California State Auditor

BUREAU OF STATE AUDITS

California Department of Corrections:

It Needs to Ensure That All Medical Service Contracts It Enters Are in the State's Best Interest and All Medical Claims It Pays Are Valid

April 2004
2003-117

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April 6, 2004 2003-117

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the California Department of Corrections' (Corrections) processes to contract for health care services not currently available within its own facilities.

This report concludes that Corrections does not adequately ensure that it enters into medical service contracts that are in the State's best interest. Specifically, Corrections staff who negotiate contracts tend to rely on a 30-year-old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids. Another barrier to cost-effective medical service contracts is Corrections' flawed negotiating practices. Some hospital contracts leave out information vital to ensuring that the State receives the discounts specified in the contracts. Other contracts do not justify awarding rates that are higher than Corrections' standard rates, violating this requirement of Corrections' contract manual. Additionally, Corrections sometimes exceeds the authorized contract amount and fails to obtain proper approvals before receiving nonemergency services. Finally, Corrections' prisons are not adhering to its utilization management program, established to ensure inmates receive quality care at contained costs. Consequently, prisons are overpaying for some services, incurring unnecessary costs for the State.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the California Department of Corrections' (Corrections) processes to contract for health care services not currently available within its own facilities concludes that:

- ☑ *Corrections staff who negotiate contracts tend to rely on a 30-year-old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids.*
- ☑ *Corrections' negotiation practices are flawed. For example, some of the Health Care Services Division's and prisons' hospital contracts leave out information vital to ensuring that the State receives discounts those contracts specify.*
- ☑ *Corrections is unable to justify awarding contracts for rates above its standards, violating this requirement of Corrections' contract manual.*

continued on next page

RESULTS IN BRIEF

The California Department of Corrections (Corrections) supervises an inmate population of about 161,000 in 32 state prisons. To fulfill its responsibility to provide medically necessary health care for these inmates, Corrections operates various facilities, including acute care hospitals and treatment centers. Because it cannot provide all the necessary health care services, Corrections contracts with medical service providers in the community, such as hospitals, specialty care physicians, and laboratories. Costs incurred for services from these outside providers have increased more than 15 percent in each of the last four fiscal years, rising to $239 million in fiscal year 2002–03. As these costs rise, so does the importance of Corrections negotiating and awarding medical service contracts that are in the State's best interest. However, despite public policy and Corrections' policies supporting the practice, Corrections does not competitively bid most of its contracts for medical services. Of 1,149 contracts awarded during fiscal years 2001–02 and 2002–03, only 259, or 23 percent, were put out for competitive bidding.

Corrections' Health Care Services Division (HCSD) provides inmate health care and says it aims to deliver both competent and cost-effective health services. In reality, HCSD and prison staff who negotiate contracts tend to rely on a 30-year-old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids. The Department of General Services (General Services) could not provide documentation to support the original justification for the policy exemption and has not evaluated whether it is currently valid. Yet, the policy exemption has the distinct disadvantage of lacking any criteria to determine whether a contract's costs are reasonable.

Another barrier to cost-effective contracts for medical services is Corrections' flawed negotiating practices. Some contracts that HCSD and the prisons have entered with hospitals leave out information vital to obtaining the discounts specified in the contracts. In other contracts, HCSD and the prisons do not justify awarding rates that are higher than Corrections' standard

rates, violating a requirement of Corrections' contract manual. Overall, contract files lack evidence that Corrections routinely uses its database of information on medical costs and utilization to negotiate contracts with medical service providers that are in the State's best interest. Further, staff at HCSD and at the prisons are not offered specialized training in negotiating contract terms and rates with providers.

☑ ***Corrections sometimes exceeds the authorized contract amount and fails to obtain proper approvals before receiving nonemergency services.***

☑ ***Corrections' prisons are not adhering to its utilization management program, established to ensure inmates receive quality care at contained costs. Consequently, prisons are overpaying for some services, incurring unnecessary costs for the State.***

The cost of medical services in the state prisons is also somewhat dependent on the varying compensation methods Corrections negotiates. Sometimes Corrections uses a daily set fee rather than a flat percentage discount, a practice that has shown to dramatically lower total hospital expenses. Moreover, because of the different compensation methods it uses, Corrections has a wide variety of rates for physician procedures compared with the rates established by the federal Medicare program.

Further hindering the effectiveness of its contracting process, Corrections sometimes approves late requests for contracts, exceeds the authorized contract amount, and fails to obtain proper approvals before receiving nonemergency services. Of the 56 contracts we reviewed, 14 (25 percent) were not submitted by HCSD or the prisons to its Office of Contract Services' Institution Contract Section within the required time frames. We also found four contracts in which prisons exceeded the funding authorized in the contracts by $5.9 million and some instances of prisons obtaining medical services for inmates before receiving General Services' approval.

Not only is Corrections unable to demonstrate that its contracts are in the State's best interest, but also its prisons may be paying inappropriate and invalid medical claims. Prisons are not adhering to HCSD's utilization management (UM) program, established to ensure that inmates receive quality care at contained costs. The UM program requires prisons contracting for medical services to perform three reviews—prospective, concurrent, and retrospective—to ensure that medical services and their prices are appropriate. However, the prisons cannot show that they perform the prospective and concurrent reviews. Further, several deficiencies in the retrospective reviews that prisons have conducted have resulted in documented overpayment of medical service charges and possible payment for nonexistent services. Nurses with the UM program are not consistently reviewing a percentage of medical service invoices to verify that the charges are appropriate to the services. In addition, the prisons' analysts with the health care

cost and utilization program (HCCUP) do not always identify discrepancies between contract rates and medical charges on providers' invoices—or even obtain evidence that medical services were actually received. Consequently, prisons are overpaying for some services, incurring unnecessary costs for the State. Until HCSD enforces its review policy for nurses in the UM program and performs quality control reviews of invoices processed by the HCCUP analysts, Corrections cannot contain or reduce health care costs at California's prisons.

RECOMMENDATIONS

To protect the State's interest when entering future contracts for medical services, General Services should consider removing its long-standing policy exemption that allows Corrections to award most medical service contracts without advertising or competitive bidding.

If General Services chooses not to remove the policy exemption, it should prescribe the methods and criteria for Corrections to use in determining the reasonableness of contract costs. For example, General Services could amend the State Contracting Manual or its policy exemption to require Corrections to follow the method it uses for the noncompetitively bid procurement process that requires agencies to conduct a market survey and prepare a price analysis demonstrating that the contract is in the State's best interest.

To improve its negotiation practices to obtain medical service contracts that are in the State's best interest, Corrections should do the following:

- Ensure that it obtains hospitals' list of established rates and uses this information to negotiate contract rates and obtain discounts specified in the contracts.

- Enforce its requirements for justifying higher rates, including obtaining and reviewing relevant documentation.

- Establish procedures to ensure that staff negotiating medical service contracts incorporate the use of costs and utilization data and document their use of these data in the contract files.

- Offer its negotiation staff specialized training in effectively negotiating favorable rates.

To fulfill its contract management responsibilities, Corrections should do the following:

- Direct its Office of Contract Services (Contract Services) to evaluate late requests using the established criteria.

- Ensure that prisons do not exceed the funding authorized in the contract by requiring Contract Services to review the contract amount and prisons' existing requests before processing any additional requests.

- Evaluate its contract processes to identify ways to eliminate delays in processing contracts and avoid allowing contractors to begin work before General Services approves the contract.

To improve its efforts to provide only medically necessary services and contain medical services costs, Corrections should do the following:

- Ensure that prisons adhere to the UM program guidelines requiring them to perform and retain documentation of their prospective and concurrent reviews.

- Clarify and update the UM program guidelines for performing retrospective reviews.

- Establish a quality control process that includes monthly reviews of a sample of invoices processed by the prisons' HCCUP analyst.

AGENCY COMMENTS

General Services stated that it would take appropriate actions to address our recommendations. Corrections generally agreed with our recommendations, but it expressed concern with our recommendations to General Services regarding the removal of the long-standing policy exemption. ■

INTRODUCTION

BACKGROUND

The California Department of Corrections (Corrections) operates 32 state prisons, oversees a variety of community correctional facilities, and supervises parolees' reentry into society. As of June 30, 2003, Corrections' total population was about 160,900 inmates, roughly the average inmate population for fiscal years 1998–99 through 2002–03. For fiscal year 2003–04, Corrections' budget is $5.7 billion.

Types of Facilities Corrections Uses to Provide Health Care to Inmates*

General acute care hospitals—provide 24-hour inpatient care, including basic services such as medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary.

Correctional treatment centers—provide inpatient health care to inmates who do not require acute care, but need health care beyond that normally provided in the community on an outpatient basis.

Outpatient housing units—typically house inmates who do not require admission to a licensed health care facility, but need monitoring or isolation from the general prison population.

Intermediate care facilities—provide inpatient care to inmates who need skilled nursing supervision and supportive but not continuous care.

Skilled nursing facilities—provide continuous skilled nursing and supportive care to inmates on an extended basis, including services such as medical, nursing, pharmacy, dietary, and an activity program.

Hospices—provide care to inmates who are terminally ill.

Source: California Department of Corrections.

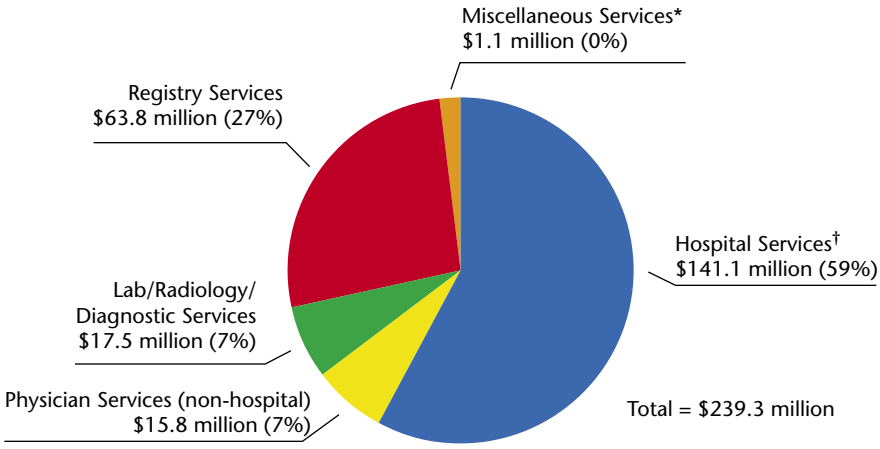
* All facilities, except outpatient housing units, are licensed by the California Department of Health Services.

To provide medically necessary health care to inmates, Corrections operates six types of facilities—four general acute care hospitals, 16 correctional treatment centers, 12 outpatient housing units, a skilled nursing facility, an intermediate care facility, and a hospice (see text box). Additionally, it contracts with the Department of Mental Health to provide all inpatient acute mental health services to inmates at the intermediate care facility at the California Medical Facility in Vacaville and to a portion of the correctional treatment center patients at Salinas Valley State Prison.

For care not available in its own facilities, Corrections contracts with medical service providers in the community. Corrections' costs incurred for contracted inmate medical and laboratory services have continued to increase in each of the last four fiscal years by more than 15 percent. In fiscal year 2001–02, costs increased by 29 percent and fiscal year 2002–03 witnessed another 20 percent increase. Figure 1 on the following page shows the variety of medical service providers that Corrections contracts with to deliver health care services to inmates, including community hospitals throughout the State that provide inpatient and outpatient medical services and specialty care physicians such as oncologists and radiologists. To provide temporary medical services when prison medical staff are unavailable or on long-term sick leave, Corrections uses medical registry contracts.

FIGURE 1

Contracted Medical Services Corrections Incurred in Fiscal Year 2002–03



Source: California Department of Corrections' unaudited expenditure data.

* Includes services such as medical equipment maintenance.

† Includes data for inpatient and outpatient hospital charges.

CORRECTIONS PLACES RESPONSIBILITY FOR DELIVERING HEALTH CARE TO INMATES ON ITS HEALTH CARE SERVICES DIVISION

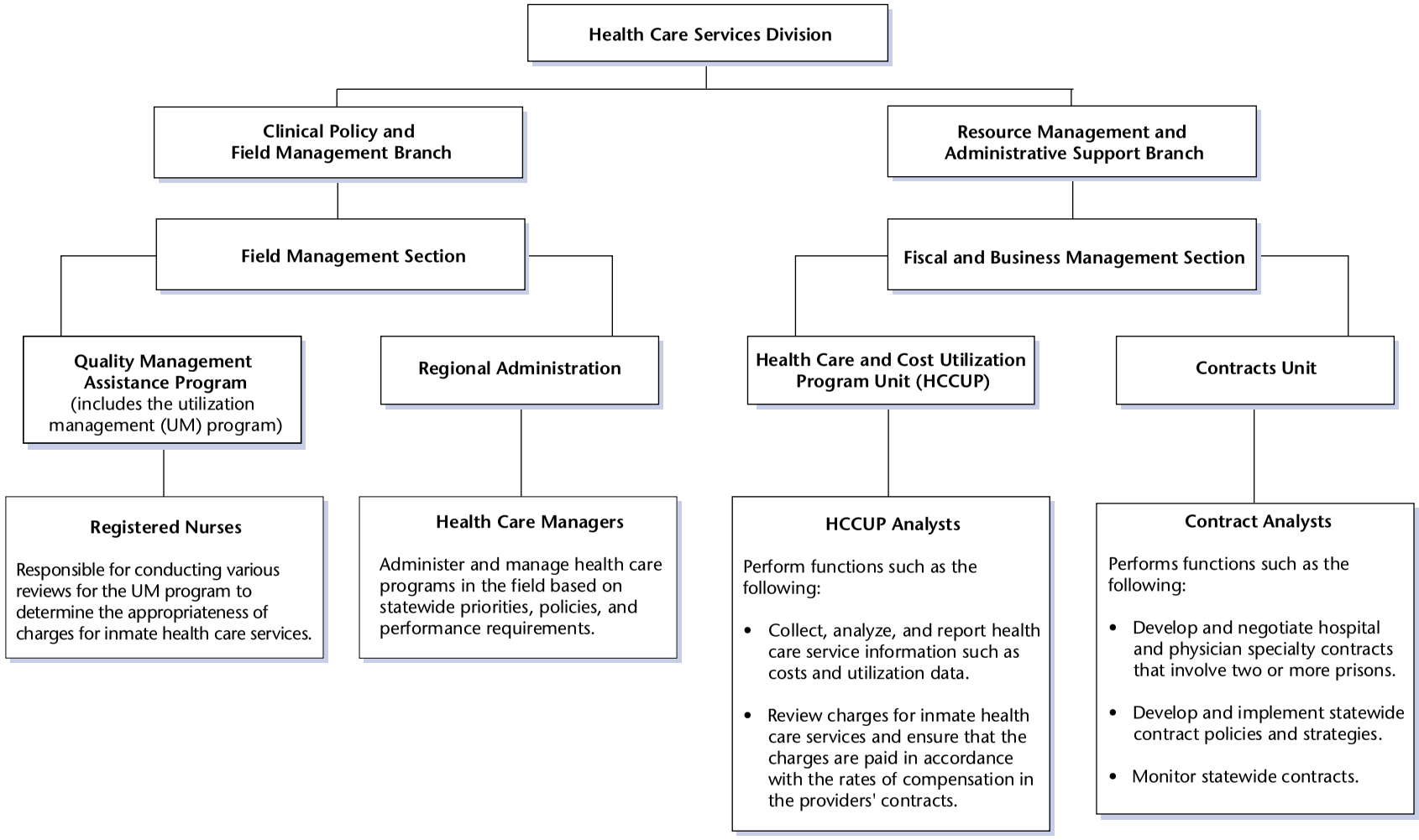
The mission of Corrections' Health Care Services Division (HCSD) is to manage and deliver to the State's inmate population health care consistent with adopted standards for quality and scope of services within a custodial environment. According to HCSD, it strives to be a leader in providing cost-effective, timely, and competent care and in promoting inmates' responsibility for their own health. As shown in Figure 2, HCSD comprises two branches that carry out its responsibilities, including negotiating and monitoring medical service contracts. Although HCSD is centrally located in Sacramento, most staff responsible for managing and delivering health care services are located in the prisons. This report refers to staff located in Sacramento as HCSD staff and those at the prisons as prison staff.

STATE CONTRACTING PROCESS

The State has established processes for departments to use when acquiring goods and services. Competition is typically at the core of these processes, which are designed to promote fairness, value, and the open disclosure of public purchasing.

FIGURE 2

Abbreviated Organization Chart for Corrections' Health Care Services Division



State law and the policies of the Department of General Services (General Services)—the State's contracting and procurement oversight department—generally require state departments to conduct a competitive bidding process that gives vendors an opportunity to submit price quotes or proposals for purchases of goods costing $25,000 or more and for services valued at $5,000 or more, with certain exceptions. Public policy strongly favors competitive bidding, and state contracts established without competitive bidding are limited by either statute or Executive Order.

Exceptions to Competitively Bid Procurements

With respect to contracts for goods or commodities (other than those related to information technology), state law allows the following limited exceptions to the requirement that departments conduct competitive bidding: (1) when only one good or service can meet the State's needs, commonly known as a sole-source contract; and (2) when the good or service is needed because of an emergency—that is, when immediate acquisition is necessary for the protection of public health, welfare, or safety. To ensure compliance with competitive bidding requirements, the State authorizes a noncompetitively bid (NCB) procurement only when the requesting department can adequately document that one of the two exceptions exists.

Regarding contracts for services, state law provides for various statutory exemptions from the requirement to bid competitively—for example, contracts performed by a public entity. State law also gives General Services the authority to prescribe the conditions under which a contract may be awarded without competition and the methods and criteria used in determining the reasonableness of contract costs. General Services exercises its authority based on what it determines is in the "best interest" of the State.

Only One Good or Service Can Meet the State's Needs

On certain occasions, a department may need to contract with a specific vendor whose goods are unique in some way. This type of contract is commonly known as a sole-source contract, and General Services refers to contracts formed under this exception as NCBs. The State Contracting Manual describes the conditions under which this type of procurement is appropriate as well

as those requiring the approval of General Services. Typically, departments must show that no other vendor in the marketplace can meet the State's needs.

Emergency Purchases

An emergency contract is another type of contract that can be formed without competitive bidding. However, it is important to note that different criteria must be applied when justifying an emergency than when justifying other types of contracts. When a department experiences an emergency involving public health, welfare, or safety and consequently needs to purchase supplies or equipment immediately, the department must justify that immediate need. The justification must demonstrate that either (1) the department could not have avoided the emergency condition by reasonable care and diligence or (2) there was an immediate threat of substantial damage or injury to persons committed to the department's care, employees of the department, members of the general public, or property for which the department is responsible. Also, a department officer must approve the emergency purchase.

General Services evaluates each emergency purchase request and either approves it or sends it back to the department for further review. State law requires Corrections to provide medically necessary health care to inmates who are committed to its care. Additionally, during the 1980s and 1990s, inmates filed various class action lawsuits alleging deficiencies with health care, leading the courts to order Corrections to remedy the deficiencies. In certain cases, the litigation has led to improvements statewide. In response to one lawsuit contending that inmates with psychiatric conditions were unable to receive necessary and adequate mental health treatment, Corrections implemented a comprehensive mental health treatment system. Other lawsuits have affected the delivery of care at specific prisons. Corrections may find itself in the position of using this exemption when a medical emergency arises that indicates a threat to the delivery of that care.

General Services' Policy Exemption for Certain Medical Service Contracts

A long-standing policy exemption authorized by General Services allows Corrections to award medical service contracts for physicians, medical groups, local community hospitals, and 911 emergency ambulance service providers without advertising or competitive bidding. The exemption also applies to any ambulance service provider that serves a single geographical area.

PARTIES RESPONSIBLE FOR CORRECTIONS' MEDICAL SERVICE CONTRACTS

Corrections has given full responsibility for the management and approval of its contracts to its Office of Contract Services (Contract Services), a separate entity from HCSD. Although HCSD and the prisons bear some responsibility for managing contracts, Contract Services coordinates, processes, and maintains all Corrections' contracts and bid packages. Contract Services' Institution Contract Section (ICS) entered a memorandum of understanding with each prison to establish a mutual goal of expediting the contract process for services that prisons need for their daily operation. The memorandum of understanding also addresses certain contract management responsibilities that the State Contracting Manual outlines as typical for an authorized representative of the State responsible for administering a contract and monitoring the contractor's performance. Table 1 shows some key contract management responsibilities and the Corrections' entities assigned to fulfill the duties.

TABLE 1

Contract Management Responsibilities Assigned to Various Corrections' Entities

Responsibility	Entity
Develop and write a clear, concise, detailed description of the work to be performed; estimate quantities and dollar amounts; and identify funding source.	HCSD, Prisons
Review draft contract provisions, scope of work, technical requirements, completion dates, benchmarks, timelines, estimated quantities, dollar amounts, and final product.	HCSD, ICS
Ensure compliance with all federal and special regulations.	HCSD (licensing issues), ICS*, Prisons
Ensure that funding is available and the contract is encumbered in conformance with the agency's policy.	ICS†, Prisons, Regional Accounting Offices
Schedule the contractor to begin work.‡	HCSD, Prisons
Maintain contract documentation.	HCSD, ICS, Prisons
Monitor the contract to ensure compliance with all contract provisions.	HCSD, ICS§, Prisons
Assess and request amendments, renewals, or new contracts as required, allowing sufficient time to process and execute such changes before the contract expires or funds are depleted to prevent a lapse in service.	HCSD, ICS‖, Prisons,
Review and approve invoices for payment to substantiate expenditures for work performed and to prevent penalties from being assessed.	Prisons (HCCUP analysts, UM nurses, contract monitors, and health care managers)
Monitor contract expenditures to ensure that sufficient funds exist to pay for all services rendered as required by contract, identify low spending levels, and consider partial disencumbrance and reassignment of funds.	HCSD (monitor spending levels) Prisons (HCCUP analysts, budget analysts, and contract monitors) Regional Accounting Offices
Verify that the contractor has fulfilled all requirements of the contract before approving the final invoice.	HCSD, Prisons (contract monitors)

Source: State Contracting Manual; California Department of Corrections, *Office of Contract Services 2002 Users Guide for Prison Staff*.

***** ICS ensures compliance with State Contracting Manual, Public Contract Code, and Government Code requirements.

† ICS only requires a program to identify a funding source on its request.

‡ ICS notifies the contractor that the contract has been approved. The contract monitor (HCSD or prison) schedules the contractor to begin services.

§ ICS only monitors certain contracts to ensure that amounts authorized for prisons' use do not exceed the total authorized amount of the contract.

‖ ICS only assesses and requests amendments for certain contracts.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested the Bureau of State Audits (bureau) to examine the process that Corrections uses to contract for health care services not currently available within its own facilities. Specifically, the audit committee directed the bureau to examine the process Corrections uses to negotiate contracts for outside health care services, including the different types of agreements it enters, its fee schedules, the roles of headquarters and prisons, and the qualifications of its negotiation staff. Further, the audit committee instructed the bureau to select a sample of contracts for outside health care services, including hospitals in both rural and urban areas, to determine whether Corrections negotiated the best value for the services, whether rates in rural and urban areas are comparable for similar services, whether rates for similar services are comparable to those under the State's Medicaid Assistance Program (Medi-Cal), and whether Corrections employs data on trends of volume and average use of contracted medical services to obtain price breaks or quantity discounts. The audit committee also asked the bureau to review Corrections' policies and procedures for processing and monitoring claims for contracted health care services to determine if Corrections verifies the validity of the claims. Finally, the audit committee requested the bureau to evaluate Corrections' implementation of certain recommendations outlined in the bureau's report titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care*, issued in January 2000.

To obtain an understanding of the State's contracting process for medical care services, we reviewed relevant laws, policies, and procedures. In addition, we reviewed Corrections' policies and procedures. Finally, we interviewed staff at Corrections and General Services.

In examining the process Corrections uses to negotiate contracts for medical services, we interviewed key staff from HCSD. We also asked 21 prisons to respond to a series of questions relating to their process for negotiating contracts and ensuring that medical service providers' rates are reasonable or competitive. Furthermore, we reviewed the background, experience, and duty statement of HCSD's negotiation staff and whether HCSD provides training to them or prison staff.

To assess whether Corrections negotiated for contracted medical services that were in the State's best interest, we reviewed a sample of 56 contracts, including contracts with hospitals in both rural and urban areas. Using Contract Services' database, we sorted contracts for fiscal years 2001–02 and 2002–03 by the method Corrections used to secure the contracts: competitive bidding, noncompetitive bidding, and using General Services' policy exemption for medical services. Then we identified contracts relating to inmate medical and laboratory services. Additionally, using Corrections' unaudited expenditure data, we summarized the total expenditures for these contracts by prison. We also summarized the data by the regional accounting offices that process the prisons' invoices. Further, we ranked the offices by expenditures and the number of prison contracts for medical services. Finally, we judgmentally selected our sample, which also includes a few contracts negotiated by HCSD and hospitals serving prisons in rural and urban areas.

To compare Corrections' rates for similar services in rural and urban areas, we grouped our sample of contracts by type of service. Using information prepared by the California Department of Finance, Demographic Research Unit, we determined if the prisons receiving the services were in rural or urban areas. Then, to the extent possible, we compared the rates.

Although the audit committee requested that we compare Corrections' rates with Medi-Cal's rates for similar services, we determined that a comparison to Medicare rates would be more beneficial because the federal program updates its rates more frequently than does the state program. We compared rates Corrections paid for inpatient hospital services to Medicare's rates using the Medicare Acute Care Hospital Inpatient Prospective Payment System PC Pricer (Medicare Pricer). The Medicare Pricer calculates payments for inpatient hospital services and required us to input data such as the Medicare provider number, date of admission and discharge, diagnosis-related group number, and invoice amount. A consultant assisted us by identifying the Medicare provider number and diagnosis-related group codes for the invoices we reviewed. Additionally, we compared Corrections' rates paid for physician services and prosthetics to Medicare's fee schedules, which are based on its Healthcare Common Procedure Coding System. Finally, we compared the rates Corrections paid for ambulance services to Medicare's blended rates for 2002 and 2003, which consist of a percentage of both its fee schedule and the providers' reasonable charges.

To determine whether Corrections employed data on trends of volume and average use of contracted medical services to obtain price breaks or quantity discounts for our sample, we reviewed contract files maintained by Contract Services and HCSD.

To assess the methods Corrections uses to determine the validity of medical service claims, we reviewed policies and procedures for its health care cost and utilization program. We also reviewed guidelines for its UM program. We selected a sample of invoices relating to our sample of medical service contracts and determined if Corrections paid only for services that were authorized, medically necessary, and consistent with the contract terms.

Finally, we evaluated Corrections' actions to implement four recommendations from the bureau's previous report issued in January 2000. We present this information in Appendix A. ■

CHAPTER 1

Processes Used by the California Department of Corrections to Solicit and Negotiate Contracts for Medical Services Do Not Represent the State's Best Interest

CHAPTER SUMMARY

The California Department of Corrections (Corrections) does not competitively bid many of its contracts for medical services. Instead, both the prisons and Corrections' Health Care Services Division (HCSD) rely on a 30-year-old state policy exemption that allows them to award contracts for most medical services without seeking competitive bids. Lacking any documented justification, this policy exemption cannot be evaluated according to current conditions in the State and does not provide any criteria for determining whether the costs of a contract are reasonable. By not competitively bidding its contracts, Corrections fails to ensure that the State meets the medical needs of inmates at a competitive price.

Also, Corrections' contract negotiation practices are seriously flawed. Some medical service contracts omit information crucial to ensuring that the State receives the discounts specified in the contracts. Other contracts lack the required justification for rates higher than Corrections' standard rates, even though Corrections' contract manual requires such justification. Further, Corrections does not appear to routinely use its database of information on medical costs and utilization to negotiate with medical service providers for the most favorable rates. Finally, Corrections needs to follow through on its intention to offer negotiation staff specialized training in negotiating contract terms and rates with providers.

Corrections' varying compensation methods also affect the cost of medical services in the state prisons. Comparing Corrections' rates in various hospitals shows that by using certain methods of compensation rather than others, Corrections can dramatically lower total hospital expenses. For example, we found that generally, Corrections generated greater savings when it was able to negotiate per diem, or daily, fees for specific services

or outcomes regardless of the actual charges. The impact that the compensation method Corrections negotiates has on the State's costs was also apparent in expenditures for individual procedures we reviewed, such as physician procedures, for which Corrections has a wide variety of rates compared with those established by Medicare.

Further hindering the effectiveness of its contracting process, Corrections executes late contracts, exceeds the authorized contract amount, and fails to obtain proper approvals before receiving nonemergency services. Corrections' Office of Contract Services (Contract Services) has full responsibility for the management and approval of all contracts. Contract Services' Institution Contract Section (ICS) entered a memorandum of understanding with the prisons to work together toward a mutual goal of expediting the contracting process. However, ICS and the prisons are not meeting this goal. We reviewed 56 contracts that HCSD and the prisons had submitted to ICS and found 14 (25 percent) late submittals. In addition, we identified four contracts in which ICS allowed prisons to exceed the authorized funding by $5.9 million. Finally, we found instances when prisons obtained medical services for inmates before receiving the Department of General Services' (General Services) approval.

BY USING A STATE POLICY EXEMPTION FROM COMPETITIVE BIDDING, CORRECTIONS FAILS TO DEMONSTRATE THAT ITS MEDICAL SERVICE CONTRACTS ARE IN THE STATE'S BEST INTEREST

Corrections solicited bids for only 23 percent of medical service contracts entered into during fiscal years 2001–02 and 2002–03.

Despite assertions about increasing its efforts to competitively bid contracts, Corrections did not solicit bids for most of the contracts we reviewed. According to its contract manual, Corrections believes its interest is best served by competitively bidding as many contracts as possible. However, Corrections solicited bids for only 23 percent of the medical service contracts it entered during fiscal years 2001–02 and 2002–03. Rather than soliciting bids, Corrections' staff rely on the policy exemption set by General Services allowing Corrections to contract for most types of medical service without soliciting and receiving multiple bids. Corrections could more effectively determine that these contracts are in the State's best interest either by using noncompetitively bid (NCB) procurements or by bidding competitively because these processes are more rigorous and require higher-level approvals. However, in continuing to rely on the policy exemption, the prisons, Contract Services, and HCSD are not demonstrating their efforts to protect the State's interest.

Corrections' Reliance on a Long-Standing Policy Exemption to Competitive Bidding for Medical Services May Not Be in the State's Best Interest

A policy exemption authorized by General Services roughly 30 years ago allows Corrections to bypass advertising and competitive bidding when awarding medical service contracts to physicians, medical groups, local community hospitals, and 911 emergency ambulance service providers. The policy exemption also applies to any contract with an ambulance service provider that serves a single geographical area. Not only does this policy exemption lack criteria for evaluating reasonable costs, but also General Services has no documentation to support it. Thus, General Services should reassess the need for this policy exemption.

The policy exemption does not preclude Corrections from competitively bidding its contracts. However, our analysis shows that Corrections is relying too heavily on the policy exemption. Specifically, Corrections deferred to the policy exemption for 852, or 74 percent, of the 1,149 medical service contracts executed during fiscal years 2001–02 and 2002–03. Of the 29 policy-exempt contracts we reviewed, Corrections could not explain its method or criteria for determining the reasonableness of the costs for 17 contracts totaling more than $190 million. Further, Contract Services has renewed 10 policy-exempt contracts at least twice, with renewal periods averaging almost two years. According to the chief of ICS, if a contract is exempt from competitive bidding, there is no restriction on the number of times it can be renewed. General Services approves Corrections' contracts that are greater than $75,000, and its approval process focuses on ensuring effective compliance with applicable laws and policies, conserving the fiscal interests of the State, and preventing acts that do not foresee or provide for the future. However, General Services' approval cannot ensure that Corrections receives competitive prices for medical services covered under the policy exemption.

Corrections relies too heavily on a long-standing policy exemption that allows it to award medical service contracts, without advertising or competitive bidding, for certain providers.

Further, the lack of documentation to support the policy exemption and General Services' lack of set time frames or procedures for reevaluating its various exemptions lead us to question whether Corrections' use of the exemption is still reasonable. State law requires General Services to prescribe the conditions under which a contract may be awarded without competition and the methods and criteria to be used in determining the reasonableness of contract costs. However, General Services says there is no available documentation or analysis to support the rationale for the exemption, although it

was likely in response to Corrections' concern that physicians have historically been opposed to competing against one another for work. Lacking the documentation to support the policy exemption's rationale and criteria for evaluating costs, we cannot determine if the conditions that existed when General Services authorized the exemption are still the same. For example, one change that has occurred since the adoption of the policy exemption is the State's enactment of the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act in 1980, which precludes Corrections from contracting with ambulance service providers outside the exclusive operating areas created by local emergency medical service agencies.

Corrections Could Better Protect the State's Interest by Using the Noncompetitively Bid Procurement Process or by Competitively Bidding for Medical Services

If Corrections stopped using the policy exemption and adopted either a competitive bidding process for medical services or the State's current process for NCBs, the State would gain greater assurance that Corrections seeks to protect its interest.

Our attorney informed us that when General Services authorized the policy exemption three decades ago, the provisions of state law that expressly require competitive bidding by state agencies had not been enacted. However, the State has made great strides in establishing contracting processes, and competition is typically at the core. Competition is designed to promote fairness, value, and the open disclosure of public purchasing. To ensure compliance with competitive bidding requirements, state law allows an NCB for a good or service not related to information technology only when the requesting department can adequately document that one of the following exceptions exist: (1) when only one good or service can meet the State's needs or (2) when the good or service is needed because of an emergency—that is, when immediate acquisition is necessary for the protection of public health, welfare, or safety. A contract for personal services may be formed without competitive bidding when state law expressly allows for an exemption, where an emergency exists, or when General Services has exercised its statutory authority and determined that conditions warrant a noncompetitive contract.

The State would have more assurance that its interest is protected if Corrections used the noncompetitively bid procurement process or competitively bids for medical services because these processes are more rigorous and require higher-level approvals.

The State would have more assurance that its interest is protected if Corrections used NCBs or competitively bid for medical services because these processes are more rigorous

and require higher-level approvals. Similar to the long-standing policy exemption for medical service contracts, General Services' current management memorandum for its NCB process allows Corrections to award contracts without advertising or competitive bidding. However, the NCB process requires departments to justify their purchases when only one good or service can meet the State's needs. For example, to use an NCB, Corrections' staff must complete a questionnaire stating, among other things, why only one vendor can provide the good or service, the consequence of not making the purchase, the results of their market survey to identify other vendors capable of offering the same or similar good or service, and how the price was determined to be fair and reasonable. Further, NCB requests that equal or exceed $5,000 (excluding requests for information technology goods) require the approval of the department director, agency secretary, and General Services.

The lowest bid R.J. Donovan Correctional Facility received for its temporary dental services was 30 percent less than the rate the California Substance Abuse Treatment Facility and State Prison at Corcoran agreed to pay its provider using the policy exemption.

Experiences at two prisons illustrate the value of soliciting bids over using the policy exemption. The California Substance Abuse Treatment Facility and State Prison, Corcoran (CSATF) used the policy exemption to contract for temporary dental services. According to its chief medical officer, CSATF attempts to recruit providers at health care conferences but has difficulty because of its remote location, noncompetitive reimbursement rates, and few available specialists. He further stated that CSATF generally locates its providers by obtaining their names from a neighboring prison. However, because CSATF did not give us documents to support how it determined the reasonableness of costs for dental services, we cannot verify that the State received a competitive price based on its needs. In contrast, the R. J. Donovan Correctional Facility (Donovan), located in San Diego, solicited bids and received two informal bids for its contract for temporary dental services. The lowest bid Donovan received for the contract was 30 percent less than the rate CSATF agreed to pay its provider. Also, despite CSATF's remote location, we were able to locate more than 170 dentistry listings in the Yellow Pages within 25 miles of the facility. Thus, CSATF might have been able to receive a lower contract price if it had either conducted a market survey under the NCB process or competitively bid its dental services contract.

Corrections states that the NCB process is too long, leaving prisons responsible for providing the services in the meantime and annoying providers who cannot receive payments because state law prohibits agencies from paying contractors who begin work before their contracts are approved. However, as previously

mentioned, the NCB process allows Corrections to award contracts without advertising or competitive bidding, and its staff need only complete a questionnaire demonstrating they made a good-faith effort to secure a competitive price and obtain the necessary approvals. With proper planning, Corrections should be able to process contracts using the NCB process in a manner that minimizes or eliminates any disruptions in service.

CORRECTIONS HAS SIGNIFICANT FLAWS IN ITS NEGOTIATION PRACTICES

In awarding its contracts for medical services, Corrections does not consistently ensure that the State is paying providers the lowest possible, or even reasonable, rates. In some cases, Corrections' contracts fail to require hospitals to include rate information; consequently, prisons cannot make sure that the hospitals' charges match the terms of the contracts and thus give the State the lowest specified prices. Also, some contracts fail to justify rates that are above Corrections' standard rates. Although Corrections' contract manual requires justification for higher rates, HCSD does not enforce this requirement. Corrections misses another opportunity to obtain the most favorable rates from medical service providers by not using its own database of information, derived from its invoices, on costs and utilization of medical services. Although HCSD said it uses such data to negotiate rates, we found scant evidence of this use either by HCSD or by the prisons. Finally, some staff at HCSD and the prisons need specialized training in negotiating contract terms and rates with medical service providers.

Corrections Has Negotiated and Awarded Many Hospital Contracts That Omit Rate Schedules to Verify Hospital Charges Are Appropriate

Corrections' contract manual states that program managers are responsible for knowing the terms and conditions of their contracts and ensuring that rates are charged in accordance with contracts. Thus, we would expect contracts to include terms and conditions that allow program managers or other contract monitors to verify that charges are in accordance with the contracts. However, the compensation terms of some hospital contracts we reviewed do not include the information needed to evaluate potential costs and determine that hospital charges are consistent with contract terms. Without this information, Corrections may be paying more than necessary for hospital services.

Because some of Corrections' contracts do not require hospitals to provide a copy of their rates, it is unable to verify the rates charged on invoices for four contracts are correct.

Of the 12 hospital contracts we reviewed, six totaling almost $34 million include terms that require Corrections to deduct a certain percentage off the charge master, which is a list of the hospital's established rates. However, because these contracts do not require the hospitals to provide copies of their rates, Corrections is unable to verify the accuracy of rates charged on invoices for four of these contracts. HCSD says it typically does not include contract language requiring hospitals to submit charge masters because most hospitals refuse to do so, stating that corporate policy precludes them from providing their rates.

For two contracts, even though they included terms stipulating that the hospitals supply copies of their charge masters, Corrections failed to obtain the rates. The terms of one contract state that payment will be less a certain percentage discount of the invoices in accordance with the provider's current rates as evidenced by the charge master and that the provider will supply a copy of the charge master, which will be kept on file at the prison. However, the prison did not obtain the charge master. The prison's correctional health services administrator II says the contract analyst requested the charge master, but the hospital did not provide it, stating that the list was too large and changed too frequently.

The failure of HCSD and prisons to require and obtain rate information from hospitals places the State at a disadvantage when it negotiates with hospitals. Obviously, Corrections cannot ensure that a contract is in the State's best interest by deducting a certain percentage from an unknown amount. Further, without rate information, prisons cannot ensure that they do not pay more than the contract terms.

Beginning July 1, 2004, Corrections will have an alternate source of hospitals' charge masters. A new state law will require hospitals to file copies of their charge masters annually with the Office of Statewide Health Planning and Development (OSHPD). Corrections can then work with OSHPD to obtain charge masters for its contracted hospitals to verify that it pays invoices consistent with contract terms.

Corrections Cannot Show That It Follows Procedures It Developed to Ensure That Rates Exceeding Its Standard Rates Are Favorable

Corrections has established the Request for Medical Rate Exemption process (rate exemption) for prisons to use when proposing to offer above-standard rates to physicians and

Some Information Prisons Must Submit for a Rate Exemption

- Where the services will be provided: at the prison, offsite, or both.
- Estimated number of hours and number of inmates the provider will see.
- Basis for requested rates: monthly, hourly, or per unit.
- Whether other providers were solicited and if not, why.
- Why the provider's service is necessary.
- Prior year's use of the services.
- Custody costs associated with alternative providers.
- Custody savings for using the provider.
- Method used to obtain the services if a similar service was not used in a prior year.

Source: California Department of Corrections, Office of Contract Services *2002 Users Guide for Prison Staff.*

Example of How Fees Are Determined Using Relative Values for Physicians

Procedure Description:	Tendon Sheath Incision
American Medical Association corresponding procedure code:	26055
Relative Value Units (RVU):	5.9
Corrections' surgery conversion factor for Sector 3, which includes nine prisons:	$75.00

RVU		Corrections' Surgery Conversion Factor		Fee
5.9	**x**	**$75.00**	**=**	**$442.50**

Source: Annual Relative Values for Physicians; California Department of Corrections, Office of Contract Services *2002 Users Guide for Prison Staff.*

medical groups that provide specialty care such as orthopedics or cardiology. However, HCSD does not always enforce the rate exemption requirement of adequately ensuring that prisons negotiate favorable rates. Until Corrections modifies and enforces its procedures to evaluate the reasonableness of proposed rates that exceed its standards, it will continue to undermine the State's goal of obtaining favorable rates.

Corrections' contract manual requires prisons to submit a rate exemption to the HCSD for review and approval. Corrections' standard rates are $100 per hour for clinic services, which include direct patient care such as medical consultations and evaluations. For each medical procedure, Corrections uses the relative value for physicians (RVP), which it computes using its established regional conversion factors for the procedure in conjunction with a numerical value (called relative value units) assigned to the procedure.[1]

Two of 56 contracts we reviewed had rates exceeding Corrections' standard rates and therefore included rate exemptions. However, despite the contract manual's requirement to justify higher rates, the prisons' rate exemptions did not provide analyses sufficient to justify approval of the higher rates. Further, the two prisons either did not adequately identify their efforts to solicit other potential providers or did not state why other providers were not contacted, as the contract manual requires.

Pleasant Valley State Prison (Pleasant Valley) submitted a rate exemption stating that the recommended provider's services were necessary because he was a board-certified or board-eligible radiologist. However, Pleasant Valley did not include an analysis to demonstrate its efforts to negotiate a favorable rate. According to the rate exemption filed by the California State Prison, Corcoran (Corcoran), no other orthopedic service

[1] In the relative value system, values are provided for physician services contained in the American Medical Association's Physicians' Current Procedure Terminology system, as well as Medicare's Healthcare Common Procedure Coding System Level II (National) Codes.

providers in the area had either the interest or the required expertise to provide the service its inmates needed. However, Corcoran did not provide a list of the providers it contacted who expressed disinterest or a list of providers who could conceivably provide the service. Moreover, the selected provider's business address was in La Jolla, almost 300 miles from Corcoran, suggesting the unlikely absence of other providers with necessary expertise within a 300-mile radius of the prison. Nevertheless, HCSD approved the exemption. According to HCSD, at the time this contract was approved, factors such as transferring its contracting staff to another division and experiencing a series of management changes contributed to a less stringent or standardized review process.

We also found that Corrections lacks procedures to address instances when HCSD initiates a rate exemption. According to HCSD, its analysts essentially apply the same standards that prisons must follow and require the signature of the assistant deputy director. Yet, we identified four instances of HCSD not providing analyses to justify its approval of higher rates.

Corrections' Health Care Services Division negotiated an hourly clinic rate that was 182 percent greater than the relative value for physician services and that inappropriately included services such as on-call coverage and education seminars.

In one instance, HCSD was unable to locate a copy of the rate exemption for a contract that increased the provider's hourly rate by 80 percent over the previous rate. Without the rate exemption, we cannot determine if HCSD had a reasonable rationale for the rate increase, but the rate is unreasonable based on our analysis. Reviewing 19 invoices from the same provider for 2002, we identified the procedure codes the provider used for services to 87 inmates during multiple visits. Using the procedure codes and the prison's regional location, we computed the amount that would have been paid for the RVPs for these services and found that the provider's hourly clinic rate resulted in payments that were 182 percent greater than if he had been compensated using the RVPs.

According to the contract, the provider's clinic rate also includes services that are not covered by the RVPs—such as on-call coverage seven days a week, 24 hours a day, and education seminars for Corrections' physicians. Although lacking a standard definition of hourly clinic services, HCSD told us that on-call coverage and education seminars should not be included. Thus, HCSD inappropriately included these services in the provider's hourly clinic rate. Further, HCSD believes that part of the provider's rate increase may have been attributable to higher travel costs resulting from rendering services to multiple prisons. However, HCSD's consideration

of travel costs when negotiating hourly clinic rates is also inappropriate because the contract specifically states that all expenses associated with travel to and from the prisons will be at the expense of the provider. Instead, HCSD could have negotiated separate rates for the on-call coverage, education seminars, and travel costs.

Corrections Cannot Demonstrate It Uses Historical Data When Negotiating Contracts

Corrections might be able to negotiate lower rates for particular services by using the cost and utilization data (utilization data) it collects to identify usage volumes and trends by type of service. However, Corrections cannot show that it routinely uses these data to negotiate contract rates. Without documentation to show that they employed utilization data, HCSD and the prisons cannot display a thorough and good-faith effort to protect the State's interest.

Without documentation to show that they employed utilization data, HCSD and the prisons cannot demonstrate a thorough and good-faith effort to protect the State's interest.

Corrections collects utilization data from each prison on their contracted medical services by requiring analysts from the health care cost and utilization program (HCCUP) to enter information from every invoice into a database. The information includes the cost, the provider, and patient-specific information on the type and duration of service. The prisons submit this utilization data monthly to HCSD.

Although HCSD and a few prisons told us they employ utilization data when evaluating and negotiating rates, we found evidence that the data had been reviewed in only two of the 21 files where such a review may have been warranted. Specifically, two contract files showed that HCSD reviewed utilization data during its evaluation of proposed rates. Corrections' contract manual requires prisons to include utilization data to justify their rate exemptions. Using the data in its negotiation and evaluation of proposed rates would also help Corrections identify its needs and secure contracts that are in the State's best interest.

Negotiation Staff Could Benefit From Specialized Training

Staff at both HCSD and the prisons have varying degrees of expertise in negotiating rates in contracts with medical service providers. Only half of the HCSD analysts who negotiate contracts have prior experience in negotiating. Moreover, because prison staff who negotiate the terms and conditions of

contracts for medical services at their prisons have uneven levels of contracting ability, the contracting and negotiating practices at prisons throughout the State are inconsistent.

To help alleviate these inconsistencies, HCSD plans to contract with outside consultants to enhance its staff's expertise in contract negotiation. HCSD then plans to have its trained staff share the techniques they have learned with prison staff. However, until Corrections equips its negotiation staff with the necessary tools to effectively negotiate favorable rates, the State may continue to miss opportunities to obtain contracts that are in its best interest.

Although its contract negotiation staff have a cross section of experience, HCSD reports that it has not given staff any specialized training in negotiating medical service contracts. Six HCSD analysts supervised by two managers have primary responsibility for negotiating contracts with hospitals and specialty care physicians when two or more prisons are involved. According to HCSD's duty statement, contract negotiation is only part of the analysts' job responsibilities, and HCSD estimates the analysts spend roughly 20 percent of their time negotiating and developing medical service contracts. When considering individuals for the analyst positions, the chief of the HCSD's Contracts Unit says she tries to hire staff with experience in several areas, including health care, state contracting, fiscal affairs, and Corrections. Our review of the background and experience of the six analysts shows that three have experience working for a health care association or as a medical assistant, five have contracting and/or fiscal experience, three have negotiation experience, and two held other positions related to health care within Corrections before accepting their current jobs.

The Health Care Services Division reported that it had not provided any specialized training to its staff or prison staff who negotiate medical service contracts.

Likewise, HCSD has not given specialized training to prison staff who negotiate medical service contracts, although these individuals have uneven amounts of contracting experience. Prison staff are responsible for negotiating the terms, conditions, and rates of medical service contracts for their prison. However, as Appendix B illustrates, the responsibility of negotiating rates with medical providers is performed by a number of prison staff with varying levels of expertise—from the chief medical officer or health care manager with extensive medical knowledge and possibly contract and negotiation expertise, to the health care budget analyst with primarily fiscal expertise. Specifically, some prisons report that the health care manager is responsible for negotiating rates, and others say the responsibility is shared by

a team of staff that includes the health care manager, HCCUP analyst, and medical contracts/budget analyst. Finally, some prisons report that their contract liaison or health program coordinator is responsible.

Varying levels of expertise create inconsistent contracting and negotiating practices at prisons throughout the State.

With these varying levels of expertise, contracting and negotiating practices are inconsistent at prisons throughout the State. Although most prisons report that they complete some type of comparison to evaluate the reasonableness or competitiveness of the proposed provider's rates, the extent of that effort varies. Some prisons report they obtain the standard rates or rely on the rate exemption. However, as we pointed out earlier, the prisons do not always comply with the rate exemption procedures. Further, one prison does not negotiate rates. Finally, some prisons compare proposed rates with the rates other local prisons pay for similar services, some compare rates to current contracts for the same or similar services, one prison compares rates by obtaining multiple bids, and another reported comparing rates to applicable rates from Medicare or the State's Medicaid Assistance Program (Medi-Cal).

Also inconsistent are the prisons' efforts to properly document and retain evidence on their negotiation and evaluation of proposed providers' rates. Specifically, 12 of 21 prisons we surveyed told us they maintain documentation for their negotiation efforts for rates above Corrections' standard rates, and 13 of 21 prisons said they maintain documentation of their efforts to evaluate provider rates to determine that the rates are reasonable or competitive. However, when we requested evidence of their negotiation efforts from six of the 12 prisons included in our sample, only two could provide the necessary documentation. Similarly, when we asked seven of the 13 prisons included in our sample for documentation of their efforts to evaluate provider rates, only three could give us such evidence.

However, HCSD recognizes that its staff as well as prison staff lack the necessary expertise. Specifically, in its Strategic Plan Outline, HCSD stated that one of its short-term strategies would be to consult and perhaps contract with other state agencies or outside consultants for enhanced expertise in negotiation strategies and procedures. HCSD plans to train its staff and then share the techniques with the contract negotiation staff at each prison.

WIDELY DIVERGENT COMPENSATION METHODS IN ITS MEDICAL SERVICE CONTRACTS LIMIT CORRECTIONS' ABILITY TO CURB MEDICAL EXPENSES

Corrections' range of compensation methods in its hospital contracts makes it difficult to compare rates for similar services statewide. However, our comparison of charges for nine hospitals shows that Corrections receives more favorable rates for some methods of compensation over other methods. Similarly, our comparison of Corrections' rates to those set by the federal Medicare program and to actual hospital charges reveals that in some instances Corrections' method of payment yields lower costs to the State. Comparison of physician rates and other nonhospital rates to Medicare rates also indicates that using certain compensation methods can lower the State's costs. Finally, our comparison of rates for similar services in urban and rural areas did not lead us to conclude that rates differ solely because of geographical area.

Corrections' Hospital Expenses Vary Widely According to the Compensation Method

In our review of contracts with nine hospitals, we found various compensation methods for services, such as per diem rates or flat percentage discounts. With a per diem rate, the provider is paid a daily fee for specified services or outcomes, regardless of the actual charges. Generally, Corrections can get substantially better rates when paying a per diem rate than when paying a flat discount rate.

Table 2 on the following page presents the results of the amounts Corrections paid for hospital charges shown on 53 hospital invoices. It also shows the results of our comparison of the Medicare rates to the amounts Corrections paid and the hospital charges.

Corrections can generally generate greater savings when it is able to negotiate per diem rates for hospitals it has under contract.

Overall, Corrections negotiated some rates resulting in substantial reductions to hospital charges, but the range of rates was from 7 percent to 100 percent of total hospital charges. For example, the rate Corrections negotiated for Hospital A was 60 percent of the total hospital charges, whereas the rate for Hospital G was 85 percent of the total charges. The difference of 25 percentage points was due to the two different methods used to compensate the hospitals. Corrections paid Hospital A using both per diem rates and percentage discounts. Payments for services using the per diem rate were 53 percent of the total charges, but payments using the percentage discount were 75 percent of the total charges. In contrast, the rate Corrections

TABLE 2

Amounts Corrections Paid Compared With Medicare Rates for Hospital Services

Hospital*	Number of Invoices Reviewed	Percent of Total Hospital Charges Paid by Corrections†	Medicare Rate as a Percent of Total Hospital Charges	Corrections' Payment as a Percent of Medicare Rate†
A	17	60%	100%	60%
B	15	7	21	34
C	4	8	26	30
D	3	95	61	155
E	5	60	19	319
F	3	64	25	259
G	4	85	39	215
H	1	70	37	188
I	1	100	34	291
Overall	**53**	**23**	**26**	**90**

Sources: Hospital invoices, California Department of Corrections' contract payment logs, and Medicare's Acute Care Hospital Inpatient Prospective Payment System PC Pricer.

* Corrections requested that we not disclose the hospital names. Please refer to page 78 for its rationale.

† Percentages reflect amounts after hospitals discounted their total charges in accordance with contracts.

negotiated for Hospital G services was a flat 15 percent discount off the total charges. Thus, Corrections generated greater savings by negotiating per diem rates.

HCSD says it does not require hospitals to conform to a specified compensation method because it does not want to discourage providers from submitting proposals or miss opportunities for better rates that providers might propose. Nevertheless, because the State is generally able to generate greater savings when it pays per diem rates, it would be beneficial for HCSD to at least try to obtain this compensation method during its negotiation efforts with hospitals.

Our sample results also indicate that overall the rates Corrections negotiated were slightly below Medicare's rates. Again, the rate Corrections paid each hospital varied, from 30 percent of the Medicare rate for Hospital C to 319 percent for Hospital E. Comparing the total hospital charges Correction paid with Medicare rates, we found that the compensation method that Corrections was able to negotiate was often directly linked to the amount of savings it achieved.

By comparing Corrections' rates with Medicare rates, we are not suggesting that Corrections' negotiations should always result in rates that are lower than Medicare rates. With its Acute

Care Hospital Inpatient Prospective Payment System, Medicare considers many factors, including the hospital's operating and capital costs; the wage index of the hospital's location; its percentage of low-income patients; and whether it is the only community hospital in the area, a Medicare-dependent small rural hospital, or an approved teaching hospital. In addition, the payment system classifies a hospital's discharges according to a list of diagnosis-related groups; and it evaluates the costs a hospital incurs, adjusting for unusually expensive cases to protect the hospital from large financial losses. Because of the payment system's complexity, it is unlikely that two hospitals providing identical services would receive the same Medicare rate. Thus, our comparison is informational only.

Our Comparison of Invoices to Medicare Rates Reveals the Impact of Compensation Methods on Rates Paid

In our review of 56 contracts, we compared some invoices for medical services to three of Medicare's fee schedules: those for physician services, ambulances, and prosthetics. Generally, for physician services, payments were the lowest in comparison to Medicare's rates when Corrections based its compensation on its fee schedules rather than on discounts off established rates or on physicians' hourly rates. We also found that two competitively bid contracts for prosthetic services were below Medicare's rates. Table 3 presents the results of our comparison.

TABLE 3

Corrections' Contract Rate for Individual Procedures Compared With Medicare Rates

Percentage of Medicare Rates	Physician Services*†	Ambulances*	Prosthetics*
100 or less	6	0	2
101–200	12	4	0
201–300	6	1	0
301–400	7	0	0
401–500	1	0	0
501–2000	3	0	0

* These columns represent the number of contracts we reviewed with invoices indicating procedures that we were able to compare with Medicare's rates.

† For one physician's contract, the invoices included procedure codes, but the physician was compensated based on an hourly rate in accordance with the contract terms. We converted the amount paid to a charge per procedure before comparing it to Medicare's rate.

For invoices relating to 14 contracts, we compared the rates Corrections paid for physician services with Medicare's physician fee schedule. Medicare publishes rates annually using its Healthcare Common Procedure Coding System procedure codes. Our results show a wide range between the amounts Corrections paid for the procedures and Medicare's rates. Specifically, for six contracts, Corrections paid for 12 procedures at lower rates than Medicare's rates. However, for one contract, Corrections paid for five procedures at rates that were 1,000 percent or more than Medicare's rates. When the compensation method was based on Corrections' fee schedules, it appears that Corrections paid the lowest amounts. Generally, when Corrections based the compensation method on discounts off the established rates or on hourly rates, the physicians received higher compensation compared with Medicare's rates.

State law governing local emergency medical services agencies prevents Corrections from negotiating lower rates for emergency ambulance services.

Our comparison of procedures from four contracts for ambulance services reveals that Corrections' rates were generally higher than those set by Medicare, ranging from roughly 120 percent to 280 percent higher. However, Corrections has no ability to negotiate lower rates. State law allows each county to develop a program for emergency medical services (EMS) and designate a local EMS agency. A local EMS agency may create one or more exclusive operating areas in the development of a local plan that restricts operations to one or more emergency ambulance services or providers of limited advanced life support or advanced life support. Then, on the recommendation of the local EMS agency, a county can adopt ordinances governing the transport of patients, including the rates, which are not open to negotiation. Thus, because the local EMS agency designates the exclusive providers of prehospital emergency services and sets their rates, Corrections has no ability to negotiate lower rates or enter contracts with other providers in their regions.

Finally, our comparison of two contracts for prosthetic services shows that Corrections rates were below Medicare's rates. Corrections awarded both contracts through the State's competitive bidding process, and the compensation method was a set percentage of the maximum allowable rates for Medi-Cal.

Our Comparison of Rates for Similar Services in Urban and Rural Areas Does Not Confirm That Location Was the Primary Factor Driving the Rates

After reviewing several contracts in which we were able to compare rates for similar services, we cannot conclude that rates differ solely due to the geographical area.

As previously mentioned, rates for hospital, physician, ambulance, and prosthetic services can be based on many factors other than location, including Corrections' compensation method and the rates set by other regulatory entities such as counties. Additionally, Corrections typically groups prisons in the same geographical area—some comprising both rural and urban areas—to obtain favorable rates for all prisons when it contracts for medical services on a temporary basis.

The results of our comparison of four contracts indicated that rates in urban areas were lower than those in rural areas. However, based on these few instances, we cannot conclude that the rate Corrections pays for similar services is driven solely by the geographical area.

Finally, in a few instances, the results of our comparison indicated that rates in urban areas were lower than those is rural areas. Specifically, our review of two contracts for dental services shows that the rates paid in the urban area were lower by 22 percent. Our review of two contracts for physical therapy services also indicates that the rates paid in the urban area were lower by 20 percent. However, based on these two instances alone, we cannot conclude that the rate Corrections pays for similar services in rural and urban areas is driven solely by the geographical area.

THE OFFICE OF CONTRACT SERVICES CAN IMPROVE ITS OVERSIGHT OF CORRECTIONS' CONTRACTS

Corrections' Office of Contract Services (Contract Services) has full responsibility for the management and approval of its contracts. Contract Services' Institution Contract Section (ICS) entered a memorandum of understanding with the prisons to work together toward the goal of expediting the contracting process. However, ICS and the prisons are not meeting this goal. In our review of 56 contracts that HCSD and the prisons submitted to ICS, we found that 14 contracts (25 percent) had been late. In addition, we identified four contracts in which ICS allowed prisons to exceed the authorized funding. Finally, we found instances when prisons obtained medical services for inmates before receiving the approval of General Services. By not complying with procedures designed to avoid executing

late contracts and exceeding the authorized contract amount and by failing to obtain proper approvals before receiving nonemergency services, Corrections limits the effectiveness of its contracting process.

HCSD and Prisons Have Not Submitted Many Medical Service Contracts to ICS Within Required Time Frames

Although ICS has established the minimum time necessary to process new and renewed contracts, and Corrections' policy memorandum sets forth criteria under which contracts can be submitted late, the prisons and HCSD do not submit their medical service contracts to ICS on time. Of the contracts we reviewed, 25 percent were late, and some of those lacked justifications that meet Corrections' criteria for late submittal. Whenever Corrections submits a late request for a new contract or amendment, it puts the State at risk of not having sufficient funds set aside to cover the cost of services while approval of the contract or amendment is pending.

Reasons justifying late contract and amendment requests do not always appear to meet Corrections' policy criteria.

ICS has set the lead time for processing new contracts for hospital, pharmacist, and ambulance services at nine months; the lead time for processing new contracts for laboratory, dentist, and radiology services is six months. In addition, amendment requests must be submitted 60 days before the proposed effective date or contract expiration date. In May 1998, Corrections issued a policy memorandum prohibiting late submittal of contracts or amendments except in cases of emergency services as defined by state law, protests and rebids associated with the request for proposal process, or situations resulting from unusual circumstances beyond Corrections' control. The policy memorandum also established procedures for addressing late contract or amendment requests. A prison's late justification request must include (1) the purpose of the service, (2) an explanation of why the request for services is late and any extenuating circumstances, (3) a description of the adverse effect if the request is denied, and (4) the measures being taken to prevent future late submittals. The prison's chief medical officer or health care manager must sign late requests for medical services, and the regional administrators for both HCSD and the Institution Division must receive copies. The Institution Division has the ultimate responsibility of safely housing inmates.

The prisons or HCSD submitted late contract or amendment requests for 14 of the 56 contracts we reviewed. According to ICS, all 14 late requests meet the criteria outlined in the policy

memorandum because in most cases the situations were beyond HCSD's or the prisons' control. However, we found five of the 14 late requests that do not appear to meet the criteria. For example, the reason the Valley State Prison for Women (VSP) gave for its late request was that it had a catastrophic case with high costs it could not have anticipated. HCSD's policies and procedures direct prisons to continually monitor their contract expenditures to ensure that sufficient funds are available to pay for all services rendered and request amendments promptly as needed to add funds to the contract. Additionally, VSP has access to its utilization data and can identify volumes and trends by type of service. However, our review of VSP's contract payment log shows the balance remaining for it to pay for services as of August 13, 2002, had dropped to less than $20 before it requested additional funding on October 7, 2002. Thus, if VSP was monitoring its contract expenditures and reviewing its utilization data, it could have avoided the late request.

The reason cited by the California Rehabilitation Center (CRC) for its late request was that its HCCUP analyst was working at three prisons and was unable to closely monitor and track its contract expenditures. However, this situation does not appear to be beyond Corrections' control because the CRC acknowledged in its request that closer monitoring and tracking of its expenditures would prevent future occurrences. In another example, HCSD justified one of its late requests merely by citing program oversight caused by changes in the division and its negotiation staff, which also appears to be within Corrections' control. Finally, the reason Folsom State Prison (Folsom) gave for its late request was that it inadvertently used the wrong compensation method to pay an oral surgeon. Again, this situation does not appear to be beyond Corrections' control because the appropriate compensation method should have been addressed during its contract negotiations.

Until Corrections establishes more stringent procedures to monitor compliance with its policy, it will not fulfill its objective of reducing unnecessary late submittals of contracts or amendments.

Corrections' policy, if followed, could result in better planning and monitoring of its contracts. However, ICS' determination that late requests resulting from situations "beyond Corrections' control," such as those we have described, undermines the effectiveness of the policy.

The policy memorandum also requires Contract Services to generate a quarterly report card outlining all late contract and amendment requests and to distribute a copy of the report card to its division deputies. Contract Services distributes the reports to division deputies and associate wardens at the

prisons twice each year, but it does not use the report. However, an opportunity exists for Corrections to use the report cards as a tool to enforce compliance with its policy. For example, associate wardens and HCSD could submit a corrective action plan for reducing late contract and amendment requests to Contract Services. Until Corrections establishes more stringent procedures to monitor compliance with its policy, it will not fulfill its objective of reducing unnecessary late submittals.

Corrections Does Not Always Ensure That Prison Spending Remains Within the Authorized Contract Amounts

HCSD initiates master contracts that include hospitals, medical groups, and certain physician services for some or all of the prisons. To save processing time and costs, Corrections developed the notice to proceed (NTP), an internal document from ICS authorizing funds for any prison choosing services under the master contracts. General Services must approve all master contracts exceeding $75,000 but does not review NTPs. Although the total amount of the NTPs that ICS issues against a master contract should not exceed the authorized amount of the master contract, we found a few master contracts where the NTPs did exceed the authorized amounts. To prevent similar errors in the future, ICS says it clarified the NTP process in a staff meeting after we brought this error to its attention. However, until ICS ensures that its staff are able to detect this type of error, the State risks not having sufficient funding to pay for necessary medical services.

For four of the 23 master contracts reviewed, prisons were given spending authority that exceeded the contract amounts by $5.9 million.

Of the 56 contracts in our review, 23 were master contracts with multiple NTPs issued to prisons. For four of the 23 master contracts, ICS issued NTPs totaling more than the authorized amount of the master contract amount. For one master contract, ICS issued 12 NTPs in a seven-week period that exceeded the master contract by $1.7 million. In another instance, ICS issued 12 NTPs in a six-week period that exceeded the master contract by $1.5 million. In the third instance, ICS issued 10 NTPs that exceeded the master contract by $14,510. In the fourth instance, over nearly a year, ICS issued 24 NTPs that exceeded the contract by $2.7 million.

In the first two instances, ICS cites a sizable balance of unpaid invoices and an urgent need to process the master contracts as the reasons its contract analysts inadvertently failed to follow the standard contracting procedure of verifying the master contract funding levels. To remedy the oversight, ICS adjusted the NTPs to ensure additional funds are available to cover each

of the NTPs for the remainder of the contract term. In the third instance, ICS identified the error and processed an amendment to the master contract for $900,000. In the fourth instance, ICS stated that the error occurred because the contract amount shown in its database was incorrect. ICS amended the contract after we brought this error to its attention.

Some Medical Services Are Rendered Before General Services Approves the Contracts

In some instances, prisons received medical services for inmates before the contracts for those services met the State's approval requirements. The basic policy outlined in the State Contracting Manual prohibits a contractor from starting work until receiving a copy of the formally approved contract from either General Services or Corrections. For contracts under $75,000, state law allows General Services to grant an exemption from its approval when the state agency meets certain conditions. Corrections has been granted this exemption. Further, certain exempt contracts must be formally approved by the agency. Receiving services before obtaining all approvals puts Corrections at risk for not having sufficient funding available to pay for services, paying higher costs, and exposing the State to litigation. Thus, it is important for Corrections to ensure that its contracts have all required approvals before providers render their services.

We identified five contracts where services were rendered between 15 and 134 calendar days before Corrections obtained General Services' approval. The State Contracting Manual recognizes that occasionally an unavoidable lag time might exist between the practical need for services and the formal approval of a contract. However, for at least two of these contracts, Corrections could have avoided processing delays. For example, for one contract, it took HCSD roughly eight months to communicate the results of security assessments to three potential providers. According to HCSD, factors such as transferring its contracting staff to another division and experiencing a series of management changes contributed to this delay. For another contract, it took ICS almost five months before it started processing a request it had received from a prison. According to ICS, this delay was caused by its excess workload and staff turnover.

We identified five contracts where services were rendered between 15 and 134 calendar days before Corrections obtained General Services' approval.

When Corrections starts a contractor working before contract approval, it has to wait until the contract is received before paying the contractor. This practice may discourage many

potential providers from working with the State and make it difficult for Corrections to obtain the necessary medical services for the inmate population.

ICS Does Not Always Require Prisons to Demonstrate the Unavailability of Medical Registry Contractors Before Approving Their Contract Requests

ICS is responsible for awarding and managing medical registry contracts but does not always verify that the prison made an effort to obtain the required services from a provider included in a medical registry contract before approving a prison's request for a contract with a nonregistry provider.

Prisons use medical registry contracts for temporary medical services when prison medical staff are unavailable or on long-term sick leave. A medical registry contract includes several providers of one service—psychiatric technicians, licensed clinical social workers, or nurses, for example—listed in the order in which prisons should contact them. ICS requires prisons to follow the hierarchy outlined in the contract and document their attempts to obtain services from the registry contractors in the specified order to avoid breach of contract. However, ICS does not always verify a prison's statement that it was unable to obtain services from a registry contractor before approving its request to obtain a nonregistry contractor, and prisons do not consistently document their efforts to obtain registry services. When a prison fails to document its inability to obtain staff using a registry provider, ICS may not be able to terminate the provider for nonperformance.

Because prisons do not always document their inability to obtain staff using a registry provider, they expose the State to potential lawsuits from registry contractors for breach of contract terms.

In four instances, ICS did not verify the prisons' inability to obtain registry contractor services before approving the prisons' requests for nonregistry contractors. For example, in October 2001, ICS approved a contract for a nonregistry psychiatrist without reviewing documents to verify the prison's inability to obtain these services from any of the nine registry contracts available statewide. In another instance, ICS approved an emergency contract in February 2003 without obtaining documentation verifying the prison's claim that it was unable to obtain a pharmacist-in-charge using the four pharmacy registries that were available. We spoke with representatives from both prisons, and they were unable to provide us with sufficient documentation of their efforts.

According to ICS, although it requires prisons to document their attempts to obtain services from the registry contractors, it does not always ask to see the documentation. However, a Corrections' registry contract typically contains a nonperformance clause stating that the contractor's failure to provide service on three occasions may result in the prisons not contacting the contractor prior to going to other contractors for the remainder of the contract term. If ICS does not ensure that prisons document their attempts to contact registry providers, it exposes the State to potential lawsuits from registry contractors for breach of contract terms. Furthermore, prisons' failure to document their inability to obtain staff using a registry provider can hinder ICS' ability to terminate the provider for nonperformance, because it cannot rely on the specific nonperformance penalty provided in those contracts.

CORRECTIONS CONTINUES TO SIGNIFICANTLY INCREASE ITS USE OF MEDICAL REGISTRY CONTRACTS

According to Corrections' unaudited expenditure data, its use of medical registry contracts is the fastest growing component of contracted medical services. Specifically, expenditures for registry contracts in fiscal year 2002–03 totaled $63.8 million, or 445 percent more than in fiscal year 1998–99. Table 4 illustrates the continued increase over the five-year period between fiscal years 1998–99 and 2002–03. Corrections uses registry contracts to provide temporary services when civil service staff are unavailable or on long-term sick leave. However, prisons are prohibited by state law from using registry staff on a permanent full-time basis and must continue their recruitment efforts.

TABLE 4

Growth in Corrections' Annual Expenditures on Registry Contracts Over a Five-Year Period

Fiscal Year	Total Expenditures	Annual Increase
1998–99	$11,722,236	—
1999–2000	14,795,111	26%
2000–01	28,869,934	95
2001–02	46,790,565	62
2002–03	63,821,909	36

Our analysis shows that four types of registry contracts comprise 89 percent of total registry expenditures for the five-year period: registry contracts for psychology, psychiatry, and related technician services (37 percent); nursing services (31 percent); physician services (11 percent); and pharmacists and pharmacy technician services (10 percent). Further, our analysis indicated that for each type of contract, less than nine prisons accounted for about 50 percent of the registry expenditures in fiscal year 2002–03. For that year, eight prisons, with a job vacancy rate of 30 percent, accounted for roughly 50 percent of the registry expenditures for psychologists, psychiatrists, and related technicians. Five prisons, with a job vacancy rate of 27 percent, accounted for roughly 50 percent of the registry expenditures relating to nursing services. Furthermore, six prisons, with a job vacancy rate of 20 percent, accounted for roughly 50 percent of the registry expenditures related to physician services. Finally, seven prisons, with a job vacancy rate of 14 percent, accounted for roughly 50 percent of the registry expenditures related to pharmacists and pharmacy technicians.

In our review of Corrections' recruitment efforts for the period January 2003 through January 2004, we found that Corrections made numerous efforts to recruit medical staff in the four professions. Specifically, Corrections staff participated in career fairs and national medical conferences, gave presentations, and provided tours to prospective employees. Additionally, Corrections sent application packets to potential candidates in a few target areas.

Corrections has made numerous efforts to recruit medical staff.

Besides its recruiting efforts, Corrections says it offers recruitment and retention bonuses for many positions. Specifically, psychiatrists, psychologists and psychiatric technicians are eligible for monthly or annual recruitment and retention bonuses ranging from $200 to $3,900. Nurses are eligible for monthly and one-time bonuses ranging from $200 to $2,000. Moreover, physicians and surgeons at all prisons are eligible for monthly bonuses of $200. Finally, pharmacists at all prisons are eligible for an $800 monthly bonus, except at the California Medical Facility, where pharmacists are eligible for a $1,000 monthly bonus. Pharmacists at all prisons are also eligible for a one-time bonus of $2,400 after 12 months employment.

Corrections requested additional authorized positions for fiscal year 2003–04 through the State's budget process. Specifically, Corrections requested 8.5 psychiatrist and psychologist

positions for one of the eight prisons with the highest registry expenditure, 32 nurse positions for three of the five prisons with high usage of registry contracts, and one pharmacist and one pharmacy technician position at one of the seven prisons with the highest registry expenditures. In fiscal year 2003–04, Corrections received additional funding to establish most of the requested positions.

Nevertheless, HCSD should continue to monitor prisons' registry contract expenditures and evaluate the prisons' needs so that it can identify opportunities to control expenditures and ensure that prisons are not violating state law by using registry staff on a permanent basis.

RECOMMENDATIONS

To protect the State's interest when entering all future contracts for medical services, General Services should consider removing its long-standing policy exemption that allows Corrections to award, without advertising or competitive bidding, medical service contracts with physicians, medical groups, local community hospitals, 911 emergency ambulance service providers, and an ambulance service provider serving a single geographical area.

If General Services decides that it is not in the State's best interest to remove the long-standing policy exemption, it should prescribe the methods and criteria for Corrections to use in determining the reasonableness of contract costs as follows:

- Require Corrections to undertake procedures similar to those required in the NCB process. Specifically, it should require Corrections to conduct a market survey and prepare a price analysis to demonstrate that the contract is in the State's best interest.

- Require Corrections to obtain approval of its market survey and price analysis from its director before submitting this information along with its contract to General Services for approval.

To improve its negotiation practices to obtain medical service contracts that are in the State's best interest, Corrections should do the following:

- Work with the Office of Statewide Health Planning and Development to obtain hospitals' charge masters, and use this information to negotiate contract rates and obtain discounts specified in the contracts.

- Ensure that HCSD enforces rate exemption requirements, including obtaining and reviewing documentation to verify prisons' justification for higher rates.

- Establish procedures to ensure that the rate exemptions initiated by HCSD undergo an independent review and higher-level approval process.

- Adopt procedures that require staff to consider utilization data when negotiating medical service contracts. These procedures should also require staff to document the use of these data in the contract file.

- Ensure that HCSD offers specialized training for its negotiation staff so they can effectively negotiate favorable rates. HCSD should then share any strategies and techniques with the prisons' negotiation staff.

- Ensure that HCSD tries to obtain per diem rates as a compensation method when negotiating hospital contracts. Additionally, HCSD should document its attempts to obtain per diem rates.

To fulfill its contract management responsibilities, Corrections should do the following:

- Direct ICS to evaluate late requests using the criteria outlined in the policy memorandum. Additionally, ICS should request HCSD and the prisons to provide relevant documentation to support their requests.

- Continue generating report cards periodically and establish procedures for staff such as prisons' associate wardens to submit corrective action plans to Contract Services to monitor.

- Ensure that ICS staff review the master contract and outstanding NTPs before issuing additional NTPs so that it does not exceed the master contract amount.

- Evaluate its contract-processing system to identify ways for HCSD, ICS, and the prisons to eliminate delays in processing contracts and avoid allowing contractors to begin work before the contract is approved.

- Modify its procedures to require prisons to submit documentation to ICS demonstrating their attempts to obtain services from registry contractors with their requests for services from a nonregistry contractor.

- Direct ICS to review prisons' documentation and ensure that prisons have made sufficient attempts to obtain services from registry contractors. Additionally, ICS should use these data to identify trends of nonperformance and terminate registry providers, when necessary.

To rein in costs associated with the use of medical registry contracts, Corrections should continue to monitor prisons' registry expenditures on a monthly basis and evaluate their need for services. ■

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CHAPTER 2

Prisons Are Not Ensuring That They Pay Only Appropriate and Valid Medical Claims

CHAPTER SUMMARY

Although the California Department of Corrections' (Corrections) Health Care Services Division (HCSD) established its utilization management (UM) program to ensure the quality of care inmates receive while containing cost, the prisons are failing to verify that they pay only for valid charges. The UM program requires prisons contracting for medical services to perform three reviews—prospective, concurrent, and retrospective—to determine that inmate services are necessary and that charges are valid (see text box). However, the prisons lack evidence that they complete the prospective and concurrent reviews. Also, the retrospective reviews are deficient in several ways, resulting in documented overpayment of medical service charges and possible payment for nonexistent services.

One deficiency of the retrospective reviews is that nurses in the UM program (UM nurses) are not consistently reviewing a percentage of medical service invoices to ensure that the charges are appropriate to the services. Although HCSD has an informal policy requiring UM nurses to review 10 percent of medical service invoices, seven of 21 prisons report that their UM nurses review less than 10 percent of the invoices, with the other 14 prisons reporting that their UM nurses review from 10 percent to 100 percent of invoices. Second, analysts with the prisons' health care cost and utilization program (HCCUP) do not always identify discrepancies between contract rates and medical charges on providers' invoices—or even obtain evidence that medical services were actually received. Consequently, prisons are overpaying for some services, incurring unnecessary costs for the State. Until HCSD enforces its retrospective review policy for UM nurses and performs

Required Utilization Management Reviews

Prospective review ensures that requested services are medically necessary and the proper approvals exist before the provider renders services.

Concurrent review monitors inmate medical services that require a hospital stay and validate the appropriateness of the level of care, medical necessity of treatment and procedures, and appropriateness of the place or site for services.

Retrospective review examines charges from medical providers before authorization of payment to ensure that they are appropriate, correct, have proper approvals, meet criteria for medical necessity, and are within contractual provisions.

Source: California Department of Corrections' Health Care Services Division utilization management program guidelines.

quality control reviews of HCCUP analysts' invoice processing, Corrections cannot contain and reduce health care costs at California's prisons.

PRISONS DO NOT ALWAYS COMPLY WITH HCSD'S UTILIZATION MANAGEMENT POLICIES

In 1996, HCSD established its UM program to maintain quality health care delivery to inmates (see text box) while containing cost. In 1999, HCSD issued UM guidelines to update the program and ensure systematic application of utilization management in all prisons.

Objectives of the Utilization Management Program

- Provide cost-effective utilization of medically necessary services.
- Ensure that quality care is achieved.
- Improve efficiency in the use of internal and external contract health resources.
- Decrease the use of community hospitals.
- Establish and maintain accountability, keeping Corrections current with cost-conscious medical practice.
- Identify quality and risk management issues.
- Decrease litigation.
- Practice in accordance with accepted community standards.
- Comply with regulatory and licensing requirements.
- Standardize the UM program systemwide.

Source: California Department of Corrections' Health Care Services Division utilization management program guidelines.

The UM guidelines require UM nurses at each prison to complete a series of reviews before, during, and after delivery of medical services. The guidelines require nurses to review invoices to make sure the charges are for medically necessary services and HCCUP analysts to review invoices for consistency with contract terms. However, prisons are not consistently performing these reviews. As a result, Corrections cannot demonstrate that it pays only for services that are authorized and medically necessary.

Nurses Play a Major Role in the UM Program

Corrections considers the UM nurses vital to the success of its UM program and expects them to spend 85 percent of their time conducting the three UM reviews: prospective, concurrent, and retrospective. As of February 2004, Corrections had 33 UM nurses.

The UM guidelines require health care providers to submit a request for services for all nonemergency consultations, treatments, procedures, and admissions. During a prospective review, the UM nurse may approve health care providers' requests that meet the criteria outlined in Corrections' Medical Standards of Care. However, if the UM nurse finds that a request for services does not meet the criteria, he or she must forward the request to either the prison's health care manager or the designated physician advisor. The

Medical Authorization Review (MAR) and Health Care Review (HCR) committees also evaluate requests for medical services excluded by state regulations.[2]

The UM guidelines require concurrent reviews for services that an inmate receives as an inpatient in a Corrections or community health care facility. A UM nurse has primary responsibility for conducting a concurrent review, which has two components: an admission review and a continued-stay review. The UM nurse must perform the admission review within 24 hours of the inmate's admission to verify the appropriateness and medical necessity of the hospitalization. In the continued-stay review, the UM nurse regularly evaluates the inmate's level of care, delays in service, appropriateness of tests, patient's complications, and discharge plans.

Finally, as part of the retrospective review, the UM nurse reviews invoices forwarded by the HCCUP analyst and determines the appropriateness of the charges. The prisons' health care managers are responsible for ensuring that UM nurses fulfill their responsibilities, although HCSD oversees the UM program.

Prisons Cannot Show That They Consistently Perform Prospective and Concurrent Reviews When Required

Our review of invoices requiring prospective and concurrent reviews revealed that many of the prisons are unable to demonstrate that they complete the reviews. By not having the documentation of these reviews, prisons cannot show that they do not pay for unnecessary medical services. Table 5 on the following page presents the results of our review of prospective and concurrent reviews for 248 invoices relating to 15 prisons. Eighty-seven invoices did not require prospective reviews and 211 invoices did not require concurrent reviews. For example, concurrent reviews are only required when inmates require inpatient hospital services for more than 24 hours, and many of the invoices we reviewed did not meet this criteria. In addition, other invoices we reviewed were for temporary services from registry contracts, and these services do not require either of the reviews.

[2] State regulations require an MAR committee be established within each correctional treatment center's (CTC) service area. The MAR committee must be composed of representatives from the health care staff of each prison within the CTC's service area and consist of not less than three service area staff physicians. Those cases that receive MAR committee approval are forwarded to the HCR committee, which must consist of, at a minimum, HCSD's assistant deputy director of operations, chief medical officer of health policy, and assistant deputy director of program development; two selected specialist physicians; and a nonvoting UM nurse, as necessary.

TABLE 5

Review of Compliance With Prospective and Concurrent Reviews

Prison	Prospective Reviews			Concurrent Reviews		
	Invoices Requiring	Invoices Without	Percentage Without	Invoices Requiring	Invoices Without	Percentage Without
Avenal State Prison	10	9	90%	6	6	100%
California Institution for Men	2	0	0	0	NA	NA
California Medical Facility	12	12*	100	0	NA	NA
California Men's Colony	22	19	86	0	NA	NA
California State Prison, Corcoran	11	9	82	1	1	100
California State Prison, Sacramento	7	3	43	0	NA	NA
California State Prison, Solano	16	9	56	5	5	100
California Substance Abuse and Treatment Facility and State Prison at Corcoran	7	7	100	0	NA	NA
Central California Women's Facility	8	8	100	1	1	100
Folsom State Prison	15	15	100	6	6	100
High Desert State Prison	8	4	50	6	0	0
Pelican Bay State Prison	17	12	71	2	2	100
Pleasant Valley State Prison	10	7	70	6	6	100
Salinas Valley State Prison	8	5	63	0	NA	NA
Valley State Prison for Women	8	6	75	4	3	75
Totals	**161**	**125**		**37**	**30**	

Source: Bureau of State Audits' review of numerous documents such as invoices, requests for services, and concurrent reviews.
NA = Not applicable.

* According to the California Medical Facility's chief deputy, Clinical Services, once the first treatment for oncology services is approved, it does not require prospective reviews for the rest of the treatments. However, the contract terms for the provider of services for 10 of the 12 invoices state that prior authorization must be obtained in writing from the prison's health care manager or designee in accordance with the UM guidelines. The prison did not provide us with evidence of prior authorization for the initial authorization of the oncology services or any of the recurring treatments. Therefore, we have included these 10 invoices in Table 5.

Eleven prisons could provide evidence to support their prospective reviews, but only two prisons provided support for their concurrent reviews. Prisons report that several factors limited their ability to provide evidence of their prospective and concurrent reviews, but the most common reason was that the

medical records move with the inmates when they are paroled or transferred to other prisons. However, the UM guidelines clearly state that UM documentation is not to be filed in the Unit Health Record, which transfers with the inmates, but must be kept on file for a minimum of three years. By failing to retain the documentation to support their UM reviews, prisons have difficulty demonstrating that they are paying only for medically necessary services.

With Unclear Guidelines, Prisons Inconsistently Perform Retrospective Reviews

UM nurses are charged with reviewing invoices for medical services—a main component of the retrospective review. However, Corrections has not given UM nurses new documented instructions on how many and what type of invoices the nurses should review. The resulting confusion is reflected in the reports from 21 prisons that show their UM nurses review anywhere from zero to 100 percent of varying types of invoices for medical charges. HCSD's failure to provide clear guidance to the prisons regarding the changes to the UM guidelines for retrospective reviews results in inconsistent reviews and puts the State at risk for paying for unnecessary and inappropriate costs.

The utilization management nurse and the health care cost and utilization program analyst have the primary responsibility for ensuring the appropriateness of the providers' charges before making payment.

UM nurses are key to ensuring that the State pays for only medically necessary and appropriate charges. The UM nurse and the HCCUP analyst have the primary responsibility for ensuring the appropriateness of the provider's charges before making a payment, although the UM guidelines state that the retrospective review is a cooperative effort between the provider and the prison's health care manager, UM nurse, contract monitor, HCCUP analyst, and other parties as needed. The guidelines require the UM nurse to use his or her clinical expertise and act as a resource to the HCCUP analyst to determine the appropriateness of charges. Further, the duty statement of the UM nurse includes the task of adjusting billings, after reviewing authorized treatment and its documentation, for conformance with UM policies or in cases of billing irregularities. For example, the UM nurse prepares a written notice of any charges that appear unwarranted, unauthorized, unallowable, excessive, or questionable. After obtaining the health care manager's signature on the written notice, the UM nurse sends it to the provider and forwards a copy to the HCCUP analyst. The HCCUP analyst is responsible for adjusting the invoice amount for inappropriate charges identified by the UM nurse.

However, Corrections' guidelines are unclear about the number and type of invoices that UM nurses should review. The formal UM guidelines require retrospective reviews for 100 percent of charges related to inpatient and outpatient cases in a timely manner, but these guidelines were modified in several regional UM nurse meetings in 2000. Unfortunately, notes from those meetings reveal confusing sets of instructions about what types and percentage of invoices UM nurses should review. Not surprisingly, Table 6 shows that UM nurses in 21 prisons vary widely in the number and type of retrospective reviews they conduct.

TABLE 6

Percentage of Invoices UM Nurses Review

Prison	0 Percent	10 Percent	Other	Types of Invoices
Avenal State Prison			• 10-20%	Of the 10-20 percent reviewed, UM nurse estimates 60 percent are for surgical procedures and admissions and 40 percent are outpatient services.
California Correctional Center		•		Every 10th invoice **plus** every inpatient stay and high-cost* invoices.
California Institution for Men			• 5%	All inpatient and outpatient community physician and in-house surgery invoices and about 1 percent of inpatient and outpatient community hospital invoices are reviewed.
California Institution for Women			• 95%	All invoices **except** those from small businesses, registries, ambulance service providers, and the Riverside County Regional Medical Center.
California Medical Facility		•		Random count of every tenth invoice for community hospital and physician inpatient and outpatient services **plus** high-cost* inpatient hospital stays.
California Men's Colony			• 48%	Thirty-eight percent of inpatient hospital high-cost* cases that are close to reaching the stop loss provision with contracted hospitals **plus** 10 percent of outpatient and physician services.
California Rehabilitation Center			• 12%	Contract patient care invoices not covered by the prisons' hospital main contract are reviewed.
California State Prison, Corcoran			• Unknown	High-cost* cases are reviewed.
California State Prison, Sacramento		•		Invoices with possible cost savings as determined by the type of service, contract rate, and communication between the UM nurse and HCCUP analyst.
California State Prison, San Quentin			• 100%	Prison reported 100 percent but also stated that all invoices **except** those for per diem hospital and registries were reviewed.
California State Prison, Solano		•		Random selection of invoices.
California Substance Abuse Treatment Facility and State Prison at Corcoran		•		Master contract hospital physician services **plus** all high-cost* cases.

Prison	0 Percent	10 Percent	Other	Types of Invoices
Central California Women's Facility		•		Invoice randomly selected by UM nurse or on occasion the HCCUP analyst will refer it if there is a concern.
Correctional Training Facility	•			UM nurse may be consulted if there is a billing concern.
Folsom State Prison			• 1%	Hospital and/or physician invoices that are percentage discount of total charges, high-cost* cases, and unusual physician invoices including lengthy exams or extraordinary health care procedures.
High Desert State Prison		•		Certain high-cost* cases and all emergency services provided by providers not under contract.
Pelican Bay State Prison			• 75%	Invoices for services generated through specialty clinics for consultations and services (including surgeries, special procedures, and hospital admissions).
Pleasant Valley State Prison			•	No certain percentage reviewed. Currently, high-cost* cases, invoices for emergency treatment by providers not under contract, and invoices with concerns identified by HCCUP analyst.
R.J. Donovan Correctional Facility		•		Inpatient hospital invoices and invoices from hospital providers that contain a stop loss provision.
Salinas Valley State Prison	•			None
Valley State Prison for Women	•			None
Totals	**3**	**8**	**10**	

Source: Responses to Bureau of State Audits' inquiry received from the California Department of Corrections' prison staff.

* Generally, high-cost cases have invoices with charges greater than $50,000.

The prisons' detailed reasons for their various approaches to reviewing invoices indicate confusion about the requirements for what retrospective reviews the UM nurses should be performing. Prisons gave us numerous explanations for their approaches. For example, eight prisons told us that UM nurses review 10 percent of medical service invoices, and two specifically cited changes HCSD made to the UM guidelines as the reason for this approach. According to HCSD, it verbally communicated a change to the retrospective review policy during three regional meetings of UM nurses in April and May 2000.

Specifically, HCSD says the depth of retrospective reviews should be weighed against the expected savings and the current average cost savings of 10 percent. The notes from another regional UM nurse meeting held in July 2000 indicate that UM nurses were again given verbal updates to the retrospective review policy. However, the notes are inconsistent. One set of notes instructs UM nurses "to curtail their retrospective reviews to noncontract,

high-cost bills" and a review of 10 percent of those invoices. Another set of notes indicates that the UM headquarters staff confirmed "the current directive" that called for retrospective reviews of a random 10 percent of invoices for physicians and per diem-contracted hospitals and 100 percent of invoices for noncontracted hospitals.[3] These notes add that "all central UM nurses should be doing the same amount and type of reviewing with shared providers to decrease confusion and noncompliance among the contract providers." Later, on September 15, 2000, the California Medical Facility received specific instructions from HCSD to "apply retrospective reviews to 100 percent of all invoices received by noncontracted providers and to randomly review 10 percent of all contract providers. To allow for an objective and impartial selection of the 10 percent, it was agreed that California Medical Facility's HCCUP analyst would mark every 10th invoice received, alerting the UM nurses of which invoices to apply a full and in-depth review."

HCSD acknowledges that there is no formal policy to address the change to the UM guidelines for retrospective reviews. HCSD says it conducted a review of industry practices, and all the information it received supported reviewing a sampling of invoices rather than 100 percent of them. Additionally, HCSD wanted to place primary emphasis on its prospective and concurrent reviews. However, as we pointed out earlier, the prisons could not demonstrate that they perform prospective and concurrent reviews consistently. Further, as Table 6 indicates, the prisons are confused about the requirements for retrospective reviews. HCSD's failure to provide clear guidance to the prisons regarding the changes to the UM guidelines for retrospective reviews results in inconsistent reviews and puts the State at risk for paying unnecessary and inappropriate costs.

Failing to Adequately Monitor Medical Service Invoices, Prisons Sometimes Overpay Providers, Unnecessarily Increasing the State's Medical Costs

Our review of 39 invoices totaling roughly $325,600 and a contract payment log for one contract revealed prisons overpaid medical service charges by $77,200.

In addition to working closely with UM nurses to determine the appropriateness of medical service charges, the prisons' HCCUP analysts are responsible for reviewing all medical service invoices for consistency with the providers' contracts. However, our review of 39 invoices totaling roughly $325,600 and a contract payment log for one contract revealed that prisons overpaid some medical services charges by $82,900 and

[3] A noncontracted hospital is one with which Corrections has no contract at the time the hospital provides services.

underpaid other charges by roughly $5,700, resulting in a net overpayment of $77,200. Prisons' overpayments suggest that the HCCUP analysts' reviews are sometimes ineffective. This failure of the prisons to sufficiently monitor medical service invoices results in the State incurring unnecessary costs. Further, HCSD's health care managers approve invoices, but HCSD does not perform quality control reviews of the invoices that prison's HCCUP analysts process. Quality control reviews would enhance HCSD's efforts to reduce health care costs and promote costs containment. Until HCSD establishes a process for quality control reviews, the type of errors that we found will most likely continue to occur.

The State Contracting Manual requires agencies to monitor contracts to verify that the contractor fulfills all provisions of the contract before approving the invoices. In this regard, the Institution Contract Section's memorandum of understanding with the prisons addresses their responsibilities for contract monitoring, and Corrections' policy requires its regional accounting offices to forward all medical service invoices to the prisons for HCCUP analysts' review.

Avenal State Prison overpaid almost $53,000 for one contract and made no attempt to collect the overpayments before the provider went out of business.

Our review revealed that HCCUP analysts did not always identify discrepancies between contract rates and medical charges on the providers' invoices. For example, Avenal State Prison (Avenal) overpaid almost $53,000 for one contract in which the amendment stated that Corrections would compensate the provider, effective July 1, 2001, at a rate of 20 percent less than the established rate of payment for services rendered. However, the HCCUP analyst overpaid 84 invoices in fiscal years 2001–02 and 2002–03 by failing to deduct the 20 percent. According to Avenal's health care manager, it did not deduct the 20 percent discount because the amendment was not received until early March 2003. Nevertheless, Avenal made no attempt to collect the overpayments when the amendment was approved, and the provider is no longer in business.

California State Prison, Corcoran (Corcoran) overpaid rates for physician services on eight invoices totaling roughly $17,000 because the HCCUP analyst did not adhere to contract terms requiring Corrections to pay the lower of its standard rate or the provider's invoices rate. For another contract, Corcoran paid $375 for physician on-call services, even though the contract had no provision for these services. Corcoran's hospital administrator stated that its two psychiatrists could not possibly cover all on-call services, so the chief psychiatrist decided to compensate the

provider for on-call services. Moreover, the California Substance Abuse Treatment Facility and State Prison at Corcoran (CSATF) improperly paid a provider $7,900 to interpret X rays, though the contract had no provision for X rays. Likewise, Folsom State Prison paid $1,000 for oral surgery procedures not included in the provider's rate schedule agreed to in the contract. According to the prison's health care manager, the chief medical officer directed the chief dental officer to review invoices and authorize payment for all dental services. He further stated that the HCCUP analyst had no record of the oral surgery services that were paid, which is inconsistent with the UM guidelines requiring the analyst to review all medical service invoices.

Additionally, the HCCUP analysts did not always comply with UM guidelines requiring them to ensure that contract discounts are taken and medical invoices are returned promptly to Corrections' regional accounting offices for payment. We found 50 instances, totaling roughly $12,700, of prisons either failing to meet the time frames for payments or not taking full discounts and as a result losing the discounts. We also found 25 instances of prisons incurring late payment penalties totaling roughly $5,900. However, it is in the State's best interest for Corrections to take advantage of all discounts and minimize late payments. For example, to avoid late payment penalties, the California Prompt Payment Act establishes that the maximum time from an agency's receipt of an undisputed invoice to issuance of a warrant for payment is 45 calendar days. Prisons' failure to pay for services in accordance with the contract terms, as well as state laws and policies for prompt payment, undermines the State's ability to contain its medical services costs.

Finally, even though they have paid for services, many of the prisons could not show evidence that the inmates received the medical services. Evidence could consist of copies of physician progress notes from the medical file, a list of inmates scheduled and seen at clinics, time sheets or gate logs, physician reports taken at the hospital, or an itemized listing of services and progress throughout the stay. HCCUP analysts in two prisons paid for provider services totaling $13,500 based on time sheets that were not approved, and HCCUP analysts in two other prisons paid for services totaling almost $4,700 without obtaining the time sheets. Additionally, one prison's HCCUP analyst could not support almost $16,000 relating to implantable devices for an inmate. Further, two prisons did not provide documentation to support services paid on 14 invoices totaling nearly $35,000.

RECOMMENDATIONS

To improve its efforts to provide only medically necessary services and contain medical service costs, Corrections should do the following:

- Ensure that the UM nurses adhere to the UM guidelines requiring them to perform and retain documentation of their prospective and concurrent reviews.
- Direct HCSD to establish a quality control process that includes a monthly review of a sample of prospective and concurrent reviews performed by the prisons.
- Clarify and update the UM guidelines for performing retrospective reviews.
- Direct HCSD to establish a quality control process that includes a monthly review of a sample of the invoices processed by the prisons' HCCUP analysts.
- Ensure that prisons recover any overpayments that have been made to providers for medical service charges. Similarly, prisons should rectify any underpayments that have been made to providers.
- Evaluate its payment process to identify weaknesses that prevent it from complying with the California Prompt Payment Act.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: April 6, 2004

Staff: Joanne Quarles, CPA, Audit Principal
Tammy Lozano, CPA, CGFM
Matt Espenshade
Sheryl Liu-Philo, CPA

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APPENDIX A

Status of Certain Recommendations From Bureau of State Audits Report Issued in January 2000

The Joint Legislative Audit Committee requested the Bureau of State Audits (bureau) to evaluate the California Department of Corrections' (Corrections) implementations of several recommendations outlined in the bureau's report titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care,* issued in January 2000. Table A.1 on the following pages summarize the results of our evaluation.

TABLE A.1

Status of Certain Recommendations From the Bureau of State Audits' Report Titled *California Department of Corrections: Utilizing Managed Care Practices Could Ensure More Cost-Effective and Standardized Health Care*

Recommendation	Progress	Plan
Corrections should report to the Legislature on its progress in adopting managed care techniques and the specific barriers that preclude it from operating more effectively in a managed care environment. The report should identify any resources, including staff, needed to develop the infrastructure necessary to collect and analyze data that will allow it to comprehensively and systematically review its medical operations. In the meantime, it should proactively review its medical operations to the extent possible.	In 2002, Corrections issued two reports to the Legislature addressing its inmate medical services delivery plan and its plan to comply with the settlement requirements of *Plata v. Davis,* et al. Corrections received additional resources to implement its plan for delivering medical services in fiscal year 2002–03. Corrections has established its QMAT to evaluate the quality of its prisons' medical care. The QMAT comprises medical and custody staff that review clinical care and access, custody interface issues, and audits of each prison's medical program. The QMAT conducted quality reviews at seven prisons during fiscal year 2001–02. However, Corrections found that the quality reviews were not sufficiently focused to evaluate the quality of the clinical practice of physicians and nursing staff. As a result, between fall 2002 and November 2003, Corrections developed, tested, and evaluated an improved audit instrument for its staff to use when conducting QMAT quality reviews.	Corrections plans to begin its Quality Management Assessment Team (QMAT) quality reviews using the new audit instrument in May and June 2004.
Corrections should ensure that each facility operates in an optimal manner by periodically reviewing key operating data, such as costs and lengths of stay, and investigate unusual or inconsistent data. Further, it should take appropriate steps to minimize unnecessary costs and verify that the corrective action resulted in the desired change. Such reviews should be limited to those where the potential savings can reasonably be expected to exceed the evaluation costs.	Corrections has not implemented a comprehensive system that would allow it to review comparative analyses of costs and operational data within its inmate medical services delivery system. Corrections acknowledges the delay in development of a comprehensive management system has hampered its ability to avoid costs and monitor corrective action. Despite substantial barriers, including the current fiscal and information technology environment, Corrections stated that it has continued to work with the administration and improvise in the interim through development of a pharmacy data application designed to collect, analyze, and report select pharmacy data from the prison Pharmacy Prescription Tracking System and a utilization management application designed to collect, analyze, and report key data and operating costs, including contract costs. In January 2002, Corrections was in the early stages of designing a Strategic Offender Management System (SOMS) to capture and share offender information internally and with other criminal justice and law enforcement entities. SOMS will contain a health care management component, but it has not been implemented.	Corrections is working toward merging data from its three databases—those of the health care cost and utilization program, Office of Contract Services, and the utilization management program—by February 2005. Additionally, Corrections plans to implement SOMS by 2010.

Recommendation	Progress	Plan
Identify the specific areas where the level of medical care, such as chronic care services, differs because of litigation or other reasons. If differences exist, it should determine the additional resources, including staff, necessary to remedy any inconsistencies, and seek the appropriate budgetary changes to ensure a consistent level of care at each facility to the extent possible.	Corrections developed a plan to comply with the settlement requirements of *Plata v. Davis*, et. al. Corrections' plan includes a multiyear rollout of the Inmate Medical Services Program Policies and Procedures at all prisons to ensure improved access to and continuity of medical care.	Corrections states it is in the beginning stages of implementing its plan. Corrections' multiyear plan for implementing improvements delivering medical services to inmates consists of a comprehensive, multifaceted approach to address the complexity and extreme magnitude of the effort required to improve and standardize delivery of inmate medical services at all prisons. The approach includes the following: (1) A new system for intake health screening to ensure a more timely and comprehensive assessment of inmate needs as they enter or transfer between Corrections' prisons; (2) improved access to medical services; (3) implementation of comprehensive preventative services and chronic care programs using standardized data collection forms and guidelines consistent with national consensus panel recommendations; (4) staffing each institution with a registered nurse 24 hours a day, seven days a week to ensure that appropriate professional patient assessment is performed; (5) tracking of specialty services from the time of the request for specialty services by the physician through the specialty appointment, the return of the specialty consultant's report, and follow-up by the on-site primary care physician; (6) development of mechanisms that hold medical staff accountable for providing timely and appropriate services; and (7) development of a comprehensive program of on-site monitoring of compliance with the policies and procedures.
Work with the Department of Health Services (Health Services) to ensure that all Correctional Treatment Centers (CTCs) become licensed and that Corrections is providing only the level of care appropriate for an unlicensed facility in those not yet licensed.	Corrections stated that as of February 2004, nine of its 16 CTCs had been licensed. According to Corrections, numerous factors have contributed to delays in licensing its CTCs, such as a lack of statewide standards, inadequate staff training, barriers relating to the construction of CTCs, and inconsistencies in the licensing survey process.	Corrections plans to work with Health Services to ensure the development of consistent prelicensing standards and surveys. It also plans to complete the development of statewide CTC standards by 2005. Finally, Corrections anticipates the licensure of an additional six CTCs in fiscal year 2004–05, two in fical year 2005–06, and two in later years.

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APPENDIX B

Prison Staff Responsible for Negotiating Medical Service Contract Rates

Prison staff are responsible for negotiating the terms, conditions, and rates of medical service contracts for their prison. Table B.1 summarizes the prison staff responsible for negotiating rates with medical providers.

TABLE B.1

Facility	Prison Staff
Avenal State Prison	Health care manager, medical contracts/budget analyst, health care and cost utilization program (HCCUP) analyst
California Correctional Center	Chief medical officer, contract manager
California Institution for Men	Health care manager
California Institution for Women	Health care manager/chief medical officer, correctional health services administrator, health program coordinator, and HCCUP analyst
California Medical Facility	Contract liaison
California Men's Colony	Health care manager, medical contract manager
California Rehabilitation Center	Health care manager or designee
California State Prison, Corcoran	Health care manager and/or hospital administrator in collaboration with budget analyst
California State Prison, Sacramento	Contract manager, procurement and services officer/ business services officer
California State Prison, San Quentin	Health care manager, chief physician and surgeon
California State Prison, Solano	Health care manager or designee for standard rates, otherwise HCSD performs negotiation
California Substance Abuse and Treatment Facility and State Prison at Corcoran	Health care manager
Central California Women's Facility	Contract monitor
Correctional Training Facility	Chief medical officer or contract analyst
Folsom State Prison	Health program coordinator
High Desert State Prison	Health program coordinator
Pelican Bay State Prison	Associate governmental program analyst (contracts), health program coordinator, subject to approval by health care manager

continued on next page

Facility	Prison Staff
Pleasant Valley State Prison	Health care manager/chief medical officer, medical contract analyst, correctional health services administrator
R.J. Donovan Correctional Facility	Health care manager/chief medical officer, health care budget analyst, central supply material and stores supervisor I
Salinas Valley State Prison	Health care manager and HCSD
Valley State Prison for Women	Supervisor of area where services will be provided

Source: Responses to the Bureau of State Audits' inquiry received from the California Department of Corrections' prisons.

Agency's comments provided as text only.

State and Consumer Services Agency
915 Capitol Mall, Suite 200
Sacramento, CA 95814

March 19, 2004

Elaine Howle, State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Enclosed is our response prepared by the Department of General Services to the Bureau of State Audits' Report No. 2003-117 entitled, *California Department of Corrections: Needs to Better Ensure That It Obtains Medical Services Contracts That Are in the State's Best Interest and Its Payments Are Only For Valid Medical Claims*. A copy of the response is also included on the enclosed diskette.

If you have any questions or need additional information, please contact me at (916) 653-4090.

Sincerely,

(Signed by: Fred Aguiar)

Fred Aguiar, Secretary
State and Consumer Services Agency

Enclosures

MEMORANDUM

Date: March 19, 2004 File No.: 2003-117

To: Fred Aguiar, Secretary
State and Consumer Services Agency
915 Capitol Mall, Room 200
Sacramento, CA 95814

From: **Department of General Services**
Executive Office

Subject: **RESPONSE TO BUREAU OF STATE AUDITS' REPORT NO. 2003-117– "CALIFORNIA DEPARTMENT OF CORRECTIONS: NEEDS TO BETTER ENSURE THAT IT OBTAINS MEDICAL SERVICES CONTRACTS THAT ARE IN THE STATE'S BEST INTEREST AND ITS PAYMENTS ARE ONLY FOR VALID MEDICAL CLAIMS"**

Thank you for the opportunity to respond to the Bureau of State Audits' (BSA) Report No. 2003-117 which addresses two recommendations to the Department of General Services (DGS). The recommendations pertain to state policies related to the procurement of medical care services. The following response addresses each of the recommendations.

OVERVIEW OF THE REPORT

The DGS has reviewed the findings, conclusions and recommendations presented in Report No. 2003-117. The DGS will take appropriate actions to address the recommendations.

In summary, based on its review of the California Department of Corrections (Corrections) medical care services contracting program, the BSA concluded that the DGS should reevaluate its long-standing policy of allowing most medical care services contracts to be awarded without seeking competitive bids. Currently, state policy (see Management Memo 03-10, Attachment D) exempts a number of categories of contracts including medical care services from state requirements related to advertising and competitive bidding. These categories are exempt based on a determination by the DGS that competitive bidding is not feasible.

As noted in the following response to the BSA's recommendations, the DGS will take the lead in convening a meeting of the various state agencies that currently use the medical care services competitive bidding exemption. In addition to Corrections, it is foreseen that this meeting will include such major users as the Departments of Health Services, Mental Health, Developmental Services, Youth Authority and Veterans Affairs. The meeting will include a discussion of the BSA's recommendations and the full exchange of ideas, potential impacts and solutions prior to the implementation of any new requirements for the procurement of medical care services. If deemed necessary, the DGS will promptly implement additional safeguards to ensure that the services are procured in the state's best interest.

It should be noted that the DGS takes very seriously its role in ensuring that, where feasible, competitive processes are used to procure the state's goods and services. Competition is one of the basic tenets of the state's procurement system. As noted by the BSA, the DGS has made great

strides in establishing processes that ensure competition. These strides are shown in a number of actions that have been taken over the last couple of years. For example, except for contracts exempted by statute or policy such as those for medical care services, the DGS has implemented a process that requires the completion of a non-competitively bid (NCB) contract justification form for non-competitive information technology (IT) and non-IT goods and services acquisitions of $5,000 or more. The form requires the approval of the department director and Agency Secretary or immediate next ranking official and, depending on dollar amount, the DGS director or designee. The NCB form requires thorough explanations to be provided on why the good or service requested is restricted to one supplier and how the proposed price was determined to be fair and reasonable. Further, the NCB process requires that a corrective action plan be provided for any submittals that resulted from a department not allowing sufficient time to complete the competitive acquisition process.

While the DGS has oversight responsibility for the state's contracting program and has implemented and is continuing to implement numerous administrative controls governing that program, each state agency is ultimately responsible and accountable for its own acquisitions. This includes ensuring the necessity of the goods and services, securing appropriate funding, writing the contract in a manner that protects the state's interests, obtaining required approvals and complying with laws and policies including those governing competitive bidding and the need to determine and justify that an offered price is fair and reasonable when competition is limited. This placement of responsibility with departments is a key ingredient in ensuring that the procurement process is streamlined to remove repetitive, resource intensive, costly and time consuming processes.

In administering its oversight responsibility, the DGS is continually striving to balance the appropriate level of control and oversight to ensure the quality and openness of the state's acquisition process with the need for departments to have effective and efficient methods of procuring goods and services. The necessity of obtaining an appropriate balance of control and oversight without unnecessarily restricting the acquisition process is particularly important during the state's current fiscal crisis. Since the effective and efficient use of competitive acquisition systems is a primary tool that is used by state government to reduce operating costs, the BSA's concern that it may not be in the state's best interest to exempt medical care services contracts from advertising and competitive bidding will be promptly reviewed and addressed.

The following response only addresses the recommendations that were presented to the DGS. In general, the actions recommended by the BSA have merit and will be promptly addressed.

RECOMMENDATIONS

CHAPTER 1

RECOMMENDATION # 1: ***To protect the State's interest when contracting for medical care services, General Services should consider removing its long-standing policy exemption that allows Corrections to award, without advertising or competitive bidding, medical care services contracts with physicians, medical groups, local community hospitals, 911 emergency ambulance services providers, and a single ambulance service provider serving a geographical area, for all future contracts.***

DGS RESPONSE # 1:

The DGS will reevaluate the need for the policy exemption that allows state agencies, including Corrections, to award, without advertising and competitive bidding, medical care services contracts. Although this exemption most likely resulted because of a determination that medical services providers such as physicians would typically not bid for state work, documentation is no longer available to support the department's decision-making process that occurred many years ago. Therefore, the DGS agrees that a determination needs to be made as to the validity of the exemption based on the current marketplace.

As part of the evaluation process, in the near future, the DGS will convene a meeting of the various state agencies that currently use the medical care services advertising and competitive bidding exemption. In addition to Corrections, it is foreseen that this meeting will include such major users as the Departments of Health Services, Mental Health, Developmental Services, Youth Authority and Veterans Affairs. This consultative process will allow for both a discussion of the BSA's recommendations and the exchange of ideas, potential impacts and solutions prior to the implementation of any new requirements for the procurement of medical care services.

RECOMMENDATION # 2: ***If General Services decides that it is not in the State's best interest to remove the long-standing policy exemption, it should prescribe the methods and criteria for Corrections to use in determining the reasonableness of contract costs as follows:***

- ***Require Corrections to undertake procedures similar to those required in the NCB process. Specifically, it should require Corrections to conduct a market survey and prepare a price analysis to demonstrate that the contract is in the State's best interest.***

- ***Require Corrections to obtain approval of its market survey and price analysis from its director before submitting this information along with its contract to General Services for approval.***

DGS RESPONSE # 2:

Based on the results of the previously discussed evaluation of the current policy to exempt medical care services contracts from advertising and competitive bidding, if deemed necessary, the DGS will strengthen existing contracting requirements to ensure that those services are procured in the state's best interest. As part of this process, the DGS will consider adding additional safeguards, such as those required in the NCB process, to ensure that contract costs are fair and reasonable.

CONCLUSION

The DGS is firmly committed to effectively and efficiently overseeing the state's contracting program. As part of its continuing efforts to improve this program, the DGS will take appropriate actions to address the issues presented in the report.

If you need further information or assistance on this issue, please call me at 376-5012.

(Signed by: Ron Joseph)

Ron Joseph, Interim Director
Department of General Services

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Agency's comments provided as text only.

Youth and Adult Correctional Agency
1515 K Street, Suite 520
Sacramento, CA 95814

March 23, 2004

Ms. Elaine Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for the opportunity to review and comment on the draft of your recent audit titled, "California Department of Corrections: *Needs to Better Ensure That It Obtains Medical Services Contracts That Are in the State's Best Interest and Its Payments Are Only For Valid Medical Claims."* We are forwarding the enclosed memorandum prepared by the California Department of Corrections (CDC) as our response to the draft audit.

In our efforts to continually improve all aspects of the CDC's health care services delivery system, we welcome the independent review and recommendations provided by the Bureau of State Audits. We look forward to providing you with periodic updates that document our continued efforts to improve our negotiation and contracting processes for medical services.

If you have any questions concerning our response, please contact me at 323-6001.

Continued success,

(Signed by: Roderick Q. Hickman)

RODERICK Q. HICKMAN
Secretary
Youth and Adult Correctional Agency

Enclosures

* California State Auditor's comments begin on page 79.

State of California Department of Corrections

Memorandum

Date: March 23, 2004

To: Roderick Q. Hickman
Secretary
Youth and Adult Correctional Agency
1515 K Street, Suite 520
Sacramento, CA 95814

Subject: **BUREAU OF STATE AUDITS' DRAFT REPORT "CALIFORNIA DEPARMENT OF CORRECTIONS: NEEDS TO BETTER ENSURE THAT IT OBTAINS MEDICAL SERVICES CONTRACTS THAT ARE IN THE STATE'S BEST INTEREST AND ITS PAYMENTS ARE ONLY FOR VALID MEDICAL CIAIMS"**

The California Department of Corrections (CDC) has reviewed the Bureau of State Audits' Report titled "California Department of Corrections: Needs to Better Ensure That It Obtains Medical Services Contracts That Are in the State's Best Interest and Its Payments Are Only For Valid Medical Claims."

The CDC wishes to express its appreciation for the time and effort of the auditors dedicated to this review. As the report points out, CDC has achieved contracted rates with some of its hospital providers that are equal to or below Medicare rates. The report further indicates that the CDC achieves cost efficiencies as a result of negotiating hospital per diem rates and physician fees. In addition, the report acknowledges CDC's successes in achieving competitive physician rates through the use of the established physicians' fee schedule.

The Department has also implemented several processes to reduce the number of late contracts. In 1991, contract processing time frames were established/published to ensure requests were submitted in sufficient time to obtain contract approval prior to commencement of services. In 1995 a contract renewal process was implemented to serve as a reminder and provide a simplified method for institutions to request renewal services. In 1998 the Semi-Annual Report Card Summary was created as a tool for management to assess the timeliness of contract request submittals.

The Department is committed to continually seeking additional methods to improve the timeliness and overall efficiencies of contract processing and providing ongoing training of institution and contract staff. The Department will continue its successful practices, as noted in the report, such as:

- Monitor prison registry expenditures
- Obtain hospital per diem rates
- Utilize CDC's established physicians' fee schedule rather than hourly rates
- Issue the Contract Report Card

As the report correctly points out, there are areas where CDC can improve its practices. We will continue to report our progress on the recommendations made by the Bureau of State Audits.

If you have any questions regarding the attached response, please call me at (916) 445-7688.

(Signed by: Ernest Van Sant for)

J. S. WOODFORD
Director

Attachment

RESPONSE TO THE BUREAU OF STATE AUDITS REPORT
CALIFORNIA DEPARTMENT OF CORRECTIONS:
NEEDS TO BETTER ENSURE THAT IT OBTAINS MEDICAL SERVICES CONTRACTS THAT ARE IN THE STATE'S BEST INTEREST AND ITS PAYMENTS ARE ONLY FOR VALID MEDICAL CLAIMS

To protect the State's interest when contracting for medical care services, General Services should consider removing its long-standing policy exemption that allows Corrections to award, without advertising or competitive bidding, medical care services contracts with physicians, medical groups, local community hospitals, 911 emergency ambulance services providers, and a single ambulance service provider serving a geographical area, for all future contracts.

If General Services decides that it is not in the State's best interest to remove the long-standing exemption policy, it should consider revising this policy exemption as follows:

- ***Require Corrections to undertake a market survey similar to the market survey required in the NCB process.***

- ***Require Corrections to obtain approval of its market survey from its Director before submitting the survey results along with its contract to General Services for approval.***

The California Department of Corrections (CDC) agrees that performing market surveys is beneficial as a prospective contracting approach. In fact, the CDC currently obtains the information required in the Non Competitive Bid (NCB) market survey, via its informal hospital solicitation process, and is developing procedures to extend this process to contracting for professional services and improve documentation of the negotiation efforts. Additionally, the CDC will coordinate with the Department of General Services (DGS) and other affected departments to determine if it is in the State's best interest to remove the policy exemption.

The CDC recognizes that the above finding is directed to DGS; however, the CDC has concerns with the recommendation that the DGS should consider removing the policy exemption that allows the CDC to award, without advertising or competitive bidding, medical care services contracts with physicians, medical groups, local community hospitals, 911 emergency ambulance services providers, and a single ambulance provider serving a geographical area, for all future contracts.

The need to keep confidential health care contract negotiations was realized by the Legislature in 1995 when the California Public Records Act was changed to include Government Code Section 6254.14. Government Code 6254.14 provides in part:

(a) Except as provided in Sections 6254 and 6254.7, nothing in this chapter shall be construed to require disclosure of records of the Department of Corrections that relate to health care services contract negotiations, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations, including, but

not limited to, records related to those negotiations such as meeting minutes, research, work product, theories, or strategy of the department, or its staff, or members of the California Medical Assistance Commission (CMAC), or its staff, who act in consultation with, or on behalf of, the department ….

This section further protects the disclosure of contract terms and rates for designated periods of time. Contained within Government Code Section 6254.14 is the Legislature's intent in passing the section:

> It is the intent of the Legislature that confidentiality of health care provider contracts, and of the contracting process as provided in this subdivision, is intended to protect the competitive nature of the negotiation process…

A review of Assembly Bill 1177's history sets forth in more detail the purpose for enacting Government Code Section 6254.14. In short, without this statute, future health care negotiations would be compromised since hospitals would request rates from current contracting hospitals to use as benchmarks for structuring proposals. Such rate information sets a "floor" for rate proposals. If rates are confidential, hospitals must construct their best offer, based on their own cost structure, not based on what competitors are bidding. Without confidentiality, the CDC would not be as effective in securing favorable hospital rates. This confidentiality protection is also provided to other procurers of medical services such as the Managed Risk Medical Insurance Program and the CMAC. The current requirements for formal competitive bidding under the State Contracting Manual call for public disclosure of bid proposals at the time of the bid opening, subjecting the rates and other contract terms not only to public review but making this information available to other competitors. Eliminating the exemption and opening medical services contracts to the competitive bidding process would be contrary to the current Government Code and the Legislature's intent in enacting that Code, and would negatively impact CDC's ability to obtain favorable future contract rates.

An additional example is anesthesiology. Anesthesia providers are assigned by the hospital to provide services on a rotational basis. Only providers who have been granted privileges at a specific hospital are allowed to deliver anesthesia services in the hospital's operating rooms. Consequently, because multiple physicians are providing the same service at the same location, the NCB process does not apply, nor would the bid process apply.

The CDC is under Federal Court orders in *Coleman, Madrid,* and *Plata* to provide appropriate and timely access to medical care. The policy exemption allows the Department to meet the Federal Court mandates of appropriate and timely access to medical care, implement contracts to allow payment for emergency medical care, and protect the confidentiality of contract rates and terms to avoid compromising future negotiations. The length of time required to conduct a competitive bid and to adequately address procedural issues such as bidder's protests, as well as the unpredictability of the nature of required medical services, (e.g., specialty services, unplanned replacement of existing providers, emergency augmentation of services, etc.) would put the CDC at risk of not delivering necessary services in a timely manner. The inability to expeditiously enter into contracts for essential medical care for CDC inmates would only expose the State to additional litigation and possibly place the State in contempt of court orders. Any changes to the policy exemption could require Federal Court approval to ensure that there are no lapses in services as required under the court orders.

Work with the Office of Statewide Health Planning and Development to obtain hospital charge masters and use this information to negotiate contract rates.

The CDC agrees with the recommendation as stated above. Assembly Bill 1627 for the 2003-04 Legislative Session, Chaptered as Article 11 (commencing with Section 1339.50), Chapter 2, Division 2 of the Health and Safety Code, effective July 1, 2004, requires each hospital in California to provide a copy of its charge description master to the Office of Statewide Health Planning and Development (OSHPD). Historically, most hospitals have refused to make their charge description master a public document or provide the HCSD with a copy. Effective July 1, 2004, Health Care Services Division (HCSD) will, as part of the standard health care contract boilerplates, require hospitals to provide HCSD a copy of their charge description master each time it is updated. Further, HCSD will require every hospital to provide a copy of its current charge description master when responding to a solicitation. In addition, HCSD will meet with the OSHPD to obtain any outstanding hospital charge description masters. The HCSD will report the status of obtaining hospital charge description masters from its contracted hospitals in the Six-Month Status Report.

Ensure that HCSD enforces rate exemption requirements, including obtaining and reviewing documentation to verify prisons' justification for higher rates.

The CDC agrees with the recommendation as stated above. In anticipation of a new rate approval process, the HCSD is currently reviewing all medical contract rates to determine if they meet the rate exemption requirements. The Health Contracts Unit (HCU) analysts are providing written documentation and analysis for approval by the Assistant Deputy Director, Resource Management and Administrative Support Branch. This documentation includes the necessity of the contract, negotiations communication (including contract language issues and appropriateness of the rates), comparisons with other contracts statewide, and review of utilization data and projected costs. A new rate approval process is being developed to replace the current Request for Medical Rate Exemption process that will mandate that all rates for exempt contracts be reviewed for reasonability.

Establish procedures to ensure that the rate exemptions initiated by HCSD undergo an independent review at a higher-level approval process.

Currently, the CDC has procedures in place to ensure a high level approval of HCSD contract rates. Rate exemptions initiated by HCSD are evaluated by the HCU, reviewed by the appropriate Regional Administrator, and require approval by the Assistant Deputy Director, Resource Management and Administrative Support Branch. Additionally, complex hospital rates negotiated by the HCU are reviewed and approved by the Deputy Director, HCSD. The HCSD is reviewing the recommendation as stated above to determine if a higher level review would add value to the rate approval process. The HCSD will report its findings in the 60-Day Status Report.

Adopt procedures that require staff to consider utilization data when negotiating medical services contracts. These procedures should also require staff to document the use of these data in the contract file.

The CDC concurs with the recommendation as stated above. A new rate approval process is being developed to replace the current Request for Medical Rate Exemption process that will mandate that all rates for all exempt contracts be reviewed for reasonability. Part of this new process will

include requirements for requesting, interpreting, and including cost and utilization data within the rate review. The HCSD will report its progress in the 60-Day Status Report.

Ensure that HCSD seeks and offers specialized training for its negotiation staff so they can effectively negotiate favorable rates. Additionally, HCSD should then share any strategies and techniques with the prison negotiation staff.

The CDC concurs with the recommendation as stated above. The CDC has pursued consulting with other State agencies. We have also received a presentation from an independent consultant on hospital contract negotiation techniques and are exploring additional consultant options. Furthermore, we are currently investigating the possibility of obtaining training or other contracting assistance from the California Public Employees Retirement System.

Although the CMAC indicated that they would be unable to provide direct assistance in contract negotiations, we continue to consult with the Commission whenever our areas of jurisdiction overlap.

The CDC appreciates BSA's acknowledgement that their "sample results indicate that overall Corrections was able to negotiate rates that were slightly below Medicare's rates."

In addition to the efforts noted above, the HCSD plans to arrange for two training classes at the State Training Center for each contract analyst: 1) Negotiation Skills Workshop, and 2) Cost-Benefit Analysis Workshop. In addition, when the HCU employs new analysts, those analysts will be required to attend those same classes, as well as the Developing Analytical Skills class. In addition, and as discussed in the BSA Report, the HCSD has been exploring a consultant contract to provide specific negotiations and analytical training for HCU analysts. The HCSD will report its progress in the 60-Day Status Report.

Ensure that HCSD tries to obtain per diem rates as a compensation method when negotiating hospital contracts. Additionally, HCSD should document its attempts to obtain per diem rates.

The CDC agrees with the recommendation as stated above and will continue to secure per diem rates to the extent possible. The CDC also appreciates BSA's acknowledgement that "comparison of Corrections" rates to the Federal Medicare Program (Medicare) rates and actual hospital charges reveals that in some instances Corrections' method of payments yields lower costs to the State. Currently, approximately 73 percent of the total hospital expenditures are incurred from services provided by preferred or rate protected providers. The HCSD defines a preferred or rate-protected provider as one that offers rate protection in the form of per diem and case rates. The major obstacle in obtaining this type of structure for the other 27 percent of hospital expenditures is the fact that most of the hospitals only offer rate protection if there is sufficient volume. Many of these nonpreferred or nonrate protected providers are used primarily for emergency or very specialized one-time services. In addition, many of the providers within the respective counties' Emergency Medical Systems have rates set by the counties, from which they will not deviate.

Direct ICS to evaluate late requests using the criteria outlined in the policy memo. Additionally, ICS should request HCSD and the prisons to provide relevant documentation to support their request.

The ICS is in compliance with the recommendation as stated above and evaluates each request utilizing all of the established criteria and to ensure the request justifies why approval is in the best interest of the State as well as the contractor. Institutions and HCSD must document on each request (1) the reason for the late request, (2) the extenuating circumstances, (3) the adverse impact if denied, and (4) measures that will be taken to prevent future occurrences. In most cases, late requests are for services that were unpreventable, unforeseen and/or beyond the CDC's control, such as, critical medical services to inmate/patients. For those situations, approval may also be further supported based on the fact that the contractor provided services in good faith and is entitled to payment without further delays by seeking payment through a Board of Control claim. It is also in the State's best interest to avoid incurring late payment fees for authorized services. In order to ensure the late request policy is strictly adhered to by the institutions, ICS will elevate to the Deputy Director/Regional Administrator level for appropriate action if an institution has a high number of late requests that appear to be preventable.

Continue generating report cards periodically and establish procedures for staff such as prisons' associate wardens to submit corrective action plans to OCS to monitor.

The CDC agrees with the recommendation as stated above and will continue to generate a Semi-Annual Report Card Summary and Detail for Late Contracts (Report Card) and distribute the report to Chief Deputy Directors, Deputy Directors, Assistant Directors, Institution Regional Administrators and Wardens. The OCS will also work with the HCSD and institutions to develop a process to ensure that the Report Card is utilized by management as an effective tool to reduce late requests whenever possible. The OCS and HCSD will report their progress in the 60-Day Status Report.

Ensure that ICS staff review the master contract and outstanding NTPs before issuing additional NTPs so that it does not exceed the master contract amount.

The CDC agrees with the recommendation as stated above and has taken the necessary steps to prevent future occurrences. The ICS' current master contract procedures require contract analysts and managers to ensure that sufficient funding is available in the master contract prior to processing Notices to Proceed (NTP) associated with the master contract. When the errors were discovered, ICS reiterated the procedural requirement in a staff meeting in mid-September 2003 and issued a subsequent e-mail to all managers in February 2004 implementing a new requirement for managers to review the master contract file in addition to the current procedure of reviewing the hierarchy report to ensure sufficient funding levels are available prior to approving NTPs. The ICS has processed amendments to the masters and/or NTPs to remedy the deficiencies in the four contracts and are now in compliance with the requirement.

Evaluate its contract processing system to identify ways for HCSD, ICS and prisons to eliminate delays in processing contracts and avoid allowing contractors to begin work prior to the approval of the contract.

The CDC agrees with the recommendation as stated above. OCS will work together with the HCSD and the institutions to develop additional methods to reduce the number of late contracts. The Office of Contract Services (OCS) and HCSD will report its progress in the 60-Day Status Report

In should be noted that the OCS has taken several proactive steps to assist programs/institutions in meeting this requirement. The OCS has established internal time frames for submitting requests that will allow sufficient lead time to ensure contract approval before the requested start date of services. While these time frames have been established since 1991, this information has also been published on the Department's intranet since January 1999.

In addition to the previously mentioned Late Submittal Justification Request requirements and the issuance of the semi-annual Report Card, the OCS has also simplified the contract renewal request process to reduce the amount of late contract requests received. In 1995, the OCS developed a one page Contract Renewal Request (CRR) form to be used in place of a lengthy contract request form when requesting renewal services. The CRR is generated by the contract database and includes all pertinent information relating to the contracted services as needed by programs/ institutions to determine whether to renew or not. The CRRs are mailed to the programs/institutions 30 days prior to being due in ICS. The programs/institutions are only required to check a box that indicates, "renew" or "do not renew" and to update program/institution contact information and funding information. The CRRs require the signature of the Associate Warden, Business Services and/or the Health Care Manager/Chief Medical Officer.

The OCS also provides annual training to programs/institutions that addresses the CRR, Report Card and Late Submittal Justification processes and stresses the importance of proper contract monitoring and timely submission to avoid late contracts.

Modify its procedures to require prisons to submit documentation to ICS demonstrating their attempts to obtain services from registry contractors with their requests for services from a non-registry contractor.

The CDC agrees with the recommendation as stated above and is currently modifying its procedures. ICS currently requires institutions to submit a written certification that they have attempted but were unable to obtain services from a registry contractor. As a result of the audit recommendation, ICS is revising its current process to require institutions and/or HCSD to submit a copy of a phone contact log or fax notification as documentation that attempts were made to obtain services through the registry contract. The ICS will only initiate additional contracts upon receipt of the appropriate documentation. The ICS will be issuing a memorandum to the institutions and HCSD outlining the process, inclusive of sample tools to be used for documenting contacts. The ICS staff and managers will be trained on the new process upon completion and implementation that is anticipated to occur in April 2004. The ICS will report its progress in the 60-Day Status Report.

Direct ICS to review prisons' documentation and ensure that prisons have made sufficient attempts to obtain services from registry contractors. Additionally, it should direct ICS to use these data to identify trends of nonperformance and terminate registry providers, when necessary.

The CDC agrees with the recommendation as stated above. Upon implementation of the above-mentioned process, ICS will review the submitted documentation to ensure that the contacts made by the institutions were in accordance with the registry contract terms and conditions. If multiple institutions are routinely denied services by a contractor, ICS, the institution and HCSD will collectively make a determination if it is in the best interest of the State to terminate the contractor.

To rein in costs associated with the use of registry contracts, Corrections should:

Continue to monitor prisons' registry expenditures on a monthly basis and evaluate their need for services.

The CDC concurs with this recommendation. Several years ago, the Fiscal Management Unit of HCSD developed a Registry versus Vacancy Report that is updated on a monthly basis. This report is utilized in the CDC quarterly fiscal review process to evaluate the usage of registry in comparison with vacant positions. The reports will be provided to the HCSD Regional Administrators and Health Care Managers on a monthly basis for appropriate action.

To improve its efforts to provide only medically necessary services and contain medical services costs, Corrections should do the following:

Ensure that the UM nurses adhere to the UM guidelines requiring them to perform and retain documentation of their perspective and concurrent reviews.

The CDC concurs with this recommendation. As part of the Quality Management System, on December 18, 2003, HCSD conducted a mandatory statewide videoconference training titled: Inmate Medical Services Program Implementation – Utilization Management (UM) Program Policy and Procedure Training. Within 30 days of the completion of the standardized UM Program training, staff at the prisons were instructed to develop a corresponding operating procedure to operationalize the UM Program policy and procedure at each institution. The goal of the course was to provide information regarding effectively performing UM and included the UM review process, focus and selected scope, UM reviewer responsibilities, UM review guideline criteria, standardized UM forms, and UM reporting documents. In addition, the newly implemented UM database will capture all requests for service and required focus area documentation. This includes using prospective, concurrent, and/or retrospective reviews of the following target categories:

- Bed Management
- Medication Management
- Scheduled Specialty Services
- Emergency Care

Clarify and update the UM guidelines for performing retrospective reviews.

The CDC concurs with this recommendation. To promote a standardized percentage of review, direction was given to the field UM Nurses to perform 100 percent retrospective review on all noncontract providers and 10 percent intensive review, via random selection, to all contracted facility providers. Again, primary interest on prospective and concurrent review was emphasized to determine that services being requested were medically appropriate and delivered in the most cost-effective manner. Prospective and concurrent review improves the value of service by assuring the services being provided are appropriate and medically necessary, thereby reducing potential invoice adjustments.

The HCSD continues to review their retrospective review processes and has taken great efforts toward providing and reviewing services in a consistent and quality manner. The UM Program currently does not have the resources to perform 100 percent retrospective review, nor is that the community standard; however, we are exploring alternative options for this critical issue.

The BSA Draft Report presumes the original mission was for UM retrospective review to occur 100 percent of the time and that UM reduced it to 10 percent. In actuality, the original 1996 UM Plan (page 8) states: The first level reviewer shall develop, with the Health Care Cost Utilization Program (HCCUP) Analyst, a process to review selected billings for completeness and technical accuracy. The updated 1999 UM Guidelines (page 32) states that review of charges will occur in 100 percent of inpatient and outpatient cases. It also states that retrospective review is a cooperative effort between many parties. The intent was that 100 percent of all invoices would be processed in the same manner, not necessarily that the UM Nurse would perform an in-depth review of 100 percent of all invoices. The UM duty statement only allows 15 percent of time toward retrospective review which is not enough for review of 100 percent of all invoices.

Direct HCSD to establish a quality control process that includes monthly reviews of a sample of the invoices processed by the prisons' HCCUP analysts.

The CDC concurs with this recommendation. However, over the last year, the HCCUP has undergone a serious staffing shortage due to staff turnover and Workers' Compensation cases. This shortage has significantly impacted the program to the extent that the HCCUP has become substantially backlogged in the field, where review and processing of invoices occurs. In order to mitigate this problem, headquarters' staff has been utilized to assist in addressing the backlog. However, this has prevented HCCUP from performing statewide oversight functions normally completed by headquarters staff. In response to this problem, the HCCUP has requested and received a freeze exemption, which allows the program to fill all of its vacancies and hire behind staff that are out on Workers' Compensation. The HCCUP is currently in the process of filling its vacancies and when the positions are filled, the program will be in a better position to evaluate the implementation of a quality control process. The CDC will report on the progress of this recommendation in the Six-Month Status Report.

Direct HCSD to establish a quality control process that includes monthly reviews of a sample of prospective and concurrent reviews performed by the prisons.

The CDC concurs with this recommendation. Review and development of this area is pending. Development of a formal procedure will be included in the 60-Day Status Report.

Ensure that prisons recover any overpayments that have been made to providers from medical services charges. Similarly, prisons should rectify any underpayments that have been made to providers.

The CDC concurs with this recommendation. The CDC follows the State Administrative Manual guidelines for the recovery of overpayments. The HCSD will be working with the Regional Accounting Offices to explore alternatives for identifying and recovering overpayments. The HCSD will report on its progress in the 60-Day Status Report.

Evaluate its payment process to identify weaknesses that prevent it from complying with the California Prompt Payment Act.

The CDC concurs with this recommendation. The HCSD will be working with the Regional Accounting Office to explore alternatives to accomplish this recommendation and will report on its findings in the 60-Day Status Report.

OTHER ISSUES

Table 2 represents the results of the amounts Corrections paid for hospital charges shown on 53 hospital invoices. It also shows the results of our comparison of the Medicare rates to the amounts Corrections paid and the hospital charges. We have some concerns regarding the information contained in Table 2:

Government Code 6254.14 (a) provides that except as provided in Sections 6254 and 6254.7, nothing in this chapter shall be construed to require disclosure of records of the Department of Corrections that relate to health care services contract negotiations, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations, including, but not limited to, records related to those negotiations such as meeting minutes, research, work product, theories, or strategy of the department, or its staff, or members of the California Medical Assistance Commission, or its staff, who act in consultation with, or on behalf of, the department. The information, as presented, would allow the public to "back into the CDC rates." Therefore, we recommend that Table 2 be modified to refer to the hospitals as A, B, C, etc.

COMMENTS

California State Auditor's Comments on the Response From the Youth and Adult Correctional Agency and the California Department of Corrections

To provide clarity and perspective, we are commenting on the California Department of Corrections' (Corrections) response to our audit. The numbers below correspond to the numbers we have placed in its response.

- Corrections is mischaracterizing the results shown in the table on page 28 of our report. Specifically, the table shows that overall Corrections was able to negotiate rates that were 90 percent of the federal Medicare program's rate; however, six of the nine hospital providers had rates that were greater than Medicare's rates. Additionally, on page 27, we state that Corrections can generally generate greater savings when it is able to negotiate per diem rates. However, Corrections does not require hospitals to conform to a specified compensation method. Consequently, on page 40, we recommended that Corrections ensure that it tries to obtain per diem rates as a compensation method when negotiating hospital contracts. Finally, on page 29, we state clearly that our comparison is informational only, not meant to suggest that Corrections' negotiations will always result in rates that are lower than Medicare rates.

- Although Corrections has implemented several processes to reduce the number of late contracts, its prisons and Health Care Service Division (HCSD) do not submit their medical service contracts to its Office of Contract Services' Institution Contracts Section (ICS) within the established lead times. Specifically, as discussed on pages 32 through 34, Corrections' policy memo states that with the exception of emergency services defined by state law, protests and rebids associated with the request for proposal process, or situations resulting from unusual circumstances beyond its control, there should be no late submittal of contracts or amendments. According to ICS, all of the 14 late requests we reviewed met the policy memo criteria. However, we found five of the 14 late requests that did not appear to meet the criteria. Additionally, although

the semi-annual report card summary was created as a tool for management to assess the timeliness of contract or amendment requests, ICS does not use the report card to enforce compliance with the policy memo.

- Corrections' assertion that it currently obtains the information required in the noncompetitively bid (NCB) procurement process market survey via its informal hospital solicitation process is inconsistent with statements made by its HCSD staff and our review of 10 of 12 contract files for hospital providers. Specifically, on September 13, 2003, and March 29, 2004, HCSD staff told us that they had not solicited bids from other hospitals before entering into contracts with 10 hospital providers because either the hospitals were the only choice for a certain specialty or the hospital was located within the exclusive operating area designated by the local emergency medical service agency for ambulance service providers.

- The Bureau of State Audits' recommendations on page 39 regarding the removal of the long-standing policy exemption are directed toward the Department of General Services (General Services). On page 64, General Services states that it will reevaluate the need for the policy exemption and as part of its evaluation will convene a meeting of the various state agencies that use the exemption.

- Corrections' assertion that disclosure of hospital rates would create a "floor" during negotiations appears to be without merit. Specifically, as previously discussed, we found that HCSD staff do not routinely solicit bids before entering into contracts with hospital providers because either the hospitals were the only choice for a certain specialty or the hospital was located within the exclusive operating area designated by the local emergency medical service agency for ambulance service providers. Additionally, Corrections' concern regarding the confidentiality of its hospital contracts focuses on the competitive bidding process. However, if General Services decides that it is in the State's best interest to remove the long-standing policy exemption, Corrections also has the option of using the NCB process. Under the NCB process, it appears that both of the reasons Corrections cites would be sufficient to justify its use of the hospital provider. Moreover, the State would have more assurance that its interest is protected because Corrections would have to complete a price analysis and obtain higher-level approvals. Finally, as stated on pages 9 and 18, state law

allows Corrections to enter into emergency contracts without competitive bidding when a medical emergency arises that indicates a threat to the delivery of health care to inmates.

- We believe that Corrections has the ability to address this issue when it enters into contracts with hospital providers. Specifically, our review of contracts and invoices for 12 hospitals found that half of the hospitals billed Corrections directly on behalf of physicians who provide services at their facilities. Thus, as part of its contract terms, Corrections could require all hospitals that it contracts with to include rates for the physicians who provide services at their facilities.

- Corrections is incorrect. Corrections was unable to provide us with written procedures to address those instances when HCSD initiates a rate exemption. Instead, as stated on page 23, Corrections told us that its analysts essentially apply the same standards that prisons must follow and require the signature of the assistant deputy director. Yet, we found four instances where HCSD could not provide an analysis to justify its approval of higher rates, including one instance where the provider's hourly clinic rate resulted in payments that were 182 percent greater than Corrections' standard rate. Thus, as stated on page 40, we recommend that Corrections establish procedures to ensure the rate exemptions initiated by HCSD undergo an independent review and higher-level approval process.

- Corrections fails to mention that on page 29, we state clearly that our comparison is informational only, not meant to suggest that Corrections' negotiations will always result in rates that are lower than Medicare rates.

- Corrections is overstating the percent of hospital expenditures relating to providers that offer rate protection in the form of per diem or case rates. Our review of Corrections' analysis found that five hospitals it identified as having per diem or case rates actually had rates that were based on a flat discount off the total charges. Additionally, the contract terms for many of the remaining hospitals Corrections identified as having per diem or case rates also had other compensation methods. Thus, it would be inaccurate for Corrections to count all of these hospitals' expenditures as being incurred from services based on per diem or case rates.

- Corrections is incorrect in stating that ICS is in compliance with our recommendation. As discussed on pages 32 through 34, Corrections policy memo states that with the exception of emergency services defined by state law, protests and rebids associated with the request for proposal process, or situations resulting from unusual circumstances beyond its control, there should be no late submittal of contracts or amendments. According to ICS, all of the 14 late requests we reviewed met the policy memo criteria. However, we found five of the 14 late requests that did not appear to be unusual circumstances beyond Corrections' control and could have been avoided with proper planning.

- Corrections' statement that our report presumes the original mission was for utilization management (UM) retrospective reviews to occur 100 percent of the time and that UM reduced it to 10 percent is incorrect. Rather, our understanding of its UM program is based on Corrections' 1999 UM guidelines and notes from several regional UM nurse meetings HCSD held in 2000 that we discuss on pages 47 through 50. The "intent" that Corrections now asserts is not reflected in its UM guidelines and the resulting confusion concerning retrospective reviews is reflected in the reports from 21 prisons that show UM nurses review anywhere from zero to 100 percent of varying types of invoices for medical service charges.

- To address Corrections' concerns, we removed the hospital names from the table on page 28 and replaced the names with the letters A through I.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press