its activities will provide appropriate oversight and be aligned with state law. Specifically, it should ensure that roles and responsibilities are communicated clearly and that critical information is shared with all relevant individuals.

Division's Action: Partial corrective action taken.

The division also discussed the continued use of the partnership model with the advisory committee. This discussion concluded that the division would attempt to keep as clear a separation as feasible between enforcement staff and compliance assistance staff when using the partnership model. Using its recent involvement with flavoring manufacturers located in California, the division indicates offering the manufacturers a consultative inspection in lieu of an enforcement inspection, with separate units performing these functions. The division's discussion with the advisory committee did not conclude that there was a need for a plan for how it will operate under the partnership model. In addition, the division states it will keep the advisory committee informed on emerging partnerships and seek its input on significant issues.

Finding #3: Caltrans' safety oversight on the Skyway project appears sufficient, but improvements could be made.

Although Caltrans worked to implement the safety oversight procedures required by its policies on the Skyway project, some improvements can be made to better emphasize safety. For example, the project safety coordinator's position within the organization has limited independence from construction managers. In addition, because Caltrans' inspectors observe the safety conditions of the work site while monitoring the construction and engineering aspects of KFM's work, it is important that they are able to identify unsafe conditions. To do so, Caltrans' policy and state regulations require that construction personnel attend safety meetings every 10 working days and attend general and job-specific hazard training. However, our review of the attendance records for a sample of Caltrans' staff assigned to the Skyway project, including all seven construction managers who set an example for staff, indicated they have attended only 76 percent of safety classes identified as necessary for their jobs and only 66 percent of mandatory biweekly safety sessions.

To ensure that the project safety coordinator assigned to the Skyway project has the necessary independence and authority to evaluate and report on project safety, we recommended that Caltrans make this position be independent of the managers whose safety performance the coordinator must oversee. In addition, we recommended that Caltrans should ensure its construction managers and staff on the Skyway project attend the mandatory biweekly safety sessions and other necessary safety training.

Caltrans' Action: Corrective action taken.

Caltrans indicates establishing a safety coordinator position that is responsible for overseeing employee and contractor safety on the East Span's construction projects. To provide for the position's independence, the position will submit safety reports to the East Span's construction manager, but a safety manager from Caltrans' District 4 office will supervise the position. An individual was hired for the position in October 2006. Caltrans also reports taking steps to improve attendance at required safety meetings and training, and indicates that employees' attendance has improved.

Medical Board of California's Physician Diversion Program

While Making Recent Improvements, Inconsistent Monitoring of Participants and Inadequate Oversight of Its Service Providers Continue to Hamper Its Ability to Protect the Public

REPORT NUMBER 2006-116R, JUNE 2007

State and Consumer Services Agency's response as of December 2007

The Joint Legislative Audit Committee requested the Bureau of State Audits review the effectiveness and efficiency of the Medical Board of California's (medical board) Physician Diversion Program (diversion program). In our review, we found that although the diversion program had made many improvements since the release of the November 2005 report of an independent reviewer, known as the enforcement monitor, there were still some areas in which the program needed to improve in order to adequately protect the public. For instance, although case managers appeared to be contacting participants on a regular basis and participants generally appeared to be attending group meetings and completing the required amount of drug tests, the diversion program did not adequately ensure that it received required monitoring reports from its participants' treatment providers and work-site monitors.

In addition, although the diversion program had reduced the amount of time it takes to admit new participants into the program and begin drug testing, it did not always respond to potential relapses in a timely and adequate manner. Specifically, the diversion program did not always require a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug. Further, of the drug tests scheduled in June and October 2006, 26 percent were not performed as randomly scheduled. Additionally, the diversion program did not have an effective process for reconciling its scheduled drug tests with the actual drug tests performed and did not formally evaluate its collectors, group facilitators, and diversion evaluation committee members to determine whether they were meeting program standards. Finally, the medical board, which is charged with overseeing the diversion program, had not provided consistently effective oversight.

Medical Board's Action: Discontinued the diversion program.

In July 2007 the medical board met and determined that it would allow the diversion program to sunset on June 30, 2008. Due to the termination of the program, the medical board did not address individual audit report recommendations in its responses to the audit. Rather, the medical board described its transition plan, which was approved by the board in November 2007. Key components of the plan are outlined on the following pages:

Audit Highlights . . .

Our review of the Medical Board of California's (medical board) Physician Diversion Program (diversion program) revealed the following:

- *Case managers are contacting participants on a regular basis and participants appear to be attending group meetings and completing drug tests, as required.*
- *The diversion program does not adequately ensure that it receives required monitoring reports from its participants' treatment providers and work-site monitors.*
- *The diversion program has reduced the amount of time it takes to bring new participants into the program and begin drug testing, but the timeliness of testing falls short of its goal.*
- *The diversion program has not always required a physician to immediately stop practicing medicine after testing positive for alcohol or a nonprescribed or prohibited drug, thus putting the public's safety at risk.*
- *Twenty-six percent of drug tests in June and October 2006 were not performed as randomly scheduled.*
- *The diversion program's current process for reconciling its scheduled drug tests with the actual drug tests performed needs to be improved.*

continued on next page . . .

» *The diversion program has not been formally evaluating its collectors, group facilitators, and diversion committee members to determine how well they are meeting program standards.*

» *The medical board has not provided consistently effective oversight of the diversion program.*

Self-referred participants:

- The diversion program will no longer admit new, self-referred physicians into the program.
- Self-referred participants with three years of sobriety will be referred to a Diversion Evaluation Committee (DEC) for a determination of whether the individuals can be deemed to have completed the program.
- On June 30, 2008, self-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program is inoperative and encouraging the physicians to find another monitoring or treatment program.

Board-referred participants:

- The medical board will notify individuals seeking admission into the diversion program in lieu of disciplinary action (board-referred) that the program will be inoperative June 30, 2008, and, at that time the medical board will refer the individuals to the Attorney General's Office and enforcement for further action. Being made fully aware of this condition, participants will be given the choice of entering the program or proceeding through the enforcement process.
- Current, board-referred participants with three years of sobriety will be referred to a DEC for a determination of whether the individuals can be deemed to have completed the program.
- On January 1, 2008, board-referred participants with less than three years of sobriety will be sent a letter stating that the diversion program will be inoperative as of June 30, 2008, and that they must find another program that meets the protocols of the diversion program. In addition, the other program must be willing to report to the Medical Board's chief of enforcement on a regular basis and to immediately notify the board of any positive drug tests.

Board-ordered participants:

- The medical board will no longer approve a stipulation that requires participation in the diversion program as a condition of a disciplinary order or issuance of a probationary license.
- On July 1, 2008, the diversion program condition in all disciplinary orders will become null and void and will no longer be considered a condition of probation. However, individuals will still be required to abstain from drugs and alcohol and must submit to drug testing. Staff will continue to monitor the random drug tests of these individuals.

Out-of-state participants:

Staff will continue to liaison with programs in other states to ensure that out-of-state participants comply with that respective state's program until completion.

Medical Board of California

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

REPORT NUMBER 2007-038, OCTOBER 2007

Audit Highlights . . .

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

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

Medical Board of California's response as of January 2008

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

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

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

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

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

Medical Board's Action: Partial corrective action taken.

The medical board said that it approved a motion in November 2007 to seek legislation to allow flexibility in the initial licensing and renewal fees. In January 2008 Assembly Bill 547 was amended to include language giving the medical board the flexibility to set these fees up to a maximum of $790 and, as of January 2008, was still in committee.

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

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

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

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

Medical Board's Action: Pending.

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

- Seek legislation to increase the mandated two-month reserve to four or six months.
- Seek budget authority to reestablish the Operation Safe Medicine Unit, to expand the Probation Program, and to replace its information technology infrastructure.
- Transfer $500,000 to the Health Profession Education Foundation to assist with the funding of a loan repayment program.

Department of Mental Health, Coalinga State Hospital

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

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

Department of Mental Health's response as of December 2007

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

Investigative Highlight . . .

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

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

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

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

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

Mental Health's Action: Partial corrective action taken.

Mental Health stated that hospital management erred when it assigned the vehicles to the motor pool and subsequently to the officials who were not entitled to use law enforcement vehicles. It reported that hospital officials are now assigned light-class vehicles for business use only. It further reported that the hospital intended to transfer the two Police Interceptors to another Mental Health hospital until the hospital needs them. However, in December 2007 Mental Health still had not transferred the two Police Interceptors to another Mental Health hospital.

Regarding the home-storage permits and the vehicle mileage logs, Mental Health stated that the long commutes to the officials' "home" residences were inappropriate. It also reported that all home-storage permits are now accurate. Further, Mental Health reported that as of June 2007 all hospital employees who are assigned vehicles are maintaining vehicle mileage logs and that hospital motor pool staff are maintaining mileage logs for pool vehicles.

Finally, Mental Health reported that two of the officials have retired and that the remaining official was transferred to another hospital.

Nonprofit Hospitals

Inconsistent Data Obscure the Economic Value of Their Benefit to Communities, and the Franchise Tax Board Could More Closely Monitor Their Tax-Exempt Status

REPORT NUMBER 2007-107, DECEMBER 2007

Board of Equalization's, Franchise Tax Board's, and Office of Statewide Health Planning and Development's responses as of December 2007

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to conduct an audit to ascertain whether the activities performed by hospitals that are exempt from paying taxes because of their nonprofit status truly qualify as allowable activities consistent with their exempt purpose. Specifically, the audit committee requested that we determine the roles of the entities involved in determining tax exemptions and the extent of oversight they exercise over nonprofit hospitals to ensure that they comply with requirements for tax exemption and community benefit reporting. It also asked us to examine the financial reports and any community benefit documents prepared during the last five years by a sample of both nonprofit hospitals and hospitals that operate on a for-profit basis and determine the value and type of community benefits and uncompensated care provided. In addition, the audit committee asked us to compare the community benefits provided by nonprofit and for-profit hospitals, and compare the types of care that both types of hospitals provide without receiving compensation (uncompensated care). Further, the audit committee asked us to review the financial information and the claims submitted to the State Board of Equalization (Equalization) or other agencies by nonprofit hospitals to determine whether they meet income requirements to qualify for tax-exempt status and to assess how tax-exempt nonprofit hospitals use excess income, to ensure that the uses are permissible and reasonable in terms of expansion of plant and facilities, additions to operating reserve, and the timing of debt retirement. The audit committee also asked us to determine the most current estimated total annual value of the taxation exemptions of both state corporation income taxes (income taxes) and local property taxes for nonprofit hospitals.

Finally, the audit committee asked us to determine whether the community benefits and uncompensated care provided by nonprofit hospitals meet the requirements for exemption from local property and state income tax. However, although state law outlines the requirements a nonprofit hospital must meet to receive an exemption from paying taxes, it does not specify community benefits and uncompensated-care costs as requirements. Additionally, although state law requires most tax-exempt hospitals to annually submit to the Office of Statewide Health Planning and Development (Health Planning) a community benefits plan (plan), which may include an uncompensated-care element, the law also clearly states that the information included in the plan a nonprofit hospital submits cannot be used to justify its tax-exempt status.

Audit Highlights . . .

Our review of tax-exempt hospitals revealed the following:

- *About 223 of California's 344 hospitals are eligible for income and property tax exemptions because they are organized and operated for nonprofit purposes.*
- *Comparing financial data reported by nonprofit and for-profit hospitals indicated the uncompensated care provided by the two types of hospitals was not significantly different.*
- *Benefits provided to the community, which only nonprofit hospitals are required to report, differentiate nonprofit hospitals from for-profit hospitals, but the categories of services and the associated economic value are not consistently reported among nonprofit hospitals.*
- *The values of tax-exempt buildings and contents owned by nonprofit hospitals are frequently misreported by county assessors.*
- *Lacking more reliable data, we used the reported economic values of community benefits and tax-exempt property to estimate that reported community benefits of $656 million for 2005 were roughly 2.7 times the estimated $242 million in state corporation income taxes and property taxes not collected from nonprofit hospitals.*
- *The Franchise Tax Board, which administers state income tax exemptions, could better use available tools, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for their tax exemption.*

Finding #1: Lack of specific guidance regarding the content of community benefit plans precludes any meaningful comparison of the plans.

Although state law requires that tax-exempt hospitals submit plans to Health Planning, it does not require Health Planning to review the plans to ensure that hospitals report the same types of data consistently, nor does Health Planning do so. Further, the law provides only limited guidance regarding the content of the plan and does not mandate a uniform reporting standard. Thus, in reviewing the plans that eight tax-exempt hospitals submitted from 2002 through 2006, we found significant variations in the plans that precluded us from performing any meaningful comparison of the economic values the hospitals reported. Although the guidance provided in the law does not require uniform reporting, two hospital associations offer hospitals some guidelines. Additionally, the Internal Revenue Services (IRS) is proposing a new schedule for hospitals to prepare to be included with the informational return that all income-tax-exempt organizations must file. If adopted, the IRS anticipates using the new schedule for the 2008 tax year. The new schedule will require tax-exempt hospitals to report their community benefits and uncompensated-care costs and could influence hospitals to pattern their plans after the schedule's methodologies and format.

We recommended that if the Legislature expects plans to contain comparable and consistent data, it consider enacting statutory requirements that prescribe a mandatory format and methodology for tax-exempt nonprofit hospitals to follow when presenting community benefits in their plans. We also recommended that if the Legislature intends that the exemptions from income and property taxes granted to nonprofit hospitals should be based on hospitals providing a certain level of community benefits, it consider amending state law to include such requirements.

Legislative Action: Unknown.

Finding #2: Errors in reported property values reduce the reliability of estimated property taxes not paid by tax-exempt hospitals.

We attempted to estimate the amount of property taxes not collected from tax-exempt hospitals, using the values of the buildings and contents owned by tax-exempt hospitals that county assessors submitted on statistical reports to Equalization. Although we found numerous errors in the values that prevented us from ensuring the reliability of our calculation, this methodology resulted in an estimated $184 million in uncollected property taxes in 2005. More specifically, we found errors in the reported values for four of the 12 hospitals we reviewed, representing a total error of about $204 million. The errors for the remaining 211 nonprofit hospitals in the State that are eligible for tax exemption are unknown. Equalization performs surveys of county assessors to determine the adequacy of the procedures and practices they apply in valuing property for the purpose of taxation and for administering property tax exemptions.

To ensure that it provides accurate information regarding the value that is tax exempt, we recommended that Equalization consider including in its surveys of the county tax assessors a process for verifying the accuracy of the values reported on the annual statistical reports submitted by the county assessors.

Equalization's Action: Pending.

Equalization indicated in its response to the audit report that it plans to incorporate steps in its survey review of county tax assessors to verify proper classification of exempted property based upon the type of organization within the welfare exemption. It also stated that this will provide more accurate reporting of exempted values by hospitals.

Finding #3: Recent legislation affects the Franchise Tax Board's responsibilities for granting income tax exemptions.

We found minor weaknesses in the process the Franchise Tax Board (tax board) used in the past to determine the eligibility of nonprofit hospitals for state income tax exemptions. However, legislation effective January 1, 2008, will allow the tax board to rely on the federal income tax exemptions determined by the IRS. Although it was unable to obtain IRS reports and other information on the federal review process and thus could not gain a full understanding of the method the IRS uses to determine eligibility for tax exemptions, the tax board contended that its research of the IRS web site, publications, and tax law enabled it to conclude that the IRS process is sufficient to ensure proper determination of state exemption status. The tax board also stated that because state and federal laws on tax exemption are essentially identical, the additional audits it plans to perform—made possible by the workload reduction resulting from its use of IRS eligibility determinations—will compensate for any differences in quality between the state and federal review processes. The tax board indicated, however, that until it identifies the actual savings in workload that may occur when the new law is implemented, it cannot evaluate the opportunities for performing audits of nonprofit hospitals or plan for the number or frequency of such audits.

We recommended that, after it identifies the staff resources that are no longer required for reviewing tax exemption applications, the tax board implement its plan to use those resources for performing audits of tax-exempt entities, including hospitals.

Tax Board's Action: Pending.

The tax board stated that it will focus on increased compliance audits, as resources are available.

Finding #4: The tax board has limited assurance that nonprofit hospitals remain eligible for state income tax exemptions.

The tax board does not use the tools available to it, such as annual filings and audits, to monitor the continuing eligibility of nonprofit hospitals for income tax exemption. According to management staff at the tax board, annual filings, which contain information such as financial data and changes in business activities, offer the tax board's Exempt Organizations Unit (unit) a useful tool for reviewing ongoing compliance with the requirements for maintaining tax-exempt status. However, the unit does not review the information in the annual filings. Management at the tax board stated that the large volume of initial applications for income tax exemptions and limited personnel prevent unit staff from reviewing the annual filings. In the absence of monitoring by the tax board, hospitals exempt from income taxes sometimes submit annual filings that do not contain all the information required by the form or its instructions or information required under the California Code of Regulations (regulations).

Regular auditing is another tool the tax board could use to monitor the tax-exempt status of nonprofit hospitals. However, the tax board does not regularly conduct audits of tax-exempt hospitals, even though, based on data provided by the tax board, the revenues of these hospitals represent 17 percent of the total revenue of all tax-exempt organizations. According to the tax board, an audit can originate when members of the public express concern that a tax-exempt organization may be functioning in a manner requiring revocation of its tax-exempt status. The tax board indicated, however, that it could not identify any complaints that might have prompted audits of tax-exempt hospitals, because it does not maintain a central record of the receipt or disposition of those complaints. Rather, complaints against tax-exempt organizations are stored in the tax board's files and cannot be easily retrieved.

The tax board stated that the revenue information from annual filings entered into its automated record-keeping system could be used to identify income-tax-exempt nonprofit hospitals to be considered for audit. However, because the tax board has not ensured that all tax-exempt nonprofit hospitals are distinctly identified in its electronic data system, it is unable to efficiently generate

a list of the hospitals that might require audits. According to the tax board, creating such a list would necessitate manually reviewing the hard-copy files of the approximately 72,000 tax-exempt organizations operating in the State to determine which are tax-exempt hospitals.

Finally, the tax board told us that the IRS expects to perform an audit within three to five years after each organization receives a federal tax exemption, and it would notify the tax board of any revocations. However, the tax board does not currently coordinate with the IRS to identify audits of California tax-exempt hospitals in a manner that would allow the tax board to adequately rely on IRS audits for assurance of continuing eligibility.

We recommended that the tax board consider developing methodologies to monitor nonprofit hospitals' continuing eligibility for income tax exemption. These methodologies should include the following activities:

- Review the financial and other information from the annual filing submitted by hospitals exempt from income taxes.
- Ensure that the annual filing contains all the information the tax board's regulations specify as necessary for determining eligibility for an income tax exemption.
- Track complaints in a manner that enable the tax board to identify potential trends in noncompliance by income-tax-exempt hospitals and initiate audits of those hospitals.
- Adequately identify tax-exempt hospitals in its automated database, enabling it to use the information in the database to profile those hospitals and identify any potential noncompliance with the law.

The tax board should also gain an understanding of the frequency and depth of IRS audits of tax-exempt hospitals to identify the extent to which it can rely on IRS audits and factor that reliance into its monitoring efforts.

Tax Board's Action: Pending.

The tax board indicated that it plans to begin to develop an audit program to review the annual filings for hospitals to gain a better understanding of the compliance issues and materiality thresholds for ongoing reviews. It also stated that it has already implemented a new procedure to log all complaints into a computer database that documents the organization name, type, issue, and action taken. Additionally, the tax board indicated that as resources are available, it will begin updating the codes to separately identify tax-exempt hospitals from other types of charitable organizations. Finally, it stated that it is currently finalizing a memorandum of understanding (MOU) with the IRS that will allow the tax board to receive additional information on tax-exempt organizations. In addition to notification of final IRS actions authorized under the existing MOU, the new agreement will entitle FTB to receive information on proposed denials, revocations, and audit adjustments and names or organizations that have applied for federal exemption.

Department of Social Services

In Rebuilding Its Child Care Program Oversight, the Department Needs to Improve Its Monitoring Efforts and Enforcement Actions

REPORT NUMBER 2005-129, MAY 2006

Department of Social Services' responses as of May and August 2007

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits to review the Department of Social Services' (department) oversight of licensed child care facilities. Specifically, the audit committee requested that we assess the department's progress in meeting facility inspection requirements and determine whether the department's authority and resources were adequate to fully enforce the required health and safety standards in child care facilities. Additionally, we were asked to review the department's process for investigating and resolving complaints regarding facilities. Further, the audit committee asked us to examine the department's policies and procedures for categorizing health and safety risks identified at child care facilities and to review the reasonableness of the department's processes and practices for informing parents of problems it had identified. Finally, the audit committee requested that we review the disciplinary process the department uses when it identifies deficiencies in facilities.

Audit Highlights . . .

Our review of the Department of Social Services' (department) oversight of licensed child care facilities found that the department:

- ***Has struggled to make required visits to the facilities and carry out its other monitoring responsibilities.***
- ***Began a three-phase effort in 2005 to rebuild its oversight activities for its licensing programs.***
- ***Usually conducted complaint visits within established deadlines but did not always complete the investigations within deadlines.***
- ***Did not always determine whether child care facilities corrected the deficiencies it identified during its visits to facilities.***
- ***Could increase its use of civil penalties as a response to health and safety violations.***
- ***Appropriately prioritized and generally ensured that legal cases were processed within expected time frames; however, its regional offices did not always adequately enforce legal actions against licensed child care facilities.***

Finding #1: The department has struggled with making periodic inspection visits required by statutes, and the data it uses to track these visits are not sufficiently reliable.

State law enacted in August 2003 established new requirements for how often the department should conduct periodic inspections of child care facilities. Under this new law, the department annually must make required visits to certain facilities and random visits to at least 10 percent of the remaining facilities. The requirements further state that the department must visit each child care facility at least once every five years, which means that it would conduct visits, on average, of approximately 20 percent of the facilities annually.

However, we found that the department did not meet those statutory requirements for fiscal year 2004–05, the only full year that had elapsed since the requirements were enacted. Specifically, the department performed 68 percent of the required or random visits needed for fiscal year 2004–05. In addition, these visits represented only 8.5 percent of the licensed child care facilities in the State during the same period.

Further, the department had yet to start tracking the "once every five years" requirement to determine the facilities it needs to visit so it can ensure that all are visited within the five-year period. Moreover, we found that the data the department uses to record and track inspection visits were not sufficiently reliable. For example, we found in the data numerous instances of multiple visits being made to the same facility on the same day. As a result of these and other problems, the data may not accurately reflect the department's progress toward meeting statutory requirements.

We recommended that the department develop a plan to measure its random and required visits against its statutory requirement to visit each facility at least once every five years, assess its progress in meeting this and other statutory requirements, and ensure that the data it uses to assess its progress in meeting the various requirements are sufficiently reliable.

Department's Action: Partial corrective action taken.

The department has developed an information technology strategic plan to provide systems and tools to eliminate or mitigate problems identified in the audit, such as for measuring its random and required visits. The department stated its feasibility study related to the plan has been approved but that implementation of the plan is dependent upon funding. In the meantime, it is using interim solutions. In particular, it stated that it has developed special reports to identify child care facilities that have not received a visit and the number of facilities visited each year. In addition, the department stated that it has taken efforts to improve the accuracy of the data maintained in its systems. For example, the department completed a project that allowed automated field data to be electronically shared with its licensing information system. Finally, the department stated that it would continue its efforts to prevent any duplication of information.

Finding #2: Although the department has recently begun rebuilding its oversight operations, much more remains to be done.

In the spring of 2005 the department's community care licensing division initiated a significant effort to rebuild its operations in three phases. The rebuilding effort is intended to increase and improve the department's oversight of its licensing programs, including the child care program. The first two phases focused on rebuilding the "foundation" of the monitoring program, hiring staff, and increasing the department's monitoring and enforcement activities. At the time of our review, the department had yet to fully develop plans for Phase III, which it envisioned as a time to analyze the increased information it will have gathered and to determine any follow-up or modifications needed. However, as the department continues its rebuilding efforts, a question for the State's decision makers to consider is whether the level of monitoring that the department is working toward is sufficient to ensure the health and safety of children in child care facilities.

In addition, although the department has some existing methods and has started to implement others to help it monitor the activities of its regional offices, it has yet to develop the automated management information that will allow it to effectively perform this monitoring. Further, even though the department has established a process to inform parents of certain deficiencies it has identified at child care facilities, it has yet to make nonconfidential information about its monitoring visits to facilities readily available to the public. The department has expressed its intent to put all nonconfidential information on its Web site, but stated that implementation will be dependent on funding.

We recommended that the department continue its efforts to rebuild the oversight operations of its child care program and assess the sufficiency of its current monitoring efforts and statutory requirements to ensure the health and safety of children in child care facilities. In addition, the department should develop sufficient automated management information to facilitate the effective oversight of its child care program regional offices. Further, the department should continue its efforts to make all nonconfidential information about its monitoring visits more readily available to the public.

Department's Action: Partial corrective action taken.

As part of the department's efforts to ensure the health and safety of children in child care facilities, the department stated it contracted with the University of California, Davis (UCD) to conduct a nationwide literature review about the frequency of inspection visits, caseloads, and measures that reduce risk and increase safety. According to the department, the results of the review showed that the majority of the information provided to it involved descriptions of policies, procedures, opinions, and recommendations. The department reported that empirical studies are scarce

showing the effects of such policies, procedures, and recommendations on the health and safety of children. Although the department stated that information presented in the UCD report did not lend itself to comparison with practices in the State such as frequency of visits, it further stated its belief that the State appears to meet many of the standards that informed opinion considers to be beneficial in protecting the health and safety of children in child care. These standards include well-defined licensing requirements, background checks, and staff training and education requirements.

The department also reported that it intends to develop the necessary tools and management information to better assess its oversight responsibilities through its information technology strategic plan. (See Finding 1 for further discussion.) In addition, it stated that it accepted the recommendations of its performance review team about the use of data from one of its automated systems to facilitate quality reviews. The department further reported that its work team is identifying automated system information for use as quick performance indicators, developing procedures for electronic review of work, and designing formats for ongoing management reports to serve as routine performance indicators. Finally, the department stated its development and implementation of a web-based application to enhance public access to information depends on additional resources.

Finding #3: The department could improve its handling of complaint investigations.

Of the 40 complaint investigations we reviewed, the department completed eight outside its established 90-day deadline, ranging from 39 to 247 days late. In addition, our review of 54 complaint allegations the department deemed inconclusive revealed that in 19 instances it could have taken additional action to determine that the allegations were substantiated or unfounded. Further, we found little guidance in the department's evaluator manual about the actions the department should take in these instances. The department stated that its training in April 2006 was to include exercises designed to help new analysts evaluate evidence and reach conclusions on complaint allegations. At the time of our review, the department also planned to hold advanced complaint training for all child care licensing staff.

The department considers a complaint investigation complete when a supervisor approves the investigation. In six of its regional offices, the approval occurs after an analyst submits the investigation's findings but before corrective action is taken. The remaining six regional offices are taking part in a pilot project in which the approval occurs after the facility's plan of correction has been completed. However, the department has not yet determined which method of supervisory approval it intends to implement statewide.

Our review in one regional office of the department's complaint specialist pilot project, which it implemented in July 2005, disclosed several instances in which the department did not ensure that it took timely and appropriate action to enforce serious health and safety violations. For example, the department had taken follow-up action for only two of the seven facilities we reviewed since the complaint investigations were completed.

We recommended that the department complete complaint investigations within the established 90-day period, revise its policies to identify specific actions its child care program staff could take to reduce the number of inconclusive complaint findings, and continue its plans to train all of its analysts in evaluating evidence and reaching conclusions on complaint allegations. In addition, we recommended that the department evaluate its pilot project for supervisory approval after the plan of correction has been completed and implement a consistent process statewide for ensuring that licensees take appropriate corrective action. Further, the department should review the complaint specialist pilot project in its regional offices and use the results of its review to determine how it should modify its existing processes.

Department's Action: Partial corrective action taken.

The department reported that it implemented a new standard procedure in which monthly it identifies complaints that are pending over 90 days and makes a plan for their completion and closure. In addition, the department stated that it continued to review data on the findings of complaint investigations and found that about 30 percent were inconclusive. The department stated

that it is making modifications to its system to obtain more specific complaint data by regional office. The department also stated it will continue to study ways to reduce the number of inconclusive findings. Further, the department stated that all staff in its child care program have been trained in all facets of complaint investigations, including determining accurate findings. Moreover, in response to its pilot project regarding the timing of supervisory approval, the department issued a memo to standardize the process for reviewing and approving complaint investigations before the plan of correction has been issued. Finally, the department reported that it completed its complaint specialist pilot project and is in the process of incorporating pilot project practices into its permanent method of investigating serious complaints. However, the department encountered recruitment and retention issues among its complaint specialists and, as of August 2007, was soon to submit a request for a pay differential for these positions to the Department of Personnel Administration to address the issues.

Finding #4: The department did not always determine that facilities corrected deficiencies identified during its visits, and often its prescribed corrective action was not verifiable.

Our review found that the department did not always determine whether facilities had corrected the deficiencies arising from complaint, random, and required visits. For example, we found no evidence in the facility files that the department had determined whether deficiencies were corrected for 32 (25 percent) of 127 deficiencies the department cited from random and required visits. The department requires facilities to correct deficiencies within 30 days of being cited unless it determines that more time is needed. However, of the 95 deficiencies the department determined were corrected, we found that 31 were corrected more than 30 days after the department issued the citations. In addition, we identified various instances in which the plan of correction was not written in a way that the department could verify or measure the corrective action the facilities had agreed to take. Thus, the department did not always have ongoing assurance that the deficiencies had been corrected.

We recommended the department ensure that deficiencies identified during its monitoring visits are corrected within its established 30-day time frame, that evidence of corrective action is included in its facility files, and that required plans of correction submitted by facilities are written so that it can verify and measure the actions taken.

Department's Action: Corrective action taken.

The department developed extensive revisions to its evaluator manual, particularly regarding clearing deficiencies, granting extensions for plans of correction, and using self-certifications. The evaluator manual revisions also included guidelines for developing effective plans of correction. In addition, the department indicated that it trained its staff in these areas and that there has been an increase in supervisory involvement to ensure consistency.

Finding #5: The department could increase its use of civil penalties as an enforcement tool.

Our review found that the department could increase its use of civil penalties as a response to health and safety violations by child care centers (centers) and family child care homes (homes). In particular, we found that the department did not assess civil penalties against homes in many instances we reviewed because the regulations for homes prescribe a more limited use of civil penalties for violations than the regulations for centers do. Further, our review of selected centers and homes found that the department did not always assess civil penalties for repeat violations, even though laws and regulations require it. Moreover, the department's evaluator manual prohibits civil penalties from being assessed if a follow-up visit is not conducted within 10 working days of the date specified for corrections to be made. However, the department is not precluded from conducting subsequent visits to previously cited facilities and citing them for repeat violations of the same regulations within a 12-month period. Nevertheless, we found several instances in which the department might have assessed civil penalties but did not because it did not make any follow-up visits.

We recommended that the department ensure that it assesses civil penalties in all instances where state laws and regulations require it. Additionally, it should consider proposing statutes or regulations requiring it to assess civil penalties on homes for additional types of violations. Further, the department should consider seeking changes to the requirement that it cannot assess civil penalties if follow-up visits are not conducted within 10 days of the time that corrective action was taken.

Department's Action: Corrective action taken.

The department stated that it proposed a "zero tolerance" policy that was included in a bill that would require civil penalties to be assessed for certain high-risk violations. The bill was considered by the Legislature in 2006 but did not pass. Additionally, the department issued memos and distributed a civil penalty manual about the requirement and use of civil penalties as well as developed enhancements to the evaluator manual to further clarify the use of civil penalties. Further, the department concluded that the requirement is appropriate for follow-up visits to be made within 10 days of the plan of correction date in order for civil penalties to be assessed. Finally, the department stated that it may use progressive civil penalties to bring a licensee into compliance in the event that a follow-up visit is not made within 10 days.

Finding #6: The department has not consistently followed its guidance about using noncompliance conferences.

Our review of a sample of child care facilities at four regional offices revealed several instances in which the department did not follow guidance provided in a May 2004 memorandum about the use of noncompliance conferences to gain compliance from its licensees. For example, contrary to the May 2004 memorandum's requirements, the department did not require noncompliance conferences to be held after the initial citation for seven of 12 facilities we reviewed. In addition, we found that the department did not always conduct the noncompliance conferences promptly, given the severity of the noncompliance. In particular, the department took between two and five months to hold noncompliance conferences for five of 18 facilities we reviewed. Further, we identified instances in which the department's regional offices were inconsistent about the timing of noncompliance conferences. For example, one regional office required a licensee to attend a noncompliance conference 23 days after an incident occurred, whereas another regional office did not require a license to attend a noncompliance conference until nearly five months after an incident occurred.

We recommended that the department clarify its direction to regional office staff to help ensure that they are using noncompliance conferences promptly and in appropriate instances. Additionally, the department should reevaluate its May 2004 memorandum and, to the extent it reflects the department's current intent, incorporate the guidance into its evaluator manual. Further, the department should periodically review regional offices' use of noncompliance conferences to ensure that they are consistently following established policies.

Department's Action: Partial corrective action taken.

As of its latest response in August 2007, the department was in the process of revising the evaluator manual to incorporate the directives from its May 2004 memorandum and the recommendations from its internal review team.

Finding #7: The regional offices may not always consult legal staff as early as possible.

The department's evaluator manual states that situations involving physical or sexual abuse or ones in which there is an imminent risk to children should be referred immediately to the legal division. In addition, the manual states that regional offices should consult with their legal staff in cases in which the regional office is unsure as to whether legal action is warranted. However, we noted some cases that

caused us to question whether regional offices are consulting the legal division as early in the process as would be beneficial. The department acknowledged the need to use legal consultants more effectively by implementing in January 2006 a pilot project in Southern California to provide staff with more immediate access to legal consultants.

We recommended that the department ensure that regional office staff consult with legal division staff early in the process when circumstances warrant it by clarifying its policies as necessary and following up to determine that the policies are complied with.

Department's Action: Corrective action taken.

The department reported that the legal division's early consultation pilot project in Southern California was well received, yet significant operational changes were made because of staff turnover. It reevaluated areas of assignment and sent legal staff to regional offices to be readily available for consultation. However, the department stated that it was doubtful it would expand the pilot project to Northern California, in part because the diversion of legal counsel to full-time consultation did not seem likely. Still, the department stated that it has continued to stress the need for early legal consultation. Finally, the department indicated that it requires monthly legal consultation on all cases that may result in an administrative action.

Finding #8: The department's enforcement of legal actions continues to need improvement.

Our review of 28 legal cases—15 in which the facility's license was revoked and 13 in which facilities were placed on probation—found that regional offices did not always adequately enforce legal actions against licensed child care facilities. Specifically, we found that as of March 2006, the department had not made visits to 12 of the 15 facilities that had their licenses revoked, although it had been longer than the required 90 days in each instance. In addition, we found that the department did not make follow-up visits to two of the 13 facilities placed on probation.

The department's policies require it in some instances to exclude employees or adult residents from the facilities and require the regional office to verify at the next evaluation visit that the licensee is complying with the exclusion order. Three cases we reviewed required the department to exclude employees or adult residents from the facilities. In the three cases, the regional office did not promptly make visits to the facilities to ensure the licensee's compliance. For example, the regional office did not conduct a visit for one of the three cases until nearly a year after the exclusion order became effective.

We recommended that the department require follow-up monitoring visits to ensure that child care facilities with revoked licenses are not operating and that individuals excluded from facilities are not present in the facilities. In addition, we recommended that the department ensure that visits to facilities on probation are made within the required deadline. Further, the department should revise its policies for following up on excluded individuals to ensure that it more promptly verifies that they are not present in facilities.

Department's Action: Partial corrective action taken.

The department issued a memo in October 2006 that directed all licensing staff to consider follow-up visits to facilities with revoked licenses or those with excluded individuals as the highest priority work, equal to complaint visits. The memo also addressed instructions for ensuring that a facility is actually closed when revocation becomes effective, ensuring that an excluded person has actually left the facility, and monitoring visits to facilities on probation. In addition, the department indicated that it requested additional resources to minimize the impact on other licensing and monitoring activities. Further, the department stated that it was revising its evaluator manual to incorporate the mandates of the memo. Finally, the department stressed the importance of making enhancements to allow for automated tracking and notification for follow-up visits to facilities.