OAL, its authority to review agency regulations, and the six criteria upon which its review is based were not created until 1980. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 44; Vol. 11, No. 1 (Winter 1991) p. 38; and Vol. 10, No. 4 (Fall 1990) p. 39 for background information on this case.)

All parties have finally reached a settlement in *California Chapter of the American Physical Therapy Ass'n, et al. v. California State Board of Chiropractic Examiners, et al.*, Nos. 35-44-85 and 35-24-14 (Sacramento County Superior Court). The parties were litigating the validity of the Board of Chiropractic Examiners' (BCE) adoption and OAL's approval of section 302 of BCE's regulations, which defines the scope of chiropractic practice. On February 1, the court approved a settlement between BCE and the California Medical Association (CMA), which required BCE to adopt new section 302 on an emergency basis; OAL approved the emergency rule on April 4. Other parties and intervenors—including the California chapter of the American Physical Therapy Association, the Medical Board of California, and the Physical Therapy Examining Committee—initially objected to the settlement agreement and the proposed regulation, because it includes the practice of physical therapy within the scope of practice of a chiropractor. However, BCE later agreed to amend the proposed regulation to include an acceptable definition of the physical therapy which may be practiced by a chiropractor. BCE was scheduled to hold a regulatory hearing on the proposed adoption of revised section 302 on June 20. (*See infra* agency report on BCE for related discussion.) Thus, this lengthy case ended with no disposition as to OAL's 1987 "approval in part and disapproval in part" of section 302, which many critics believe is outside OAL's scope of authority. (See CRLR Vol. 7, No. 4 (Fall 1987) pp. 11, 30, and 100 for background information.)

On May 29, final judgment was entered in *State Water Resources Control Board (WRCB) and the Regional Quality Control Board, San Francisco Region v. Office of Administrative Law*, No. 906452 (San Francisco County Superior Court), the court holding that the wetland rules at issue are regulations within the meaning of the APA; the rules are not exempt from the APA; and since the rules were not adopted pursuant to the APA, they are unenforceable. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 44; Vol. 11, No. 1 (Winter 1991) p. 39; and Vol. 10, No. 4 (Fall 1990) p. 164 for background information; *see supra* LEGISLATION for AB 88 (Kelley), which would remove some of WRCB's rulemaking proceedings from the requirements of the APA.)

A new lawsuit, *Weber v. Smith*, No. 366633 (Sacramento County Superior Court), was filed against OAL on April 25. Weber, who had filed a request for determination from OAL in 1990, was not satisfied with the limited scope of the determination handed down by OAL on March 28. OAL Determination No. 2 (March 28, 1991, Docket No. 90-004) concluded that a regional center contracting with the Department of Developmental Services (DDS) is neither a state agency nor an agent of the state, and that such regional centers are not subject to the requirements of the APA. (*See supra* MAJOR PROJECTS.) Weber is challenging OAL's finding and declaration that it is beyond OAL's jurisdiction to prevent such privately-owned and operated community-based care centers from embracing and implementing practices and policies which DDS would be prohibited from enforcing without satisfying the APA's requirements.

OFFICE OF THE AUDITOR GENERAL

Acting Auditor General: Kurt Sjoberg (916) 445-0255

The Office of the Auditor General (OAG) is the nonpartisan auditing and investigating arm of the California legislature. OAG is under the direction of the Joint Legislative Audit Committee (JLAC), which is comprised of fourteen members, seven each from the Assembly and Senate. JLAC has the authority to "determine the policies of the Auditor General, ascertain facts, review reports and take action thereon...and make recommendations to the Legislature...concerning the state audit...revenues and expenditures...." (Government Code section 10501.) OAG may "only conduct audits and investigations approved by" JLAC.

Government Code section 10527 authorizes OAG "to examine any and all books, accounts, reports, vouchers, correspondence files, and other records, bank accounts, and money or other property of any agency of the state...and any public entity, including any city, county, and special district which receives state funds...and the records and property of any public or private entity or person subject to review or regulation by the agency or public entity being audited or investigated to the same extent that employees of that agency or public entity have access."

OAG has three divisions: the Financial Audit Division, which performs the traditional CPA fiscal audit; the Investigative Audit Division, which investigates allegations of fraud, waste and abuse in state government received under the Reporting of Improper Governmental Activities Act (Government Code sections 10540 *et seq.*); and the Performance Audit Division, which reviews programs funded by the state to determine if they are efficient and cost effective.

RECENT AUDITS:

Report No. F-005 (March 1991) contains the results of OAG's review of the state's control of its financial activities and its compliance with federal grant requirements and state regulations; this review was made as part of OAG's examination of the state's general purpose financial statements. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 45 for background information.) The report found that, although California has corrected some of the weaknesses in its internal controls identified by OAG in recent years, it has many more weaknesses to correct. The state continues to lose millions of dollars each year because agencies do not promptly identify and collect amounts owed to the state; do not effectively control expenditures; and do not manage cash to maximize benefits to the state. According to the report, for fiscal year 1989-90, 20 of the 24 agencies audited had weaknesses in the controls over their financial activities.

Among other recommendations, OAG suggested that the state uniformly prepare its budget based on generally accepted accounting principles (GAAP); GAAP is the preferred method of accounting because it is a nationally recognized set of standards which improves accountability by recognizing costs when they occur, not when they are paid for.

Report No. P-049 (April 1991) concerns the processing of complaints against physicians and other health practitioners by the Medical Board of California (MBC), the Office of the Attorney General, and the Office of Administrative Hearings (OAH). MBC is responsible for protecting consumers from incompetent, grossly negligent, unlicensed, or unethical medical practitioners. In addition to licensing physicians, MBC investigates complaints against its licensees and those of the committees and boards of the Division of Allied Health Professions. According to MBC, as of June 30, 1990, 155,734 licenses were in effect. During fiscal year 1989-90,

the Board received 6,658 complaints against health care practitioners, opened 2,689 investigations, and referred 378 cases to the AG's Office for discipline. MBC's investigation and discipline of health professionals is a lengthy process involving the Board, the AG's Office whose attorneys prosecute discipline cases, and the OAH whose administrative law judges (ALJs) preside over disciplinary hearings.

Preliminarily, the Auditor General noted that MBC's discipline system was the object of SB 2375 (Presley) (Chapter 1597, Statutes of 1990), a wide-ranging reform bill intended to expedite and strengthen the process. Among other things, the bill requires the Board to set a goal that by January 1, 1992, it will complete investigations within an average of six months from receipt of the complaint. After reviewing a selected sample of MBC enforcement cases resolved between December 1, 1989 through November 30, 1990, OAG concluded that the Board will not be able to meet this goal. MBC investigations last approximately 14 months—eight months beyond SB 2375's six-month goal. The fact that it takes an average of 117 days for the Medical Board to simply assign a case to a field investigator contributes substantially to this problem. Of the 312 cases reviewed by OAG, 22% were unassigned for six months (180 days) or longer.

After the Board completes its investigation and decides to file an accusation against a health care practitioner, the case is referred to the AG's Office, which has set a deadline of completing accusations within 60 days of receipt. However, OAG found that it presently takes the AG's Office over 200 days to prepare an accusation.

Although the functioning of OAH was beyond the scope of this audit, OAG noted that it usually takes OAH an average of 264 days (from the filing of the accusation) to complete a disciplinary hearing. Once the hearing is completed, the ALJ has 30 days in which to prepare a proposed decision and forward it to MBC's Division of Medical Quality (DMQ) or the relevant allied health licensing program. That entity then has 100 days in which to act on the proposed decision.

Thus, the Auditor General found that MBC, the AG's Office, and OAH took an average of 2.8 years to process a discipline case, from the Board's receipt of the complaint to its final disciplinary decision. Even if MBC were to meet the SB 2375- imposed six-month investigation goal and the AG's Office were to meet its self-imposed 60-day goal for the preparation of an accusation, the physician discipline process would still take 1.7 years.

OAG made other findings as well, including the following:

-Of 180 cases closed by MBC as without merit, 17% were closed for reasons that were not sufficient for concluding that the cases lacked merit.

-OAG found no evidence of supervisory approval for 15% of the 150 cases closed without merit involving allegations of physician negligence, incompetence, or drugs.

-MBC does not maintain its central file of all licensee names and complaint history as required by law, and is not always able to obtain complete case file documentation from its central file.

-MBC's toll-free complaint telephone number (1-800-MED-BD-CA) is not easily available to the public in some areas of the state.

OAG recommends that MBC evaluate the caseloads assigned to its investigators to determine the optimal caseload that would allow them to complete investigations more promptly; seek staffing levels that would allow that optimal caseload level; seek legislation authorizing it to take disciplinary action against a physician who fails to provide requested medical records within a reasonable period as determined by the Board; require MBC supervisors to approve a decision to close a case without merit if the case involves alleged negligence or incompetence; maintain case files, for cases closed with merit, in its central file at headquarters; and ensure that all telephone companies in all cities and counties throughout the state have the listing for its toll-free complaint number.

Report P-022 (May 1991) discusses whether functions of certain state entities which regulate professions may be performed at lower cost or more efficiently, or both, by other state entities which provide such services. The report assumes that the centralization of services or functions—that is, having one large entity perform functions for a number of smaller entities—results in potential benefits such as decreased costs and increased efficiency in work performance. The report notes that 50 regulatory entities in the state regulate various professions; 37 of these are located within the Department of Consumer Affairs (DCA). To varying degrees, all 50 regulatory entities are generally responsible for protecting consumers from dishonest or incompetent practitioners. To meet these responsibilities, the regulatory entities may establish qualifications for licensure, administer examinations, review license applications, and, as necessary, initiate disciplinary action.

OAG stated that many of the functions of the 50 regulatory entities surveyed are either already centralized or are being performed in such a manner that the entities should already be realizing the potential benefits of centralization. For example, the 37 entities within DCA and four regulatory entities in four other departments all rely on centralized services provided by their parent agencies to accomplish many of their functions. In addition, OAG determined that four very large, independent regulatory entities (the California Horse Racing Board, the State Bar of California, the Department of Insurance, and the Department of Real Estate), because of their size, should already be able to realize the benefits of centralization. Also, four small, independent regulatory entities rely on large state agencies to accomplish certain functions.

To determine whether certain DCA agencies could realize any benefit from having DCA perform certain functions, OAG identified for examination various functions which eleven of the entities currently provide for themselves—including license renewal, complaint tracking, and investigative services. Of the eleven agencies identified for identification, OAG determined that three entities (the Board of Guide Dogs for the Blind, the Athletic Commission, and the Cemetery Board) properly do not use DCA's automated license renewal system because they do not have enough licensees to clearly necessitate its use.

OAG also decided to review the complaint tracking systems of five DCA entities to determine whether the regulatory entities have adequate means for tracking complaints from initial receipt through final resolution to help ensure prompt resolutions to consumer complaints. The five entities chosen for review were the Cemetery Board, the Athletic Commission, the Board of Certified Shorthand Reporters, the Board of Registration for Geologists and Geophysicists, and the Board of Examiners of Nursing Home Administrators; however, OAG did not review complaint tracking at the Athletic Commission because, according to its executive officer, the Commission does not receive consumer complaints.

Thus, of the four DCA regulatory entities reviewed by OAG which do not use DCA's automated complaint and enforcement tracking system, OAG determined that none receive enough complaints to clearly necessitate use of the DCA's automated system for tracking complaints. OAG then reviewed the

complaint tracking systems utilized by these four entities, and determined that each entity's system generally provided sufficient information to enable the entity to track its complaints, although OAG noted that unspecified problems exist with some aspects of one of the entities' system.

OAG also reviewed the costs of investigations conducted by four DCA entities (the Board of Pharmacy, the Board of Dental Examiners, the Board of Funeral Directors and Embalmers, and the Cemetery Board) which do not use DCA's Division of Investigation (DOI) to perform their investigations. Analyzing only the cost (and not quality) of the agencies' investigations, OAG concluded that all four of these regulatory entities incurred lower nominal costs per hour for investigations in fiscal year 1989-90 than if they had used DOI to perform their investigations.

Based on its review of the 50 regulatory entities, OAG concluded that there appear to be limited opportunities for these entities to further realize the potential benefits of centralization.

Report No. C-775 (May 1991) evaluates the cost-effectiveness of the state's pilot Medi-Cal Therapeutic Drug Utilization Review (TDUR) program, which is operated by the state Department of Health Services (DHS). AB 2606 (Chapter 1340, Statutes of 1987) established a pilot "open formulary" and drug utilization review program in the Medi-Cal program. A formulary is simply a list of drugs. California has traditionally used a "pseudo closed formulary" approach to monitor drug usage and contain costs within the Medi-Cal program. A "closed formulary" system provides that no drugs may be prescribed if they are not on the list; a "pseudo closed formulary" system provides that drugs not on the list may be prescribed if prior authorization is obtained; and under an "open formulary" system, all drugs may be prescribed, and no prior authorization by Medi-Cal is required. Chapter 456, Statutes of 1990, allowed California to change from a pseudo closed formulary to a list of contract drugs; only drugs whose manufacturers have a contract with the state are included on the list. The implementation of this change was accomplished on a statewide basis; the new system was implemented in all California counties, including those counties which were part of the TDUR pilot program.

Many in the medical community believe that a TDUR program, which is essentially a tool for evaluating the therapeutic outcomes of prescription drugs, is an effective means of improving the health of Medi-Cal-eligible individuals so that the incidence of institutionalization is reduced. As a result, health care costs are expected to decline under such programs. The intent of California's AB 2606 pilot TDUR program was to test this hypothesis. An experiment was designed so that health care costs for Medi-Cal eligibles could be compared for a test group receiving TDUR intervention in three counties, versus a control group in two counties for whom the intervention did not occur.

The report found that the pilot TDUR program had a direct impact resulting in decreased utilization of drugs, outpatient services, and hospital care for a small group of Medi-Cal recipients during the review period; however, improvements were not noted for long-term care patients. OAG's findings indicated that the pilot program was not cost-effective, and that the TDUR program, as it is presently operated, would not be cost beneficial for the state. However, OAG noted that the potential may exist for a TDUR program to provide an effective means of controlling Medi-Cal costs, and made various recommendations for improving the cost-effectiveness of the current TDUR program.

Report No. P-961 (May 1991) concerns the delivery of care provided by the Department of Developmental Services to minors residing in the seven developmental centers throughout the state. The Department is responsible for administering the Lanterman Developmental Disabilities Services Act, which seeks to ensure that services are provided to persons with developmental disabilities and that those services are planned and provided as part of a continuum of care which is sufficient to meet the needs of developmentally disabled persons regardless of their age or handicap. According to the Lanterman Act, developmental disabilities include mental retardation, cerebral palsy, epilepsy, and autism.

The report states that the Department needs to ensure that developmental center staff obtain proper consents and approvals before using physical or chemical restraints on clients; revise the local minimum staffing guidelines at each developmental center; take appropriate action to minimize the diversions of direct care staff which require them to perform nonclient duties; and ensure that staff at the developmental centers are recording the clients' progress toward reaching objectives listed in their individual program plans and their individualized education programs.

Other Reports. During the past few months, OAG has also issued the following reports: *Federal and State Equity in EDD Owned Buildings* (Report No. F-025, March 1991); *The California Exposition and State Fair's Financial Status For the Fiscal Year Ended June 30, 1990* (Report No. F-025, April 1991); *The Martin Luther King Jr. Family Health Center Needs To Improve Its Financial Operations* (Report No. P-021, April 1991); *Public Reports of Investigation Completed by the Office of the Auditor General from August 1, 1989 through December 31, 1990* (Report No. I-116, April 1991); *Some Animal Control Agencies Need to Improve Their Management for Funds Available for Dog and Cat Population Control* (Report P-035, May 1991); *Portable Classrooms in California School Districts: Their Safety, Uses, Cost, and The Time It Takes to Acquire Them* (Report P-977, May 1991); and *Status of Franchise Tax Board/Board of Equalization Tax Settlements* (Report F-031, May 1991).

LEGISLATION:

SB 1132 (Maddy), as introduced March 8, would require the Auditor General to complete audits in accordance with the "Government Auditing Standards" issued by the Comptroller of the United States. This bill is still pending in the Senate Rules Committee.

LITIGATION:

On March 27, the California Supreme Court agreed to hear *Legislature v. Eu*, No. S019660, the constitutional challenge to Proposition 140 brought by the legislature and several individuals and legislators. Among other things, Proposition 140, which was approved by the voters in November 1990, limits the number of terms which may be served by state lawmakers and cuts the legislature's budget by approximately 40%. The mandatory budget cut was scheduled to take effect on July 1. Earlier this year, the legislature implemented a "golden handshake" program which resulted in the departure of 600 legislative employees, including some of the most experienced and knowledgeable consultants and aides.

However, in a motion for stay of Proposition 140 filed in early June, the legislature claimed that the salary savings from the "golden handshake" program were insufficient, and that it would be forced to shut down the Office of the Auditor General and the Legislative Analyst's Office. The motion seeks a stay of the provision which would cut approximately $70 million from the legislature's budget, based upon the argument that it would be too difficult to

retrieve all the laid-off employees should the initiative eventually be invalidated. The term limits provision would remain intact, pending the Supreme Court's ruling on the merits of the initiative, which is expected this fall. At this writing, with the jobs of 160 OAG employees on the line, the motion for stay is pending before the California Supreme Court.

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY (LITTLE HOOVER COMMISSION)

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The Little Hoover Commission was created by the legislature in 1961 and became operational in the spring of 1962. (Government Code sections 8501 *et seq.*) Although considered to be within the executive branch of state government for budgetary purposes, the law states that "the Commission shall not be subject to the control or direction of any officer or employee of the executive branch except in connection with the appropriation of funds approved by the Legislature." (Government Code section 8502.)

Statute provides that no more than seven of the thirteen members of the Commission may be from the same political party. The Governor appoints five citizen members, and the legislature appoints four citizen members. The balance of the membership is comprised of two Senators and two Assemblymembers.

This unique formulation enables the Commission to be California's only truly independent watchdog agency. However, in spite of its statutory independence, the Commission remains a purely advisory entity only empowered to make recommendations.

The purpose and duties of the Commission are set forth in Government Code section 8521. The Code states: "It is the purpose of the Legislature in creating the Commission, to secure assistance for the Governor and itself in promoting economy, efficiency and improved service in the transaction of the public business in the various departments, agencies, and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies, and instrumentalities and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...."

The Commission seeks to achieve these ends by conducting studies and making recommendations as to the adoption of methods and procedures to reduce government expenditures, the elimination of functional and service duplication, the abolition of unnecessary services, programs and functions, the definition or redefinition of public officials' duties and responsibilities, and the reorganization and or restructuring of state entities and programs. The Commission holds hearings about once a month on topics that come to its attention from citizens, legislators, and other sources.

MAJOR PROJECTS:

Skilled Nursing Homes: Care Without Dignity (April 1991) is part of the Commission's long-term study of the quality of care available to California's elderly population. Related Commission reports have reviewed community care (1983) and residential care (1989 and 1991) for the elderly. (See CRLR Vol. 11, No. 2 (Spring 1991) p. 47 for details.)

According to the Commission, almost 120,000 Californians are spending their final days in 1,200 skilled nursing facilities (SNFs) which are licensed and monitored by the California Department of Health Services (DHS). SNFs provide care for elderly residents who are no longer independent and need constant care. California spends almost $2 billion in Medi-Cal payments to SNFs, which is 25% of the health care budget for about 2% of the caseload.

Since 1976, the Commission has periodically examined DHS' role in regulating skilled nursing facilities and published *The Medical Care of California's Nursing Home Residents: Inadequate Care, Inadequate Oversight* (February 1989). (See CRLR Vol. 9, No. 2 (Spring 1989) pp. 38-39 for a summary of this report.) Since then, the Commission has successfully sponsored legislative reforms to improve standards, strengthen fines and penalties for violations, protect complainants' rights, and create more public access to SNF information.

Despite legislative victories, however, the Commission expressed continuing concern that the system is faltering and the elderly are still subject to abuse and neglect in SNFs. The Commission based its 1991 report on complaints, interviews with experts, and investigation of records. Complaints from advocates for the elderly and from the families and friends of SNF residents cite limited enforcement of regulations, the close association between the state licensing process and the nursing home industry, and the state's failure to implement federal nursing home reforms required by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). (*See infra* agency report on BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS for related discussion; *see also* CRLR Vol. 11, No. 2 (Spring 1991) pp. 94-95 for background information.) According to the Commission, California dismissed the OBRA 87 regulations as little more than added paperwork that would cost upward of $400 million without improving the quality of SNF care in California. But the Commission maintains that well-founded complaints indicate the need for California to meet OBRA 87's improved standards.

In its report, the Commission made three findings and seven recommendations. First, the report found that California, by failing to implement the OBRA 87 reforms, has threatened the health, safety, and well-being of SNF residents and jeopardized federal funding for Medi-Cal. The report recommended that California take immediate steps to comply with the federal standards.

Second, the report noted that 68% of California SNF residents are physically or chemically restrained, a statistic that greatly exceeds that of any other state, and found that DHS has failed to define a resident's right to informed consent for restraints. The report recommended legislation to ensure that SNF residents participate in treatment planning and have an opportunity to give (or withhold) informed consent for physical and chemical restraints. Other recommendations include legislative restriction of medications frequently abused in SNFs; DHS creation of a Medi-Cal drug approval system for long-term care patients; and DHS tracking of the number of SNF residents who are restrained, those unable to give informed consent, and those without a representative.

Additionally, the Commission noted that since its first 1983 SNF study, it has strongly recommended a meaningful system of citations and fines to support the state's efforts to improve the quality of care provided to the elderly. Despite some reforms, the Commission still found evidence of a massive amount of uncollected fines, uneven enforcement of violations, a widespread perception