CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION

Review Report

HEALTHCARE DELIVERY SYSTEM

STEVE WESTLY
California State Controller

August 2006

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California State Controller

August 2, 2006

Robert Sillen, Receiver
California Prison Receivership
1731 Technology Drive, Suite 700
San Jose, CA 95110

Dear Mr. Sillen:

Enclosed is the State Controller's Office (SCO) report of its fiscal review of the California Department of Corrections and Rehabilitation's (CDCR) inmate healthcare delivery system, now under your receivership.

My office conducted this review to ensure that CDCR healthcare expenditures are legal, necessary, reasonable, and made for valid goods purchased or services performed. During this review, the SCO focused primarily on the department's expenditures for medical services provided by outside contractors, such as hospitals, specialty-care physicians, and laboratories. In recent years, the department has increasingly relied upon outside contractors to provide a broad array of healthcare services to inmates. According to the CDCR's accounting records, expenditures for contracted services increased from $153 million in fiscal year (FY) 2000-01 to a projected $821 million in FY 2005-06, an increase of $668 million, or 437%.

My office found evidence strongly suggesting that waste, abuse, and management deficiencies are rampant in the department's expenditures and oversight of contracted healthcare services. In addition, despite previous audit recommendations by the Office of the Inspector General and the Bureau of State Audits, the CDCR has not implemented appropriate control measures to provide oversight over contract expenditures.

I hope that this review will be of assistance to you as you institute reforms to this very important program.

Should you have questions, please contact Jeffrey V. Brownfield, Chief, Division of Audits, at (916) 324-1696.

Sincerely,

/s/

STEVE WESTLY
State Controller

cc: James Tilton, Acting Secretary
Department of Corrections and Rehabilitation

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Review Report

Summary of Findings

In April 2006, the State Controller's Office (SCO) initiated a fiscal review of the California Department of Corrections and Rehabilitation's (CDCR) budget and spending practices for its healthcare delivery system. Expenditures increased from $676 million in FY 2000-01 to $1.05 billion in FY 2004-05, an increase of $377 million (56%). The CDCR, in February 2006, projected another $198 million increase in inmate healthcare expenditures, bringing the estimated total to $1.25 billion for FY 2005-06. Between February 28, 2006, and April 30, 2006, the department's accounting records reflected another increase in expenditure projection of $230 million, for a total of $1.48 billion. Despite significant increases in State spending, concerns continue to exist over the adequacy of medical care being provided to inmates. These concerns have led to lawsuits alleging substandard medical care and eventually resulted in the unprecedented appointment of a federal receiver to assume total control of the CDCR's inmate healthcare delivery system.

In February 2006, a federal court-appointed Correctional Expert found, among other things, millions of dollars in unpaid bills, some of which have been outstanding for as long as four years. In addition, some of the invoices could not be paid because services were performed without contracts. Such conditions raised further questions over the integrity and soundness of the CDCR's spending practices.

The SCO initiated this fiscal review to ensure that CDCR healthcare expenditures are legal, necessary, reasonable, and for valid goods purchased or services performed. Contracted services with outside hospitals, physicians, and other private healthcare providers accounted for all of the increases in inmate healthcare expenditures from fiscal year (FY) 2000-01 to FY 2005-06. This review therefore primarily focuses on CDCR's system of internal controls governing the processes and procedures for procuring and awarding its medical service contracts and payments for services.

Following is a summary of the SCO's findings.

Finding 1—The CDCR has not developed a comprehensive system-wide policy to manage its medical service contracts. Consequently, the department's contract management efforts are fragmented and inadequate to provide proper oversight over contract payments.

When State prisons' staff members find evidence suggesting that contractors may be engaging in abusive contract practices, such matters are not always properly and promptly addressed. For example, a State prison manager found that a contractor inflated its billings by over 28% by supplying the CDCR with an inaccurate, or possibly false, subcontractor's rate schedule. The prison staff adjusted the contractor's billings and brought the matter of contract overcharge to the attention of her counterpart at another State prison that also utilizes the contractor's services. The staff at the other prison has yet to take action to adjust the contractor's invoices and continues to pay the contractor at inflated rates.

Under a regionwide contract, this contractor is providing services to six other State prisons, which apparently are also paying the inflated rates. If the contractor's billing practices are consistent at all State prisons, then the contractor has overcharged the CDCR by an estimated $418,000 during the first 10 months of FY 2005-06. Moreover, despite being made aware of this issue and other contract performance concerns, CDCR headquarters has failed to take action for approximately three years and has issued a new contract to the same contractor effective July 1, 2006.

Finding 2—The CDCR's contract negotiation process is deficient, resulting in the prison system continuing to pay significantly more for medical services than other major purchasers of healthcare services.

The SCO found that CDCR continues to pay more than other major purchasers of healthcare services for the same inpatient and outpatient services. For example, in a prior audit, the Bureau of State Audits (BSA) found that CDCR was paying a hospital 4.16 times what Medicare would pay for the same inpatient care. The contract was renegotiated at the CDCR's request. However, under the old contract, the department on average paid the hospital $2,789 per day. Under the new contract, the CDCR is paying an average of $3,994 per day, or 43.2% more.

Given the nature of the patient population and the locations of many of the institutions, the CDCR is in a poor bargaining position to negotiate favorable rates with hospitals, medical groups, and other medical professionals. The DGS Management Memo 05-04 requiring competitive bidding and the chaos and confusion that followed the release of the memo, further hampered the CDCR's contract negotiation efforts. However, the SCO found that the CDCR compounded its difficulties by failing to properly use available information and practices to minimize the State's healthcare costs.

Finding 3—Despite a previous audit recommendation to the contrary, the CDCR's contracts continue to pay hospitals based on a percentage of the hospital's billed charges, which leads to overpayments or billing abuses.

BSA's July 2004 report recommended that the CDCR consider negotiating contract terms based on hospital costs rather than on hospital charges for outpatient services, pharmaceuticals, and supplies. The CDCR's contracts continue to stipulate that the department shall pay the hospitals based on a percentage of the hospital's billed charges, which in turn has led to overpayments or billing abuses. For example, the CDCR paid a hospital $12,379.50 (billed charges totaling $40,255 @ 30%) for drugs provided to an inmate with cancer. The SCO's analysis of the Medi-Cal Program formulary files found that Medi-Cal would pay only $300 to $400 for the same drugs.

Finding 4—An opportunity for significant State savings has been delayed for years due to protests and objections raised by a contractor who is financially benefitting from the delay.

The CDCR currently has about 150 inmates who need dialysis treatment. Most of these inmates are transported outside the institutions three times a week for dialysis treatment. Each treatment costs, on average, more than $400 plus the costs for inmate transportation and custody while outside of the prisons. After years of deliberation, the CDCR, in August 2003, initiated a process to solicit competitive bids for contractors to perform dialysis services on-site at the State prisons. One provider, who provides the dialysis treatments under a statewide contract issued on a sole-source basis, was awarded the new contract to begin an on-site treatment program at two of three State prisons. As this provider is currently providing dialysis treatments off-site at substantially higher rates than it will be able to charge under the new contract awarded by the competitive bid process, there is little financial incentive to implement the on-site dialysis program expeditiously. Even though the contract was executed on November 15, 2005, the program is still not operational as of July 2006.

Finding 5—At least two of the four prison acute-care hospitals are functioning at a fraction of their capacity, resulting in increased costs of contracted services and the need for outside hospital services.

At considerable expense, the CDCR built four acute-care hospitals. The SCO auditors visited two of the four hospitals and found both to be functioning at a fraction of their capacity. The department has encountered difficulties in recruiting and retaining qualified medical personnel to staff the various hospital functions. The problem is compounded by the fact that the hospitals do not have adequate equipment, supplies, and support services such as anesthesia service for their surgery rooms. In addition, decisions made by CDCR management also severely curtail inpatient and outpatient services performed at the prison hospitals. All but seven acute-care beds at one prison hospital have been de-commissioned, while over 90% of the acute-care beds at another prison hospital are being used by inmates with long-term needs. Major surgeries performed at one prison hospital declined from 291 cases in 2000 to eight in 2004 and eight in 2005. At the other prison hospital, only one of the two operating rooms is functioning, at a very limited capacity. The other operating room has not been functional since the hospital was built in 1993 due to a lack of proper equipment, supplies, and inadequate staffing. Therefore, instead of treating inmates from other State prisons, as they were designed to do, the two hospitals are sending their own prison patients to outside hospitals at significantly higher costs, sometimes for minor surgeries.

Finding 6—CDCR's utilization management process is ineffective in ensuring that services are necessary and consistent with prescribed guidelines or that contractors' charges are appropriate.

The utilization management (UM) nurses at the CDCR are the first-level reviewers of requests for services. Their function is to ensure contractors' compliance with prescribed guidelines and review contractors' invoices to verify that charges are appropriate for services performed. Some UM nurses informed SCO auditors that they never received any training concerning review guidelines, protocols, and procedures, and that their heavy workloads limit the scope of their reviews. The UM nurses also said that they are often reluctant to question the judgment and decisions of outside specialists, despite the fact that the specialists may have financial incentives to make referrals. In some cases, the State prison's management circumvented the utilization review process. Therefore, the UM nurses' review and monitor efforts are not always effective. For example, after a significant increase in the contracted rates, one hospital's in-patient days increased from 2,111 days in FY 2004-05 to 2,928 days for the first 11 months of FY 2005-06, an increase of 38.7% in utilization. Total hospital expenditures were expected to increase from $2,712,831 in FY 2004-05 to a projected $8,097,468 in FY 2005-06, an increase of 298%. The SCO selected a limited sample of in-patient cases for review and found evidence suggesting that some hospital stays were not necessary. For example, a UM nurse's review note shows that an inmate did not meet the criteria for hospital stay. Without explanation, the inmate was hospitalized for three days at a cost of $10,200 or $3,400 per day.

Finding 7—Some decisions regarding medical treatment are made based on legal considerations rather than on what is medically necessary and appropriate.

Some medical staff members at the State prisons believe that inmates are prone to file lawsuits that could, regardless of the outcome of the cases, blemish their records. Therefore, they sometimes make referrals knowing that the cases do not need to be referred to an outside facility. In addition, prison management is sometimes reluctant to authorize in-house services after weighing the potential fiscal impact of lawsuits against questions about the competency of the prison's medical staff and the adequacy of prison facilities and equipment. Making patient treatment decisions based on legal considerations rather than medical necessity could significantly increase the costs of inmate healthcare.

Finding 8—Internal control at State prisons is ineffective to identify and prevent overpayments or billing abuses.

Many Health Care Cost and Utilization (HCCUP) analysts interviewed told SCO auditors they have had little or no training on the criteria to review contractors' charges. Also, some HCCUP analysts said their heavy workloads precluded them from thoroughly reviewing the contractors' charges. In some cases in which the HCCUP analyst identified practices suggesting possible overcharge, the contractors were paid anyway due to the ambiguity in contract terms. In addition, some HCCUP analysts said they cannot determine the reasonableness of the

hospitals' charges when the hospitals are reimbursed based on a percentage of the amount billed. As a result, contractors have inflated their charges by billing at a higher level for services than what they should have charged. For example, one urologist was paid more than $2,000 per hour, apparently by billing on a per-patient basis using billing codes for one hour of consultation, when in actuality he spent much less time with the patients. Also, the SCO found that some contractors billed based on a per-patient basis when the contract terms specify reimbursement at hourly rates, resulting in much higher charges.

Introduction

In April 2006, the State Controller's Office (SCO) initiated a fiscal review of the California Department of Corrections and Rehabilitation's (CDCR) budget and spending practices for its healthcare delivery system. At the time the audit was initiated, the total inmate population was approximately 170,000; this number represented an increase of 10,000, or 6% over the approximately 160,000 inmates in FY 2000-01. During the same period, inmate healthcare expenditures increased significantly, from $676 million in FY 2000-01 to $1.05 billion in FY 2004-05, an increase of $384 million (57%). Moreover, the CDCR projected another $198 million increase in inmate healthcare expenditures, bringing the estimated total to $1.25 billion for FY 2005-06, a total increase of $584 million, or 86%. On a per capita basis, the average annual cost for each inmate increased from $4,225 in FY 2000-01 to $7,412 (projected amount) in FY 2005-06, a total increase of $584 million, or 86%. A summary of the department's inmate healthcare budget, as prescribed in the Budget Act and healthcare expenditures for FY 2000-01 to FY 2005-06, is provided as Appendix A of this report.

Despite significant increases in State spending, widespread concerns continue to exist over the adequacy of medical care being provided to inmates. These concerns led to lawsuits alleging substandard medical care and eventually resulted in the unprecedented appointment of a federal receiver (Receiver) to assume total control over the CDCR's inmate healthcare delivery system. Under a federal court order dated February 14, 2006, the Receiver assumed office effective April 17, 2006.

In addition, in February 2006, a federal court-appointed Correctional Expert found serious deficiencies in the CDCR's process of negotiating and managing its contracts for medical services. Among other issues identified, the Correctional Expert found millions of dollars in unpaid bills, some of which have been outstanding for as long as four years. In addition, some of the invoices could not be paid because services were performed without contracts. Further complicating matters, the CDCR was ordered by the federal court to pay this backlog of claims within 60 days. In order for the SCO pay these claims in accordance with the court order, the SCO was required to temporarily reassign staff resources and expend extraordinary efforts to meet the prescribed timeframe. Such conditions raise further questions over the integrity and soundness of the CDCR's spending practices.

The SCO fiscal review was initiated to ensure that CDCR healthcare expenditures are legal, necessary, reasonable, and for valid goods purchased or services performed.

Overview of the CDCR's Inmate Healthcare Delivery System

As of March 31, 2006, the CDCR had a total of 170,475 adults incarcerated in State prisons, camps, community correctional centers, and State mental hospitals. To provide inmates with needed medical care, the CDCR operates various medical facilities, including general acute care hospitals, correctional treatment centers, skilled nursing facilities, and outpatient housing units. Because it cannot provide all of the necessary healthcare services, the CDCR contracts with medical service providers—such as hospitals, specialty-care physicians, and laboratories—in the community. In addition, to address the chronic shortage of medical staff in various classifications, the CDCR in recent years has significantly expanded the use of registries to obtain various medical services. Such registries provide, at contracted rates, the services of medical personnel such as physicians, pharmacists, and nurses to perform many of the duties that are normally handled by the prisons' own medical staff.

Review Scope and Methodology

Based on an analysis of the CDCR's inmate healthcare expenditures (discussed in the following section of this report), the SCO focused on the department's expenditures for contracted services. According to its accounting records, the CDCR's expenditures for contracted services represent approximately 55.5% of its total healthcare expenditures ($821 million of $1.48 billion) for FY 2005-06. Past audits by the Office of the Inspector General (OIG) and the Bureau of State Audits (BSA) have disclosed internal control deficiencies in CDCR processes and procedures for managing its healthcare contracts that could lead to improper payments.

The SCO performed the following procedures.

- Reviewed pertinent statutes, regulations, and written policies and procedures regarding the CDCR's healthcare delivery system.
- Reviewed and analyzed the CDCR's healthcare budget and expenditures from FY 2000-01 to FY 2005-06.
- Reviewed previous audit reports issued by the Office of the Inspector General (OIG) and the Bureau of State Audits (BSA).
- Interviewed responsible officials at CDCR headquarters, including staff at the Health Care Services Division and other CDCR staff responsible for accounting, auditing, budgeting, contract service, personnel, and information technology functions.
- Conducted site visits of four CDCR prisons: California Medical Facility in Vacaville; California State Prison, Corcoran; California Substance Abuse and Treatment Facility in Corcoran; and Richard J. Donovan Correctional Facility in San Diego. Total FY 2004-05 expenditures for these four prisons was $206.6 million, or 19.5% of the department's $1.06 billion in inmate healthcare expenditures for the year.
- Interviewed staff members at the four State prisons visited including, but not limited to, chief medical officers, physicians/surgeons, pharmacists, nurses, Utilization Management (UM) nurses, and

Health Care Cost and Utilization Program (HCCUP) analysts. HCCUP analysts are responsible for reviewing and analyzing the institutions' healthcare expenditures and the invoices submitted by contractors to ensure compliance with terms specified in the contracts.

- Sampled, on a limited basis, previously paid invoices to evaluate the effectiveness of internal controls over payment processing and to determine whether payments were for services that are necessary, reasonable, and services actually performed.

Analysis of the CDCR's Inmate Healthcare Expenditures

As previously noted, the CDCR's inmate healthcare expenditures increased from $676 million in FY 2000-01 to $1.05 billion in FY 2004-05, an increase of $377 million (56%) over four years. Over the same period, the inmate population was constant, ranging between 160,000 and 164,000. During FY 2005-06, inmate population increased by approximately 7,000.

Total inmate healthcare expenditures continued to escalate during FY 2005-06. According to its accounting records, as of February 28, 2006, the CDCR's projected inmate healthcare expenditure was $1.25 billion compared to a budget of $1.05 billion per the 2005 Budget Act. Between February 28, 2006, and April 30, 2006, the department's expenditure projection increased by another $230 million, for a total of $1.48 billion in FY 2005-06. It should be noted that this figure significantly understates the total cost of inmate healthcare, as it does not include the costs for transporting inmates to facilities outside State prisons for medical care or costs for guarding inmates while they are outside of the prisons. Two of the institutions visited by the SCO during our review incurred well over $3 million each in unbudgeted overtime costs beyond their normal medical transportation and guard costs.

Increased costs for contracted services with outside hospitals, physicians, and other private healthcare providers accounted for all of the increases in inmate healthcare expenditures in recent years. Appendix B provides a summary of the CDCR's healthcare expenditures, by object code, for contracted services from FY 2000-01 through FY 2005-06. Total costs for contract services increased from $153 million in FY 2000-01 to a projected $821 million (April 2006 projection) for FY 2005-06, an increase of $668 million (437%). In FY 2000-01, contracted services represented 22.7% ($153 million to $676 million) of the CDCR's total inmate healthcare expenditures, whereas the ratio increased to 55.4% ($821 million to $1.48 billion) in FY 2005-06 (see Appendix C).

Previous audits have repeatedly identified deficiencies in the CDCR's processes and procedures for procuring and managing its medical service contracts. In October 2002, the Office of the Inspector General (OIG) found that the department lacks a comprehensive statewide policy for managing its medical service contracts. In April 2004, the BSA reported that the department did not seek competitive bids for most of its contracts for medical services, overpaid medical-service charges, and may have made payments for nonexistence services.

In another report, issued in July 2004, the BSA found that the department paid some hospitals two to eight times the amounts Medicare would have paid the same hospitals for the same inpatient service, and that certain contract provisions have resulted in the department paying higher amounts then necessary for inpatient and outpatient healthcare. In FY 2002-03, the audit period of BSA's July 2004 report, the CDCR's annual costs for contract services was $239 million in comparison to the projected $821 million for FY 2005-06, an increase of $582 million (244%) in three years.

Given this drastic increase in contracted expenditures, it is imperative that CDCR implement appropriate internal control measures to ensure that contracts are executed in the State's best interest and that payments are proper, legal, and for services actually rendered. Therefore, the SCO primarily focused on internal controls over the CDCR's processes and procedures for managing medical contracts and payments for medical contracts during this fiscal review.

This analysis was prepared based on data contained in the CDCR's accounting records. The SCO did not perform audit procedures to verify the accuracy of the department's accounting data.

Findings

The results of the SCO fiscal review presented here are broadly classified into three sections: contract management, utilization management, and internal control over payments.

CONTRACT MANAGEMENT

CDCR prisons have the authority to award services or purchase goods costing less than $5,000 without going through the CDCR Office of Business Services (OBS). The State prisons have authority to award contracts of up to $50,000 through competitive bids. For contract services valued between $50,000 and $75,000, the prisons are required to submit a bid proposal package to OBS, which reviews the bid package and awards the contract. For contracts valued over $75,000 that are not specifically exempted, the CDCR must solicit competitive bids from outside service organizations through the Department of General Services (DGS). The bid proposal packages are submitted to the DGS for review before being submitted for a statewide bidding process.

The Division of Correctional Health Care Services (DCHCS) and OBS are responsible for preparing the criteria for bid solicitation. The DCHCS establishes the Scope of Work and maximum acceptable compensation rates for contracts. The OBS reviews the bids for compliance with applicable State guidelines. Through this process, the CDCR enters into statewide or regional master contracts with various medical providers at specified rates.

The master contract serves as a tool that enables the State prisons to obtain services at pre-established rates rather than having to negotiate rates with each individual contractor. Once a master contract is in place, the institution can execute a Notice to Proceed (NTP) to commit funds based on the anticipated level of services at contracted rates. Contractors are not to perform any services until the NTPs are executed and funds are encumbered (committed) by the CDCR's Regional Accounting Office.

For many of the registry services, the CDCR uses the competitive-bid process to enter into multiple contracts with different medical registries for the same services. After submitting competitive bids, each registry is ranked; the ranking order establishes contact priority based on the rates submitted. When requesting services, State prisons are to first contact the registry with the lowest rate. If that registry is unable or unwilling to provide the necessary services, the State prison is to contact the registry with the next lowest contract rates. State prison staff members stated that they often had to contact several registries before locating a registry that could deliver the needed services.

FINDING 1—CDCR has not developed a comprehensive system-wide policy to manage its medical service contracts

The CDCR has not developed a comprehensive system-wide policy to manage its medical service contracts. Consequently, the department's contract management efforts are fragmented and inadequate to provide proper oversight over contract payments.

In its October 2002 report, the OIG noted that the CDCR's medical service contract costs have increased 82%, from $92 million in FY 1997-98 to $168 million in FY 2001-02; the OIG recommended that the CDCR adopt statewide policies and procedures for contract management. Since the release of the OIG report, CDCR's cost of medical service contracts have increased even more drastically, to a projected $821 million in FY 2005-06, an increase of $653 million (389%) over five years.

According to an OIG follow-up report issued April 2006, the CDCR established a health contract services unit to assist the State prisons with their medical service contract needs. The contract issues discussed in later sections of this report reveal that the efforts of the health contract services unit are clearly inadequate to address the institutions' contract needs. Moreover, from a statewide policy and procedure standpoint, the SCO found little evidence to suggest that CDCR headquarters has taken appropriate measures to provide proper oversight over contract expenditures. Specifically, the SCO found the following.

1. **Information that strongly suggests contractors may have engaged in abusive contract practices and that these issues have not been properly and promptly addressed.** Most of the State prisons' contractors provide services to multiple institutions under statewide or region-wide contracts. When a contractor engages in an abusive practice at a State prison, it is very likely that the same abusive practice exists at other State prisons. The SCO found that efforts to identify and address contract and billing abuses vary significantly, based on each State prison staff's volition. Moreover, when prison staff members do identify potentially abusive practices, such information is not always properly and promptly communicated to headquarters or other affected State prisons to prevent further abuse. For example, the CDCR entered into a region-wide contract with a medical provider for laboratory services at eight State prisons. The contract stipulates that, when the contractor uses a subcontractor to provide the laboratory service, the contractor shall be reimbursed the actual costs of laboratory tests as shown in the subcontractor's published price schedule. The contract further states that "billed charges for Send Out Testing will be disclosed on all invoices to CDC" and "Contractor will supply the (CDCR) with a copy of the subcontractor's rate schedule." The laboratory staff at the Substance Abuse Treatment Facility (SATF) suspected that the contractor had inflated the subcontractor's rates by supplying CDCR with an inaccurate, or possibly false, subcontractor rate schedule. According to the SATF laboratory staff, they knew that the rates were inflated because the subcontractor had the prior contract with the institution and the rates submitted by the new contractor for the subcontractor's services were significantly higher than what the institution has paid in the past.

The SATF laboratory staff provided the following additional information to SCO auditors.

- Despite specific contract requirements, the contractor refused to provide the SATF laboratory staff with invoices from the subcontractor to substantiate the rates charged. The SATF laboratory staff contacted the subcontractor directly and found that almost all of the contractor's rates exceeded the subcontractor's actual charges. For example, the contractor charged $250 for HCV Genotype tests, but paid the subcontractor only $135. The SATF laboratory staff then adjusted all of the contractor's invoices based on the rates furnished by the subcontractor. The adjustments totaled $36,550 of the $129,160 (28.3%) of the contractor's charges during FY 2004-05. While the contractor complained about the adjustments, it did nothing to refute them.

- The SATF laboratory staff brought the matter of contractor overcharges to the attention of the laboratory staff at California State Prison, Corcoran (CSP-Corcoran), who have yet to take action to adjust the contractor's billings. Moreover, the SATF laboratory staff indicated that six other State prisons are also continuing to pay the contractor at inflated rates. For the first 10 months of FY 2005-06, the seven State prisons (including CSP-Corcoran) paid a total of $1.48 million to the contractor. If the contractor's billing practices at the seven other institutions are consistent with its practices at SATF, the contractor has overcharged the CDCR by an estimated $418,000 ($1.48 million @ 28.3%) during the first 10 months of FY 2005-06.

- The contractor repeatedly provided SATF with inaccurate test results of hepatitis C. The SATF laboratory staff found that inmates previously tested positive for hepatitis C will often test negative when the same contractor runs the test at a later date. The contractor suggests that the test results vary based on antibody levels. The SATF laboratory staff questions this explanation because any antibody in an inmate's system would mean he or she has been infected with hepatitis C. Inaccurate test results resulted in inmates who did not have hepatitis C being given medication and inmates who did have hepatitis C not receiving necessary medication. The SATF laboratory staff further noted that many physicians have repeatedly raised concerns about the inaccuracy of test results and routinely requested that a university hospital repeat the tests of the contractor, thus duplicating the costs of laboratory services.

- The contractor does not provide the State prison with timely test results. The contract stipulates that any laboratory results revealing conditions that require immediate attention will be communicated by telephone and will be followed by written notification within three working days. According to the SATF laboratory staff, it almost always takes the contractor seven days or more to deliver the results.

- The SATF laboratory staff worked with a staff member at CDCR headquarters for more than five months to replace the contractor. However, the headquarters staff member left the department in 2003 and there has since been little action to pursue this issue. The SATF laboratory staff recently learned that CDCR headquarters renewed its contract with the contractor in question for three years effective July 1, 2006.

2. **Excessive delays in contract processing and procurement of medical equipment and supplies resulted in unnecessary expenditures, compromised services, and raised health and safety concerns.** State prison staff members interviewed told SCO auditors that it often takes months—sometimes over a year—to process a contract through CDCR headquarters and the DGS. The problem is further compounded by the CDCR's inability to meet the competitive bid requirement imposed under DGS Management Memo 05-04. In the absence of contracts, some State prisons continued to request services without contracts, while other prisons discontinued services altogether. The prisons also encountered similar delays in procurement of medical equipment and supplies that often resulted in unnecessary higher costs. Some examples include:

   - SATF staff, on February 28, 2005—seven months before the contract expiration date of September 30, 2005—requested contract renewals for four specialties (cardiology, radiology, urology, and pathology) at the same rates as the previous contracts. The State prison was notified by headquarters staff on September 30, 2005, that the contracts would not be renewed because of DGS Management Memo 05-04 abolishing the exemption of physicians, medical groups, and hospitals from the State's competitive bidding requirement. All of the clinics were closed for the entire month of October 2005. In an e-mail note dated September 30, 2005, a headquarters contract staff member told SATF staff, "If this will help, your institution is not the only one impacted." Later, headquarters staff instructed SATF staff members to continue using the specialists because headquarters intended to secure emergency contract extensions. However, DGS rejected the contract extension requests because they were not considered emergencies. As of March 31, 2006, the CDCR still has no contract in place for three of the four specialties (cardiology, urology and pathology). The same doctors continued to provide services, but they could not be paid until a federal court order was issued in April 2006 mandating payments. However, instead of seeing inmates at the prison, the cardiologist and the urologist can now see inmate-patients only at the community hospital that has a contract with CDCR; this situation has led to increased transportation and custody costs. With respect to radiology, headquarters directed SATF to use a statewide contract that doubled the rates the institution was paying the local provider. This issue is discussed further in under Finding 2 of this report.

- A contracted podiatrist for SATF was called to active duty in Iraq for at least six months. Despite the fact that some diabetic patients needed regular podiatry care, the institution waited for his return before any service could be provided. During the podiatrist's absence, the institution made only one outside podiatry referral.

- The former chief medical officer at CSP-Corcoran presented a proposal suggesting that the State could generate significant savings by acquiring equipment to perform liver biopsies in-house at various institutions. The former chief medical officer offered to train staff at other institutions to operate the equipment as well. The CDCR's records suggest that, to have a liver biopsy performed outside of the State prison would cost the department about $2,500 plus the costs of custody and transportation. After approximately 18 months, in the summer of 2005 the department finally acquired 10 machines at a cost of about $100,000. During FY 2005-06, 178 liver biopsies were performed in-house at CSP-Corcoran that led to more than $400,000 (178 @ $2,500 plus the costs of custody and transportation) in savings for this one State prison. However, the department has yet to facilitate training for use of this equipment at other State prisons. Most of the machines are still sitting idle and, presumably, other prisons are having outside facilities to perform liver biopsies at substantial cost. If the idle machines were in use, the CDCR would save an estimated $3.6 million in contracted medical services annually.

- It has taken approximately nine months to acquire the necessary parts to repair the oxygen system for one of the two surgery rooms (the other is not functional) at CSP-Corcoran. The repair equipment has been received, but the State prison still awaits a maintenance worker to make the repairs. In the meantime, the medical staff has been using and continues to use oxygen tanks in the operating room.

- At CSP-Corcoran, the prison's machine to ventilate toxic fumes arising from mixing oncology drugs failed to function for approximately 3-½ years. The new ventilation machine was not installed until May 2006. In the meantime, the oncologist initially mixed the drugs in the hospital's restrooms, exposing the staff to toxic fumes. After several staff filed worker's compensations claims, the prison's management directed the oncologist to cease this practice. The drugs were then mixed in the prison's parking lot until the new ventilation machine was installed.

FINDING 2—CDCR's contract negotiation process is deficient

The CDCR's contract negotiation process is deficient, resulting in the prison system continuing to pay significantly more than other major purchasers of healthcare services.

After the two BSA reports in 2004, CDCR took action to implement some of the audit recommendations. The department's effort was hampered in part by difficulties in recruiting physicians and other medical professionals. Given the nature of the patient population and the locations of many of the State prisons, the CDCR is in a poor bargaining position to recruit staff and negotiate favorable rates with hospitals, medical groups, and other medical professionals. In addition, the issuance of DGS Management Memo 05-04 and the ensuing chaos and confusion regarding implementation of the competitive bidding requirement for physicians, medical groups, and hospitals further hampered the department's contract negotiation efforts.

However, the SCO review found that CDCR compounded its problems by failing to properly use available information to minimize the State's healthcare costs. For example, in its July 2004 report, the BSA recommended that the CDCR obtain relevant data to estimate the hospitals' costs for use as a tool in contract negotiations and for monitoring the reasonableness of payments. The CDCR did not do so. As a result, in its efforts to implement the prior audit recommendations, CDCR often ended up paying even more to the medical providers after renegotiating its contracts. Some examples are noted below.

1. **CDCR initiated action to renegotiate contracts that resulted in the department paying considerably more to the contractor.** In its April 2004 report, BSA found that CDCR generally paid less when it was able to negotiate per diem, or daily fees, for specific services or outcomes, regardless of the actual charges. In its July 2004 audit, the BSA found that the CDCR was paying this particular hospital, on average, 4.16 times what Medicare would pay for the same inpatient care. According to officials from a hospital operated by the Tenet Healthcare Corporation (Tenet), the CDCR approached the hospital to renegotiate its contract for a per diem rate effective July 1, 2005. Based on payment data, the CDCR paid the hospital, on average, $2,789 per day in FY 2004-05 under the old contract; it paid an average of $3,994 per day in FY 2005-06 under the new contract, an increase of 43.2% over the previous year. In one case involving an inmate hospitalized from June 30, 2005, to July 5, 2005, the hospital invoice was split into two billings. The June 30 stay was billed and paid at a rate of $1,493, while the remaining four days were billed and paid using the new contract rate of $3,700, for a total of $14,800. Had the contract remained unchanged, CDCR would have paid $5,972 instead of $14,800. In amending the contract that pays the hospital more, the CDCR evidently failed to fully consider its current costs in arriving at the new contract rates.

2. **The CDCR contracted for rates well above what providers obtained from other purchasers of healthcare services.** A HCCUP analyst raised objections with the CDCR about the department contracting for rates that exceed a hospital's usual and customary rates. Usual and customary rates are hospitals' published rates for various services and supplies. In actual practice, the hospitals are willing to accept considerably less than the usual and customary rates. However, the department paid more than the usual and customer rates. The HCCUP analyst cited an example of a rehabilitation hospital that manually changed an invoice from $14,969.06 (usual and customary rate) to $21,312.06 (contract rate.) In an e-mail response, a contract manager at CDCR headquarters stated, "What's really unfortunate is that EVERY hospital we are negotiating is ending up two to three times higher."

3. **A prison was compelled to use the services of a contractor whose rate, negotiated under a statewide contract, was twice the rate of a local provider the prison was using**. Subsequent to the BSA's April 2004 audit report, the DGS issued Management Memo 05-04 requiring competitive bids for CDCR's medical contracts. CDCR encountered difficulties in recruiting medical providers—especially those with specialties—to submit competitive bids, and many institutions were forced to continue using the specialists to provide services without contracts. For example, one prison's contracts with a radiologist expired on September 30, 2005. The prison's request to renew the contract at the same rates as in the previous contract was rejected because it did not meet the competitive bid requirement. CDCR headquarters directed the prison's staff to contract with another provider through a statewide contract at rates that doubled the prison's cost for radiology services. The competitive bid requirement originated from the BSA's legitimate concerns about the CDCR's inability to determine the reasonableness of contract costs. The fact that the department is paying twice the rate of what the institution was able to obtain for the services of a local provider would appear to be contrary to the purpose and intent of the BSA recommendation.

4. **Some contractors may have been able to generate significant profits through their contracts with the CDCR with relatively little effort.** The CDCR awarded contracts to a provider for various services (oncology, physician, nursing, tele-medicine). For oncology, the negotiated contract rate is $315 per hour. However, an oncologist whom the contractor formerly employed as a subcontractor decided to directly contract with CDCR at much lower rates of $210 per hour at one prison and $175 per hour at another prison. Presumably, the lower rates are still higher than what the contractor was paying the oncologist, who otherwise would have no incentive to directly contract with CDCR. Therefore, the contractor apparently was generating at least $105 to $140 per hour in profits simply by making arrangements for the oncologist to provide services at the State prisons. Working out of his personal residence, the provider has contracts totaling approximately $91 million with various State prisons.

FINDING 3— CDCR pays hospitals based on percentage of hospital's billed charges

Despite a previous audit recommendation to the contrary, the CDCR continues to pay hospitals based on a percentage of their billed charges; such a practice leads to overpayments or billing abuses.

BSA's July 2004 report recommended that CDCR consider negotiating contract terms based on hospital costs rather than hospital charges for outpatient services, pharmaceutical, and supplies. However, the department continues to pay hospitals based on a percentage of the hospital's billed charges. Most HCCUP analysts interviewed told SCO auditors that they have not received any training nor have they been provided any guidelines on what constitute appropriate charges. This practice could lead to overpayments or billing abuses, as in many cases the institutions' staff cannot determine the reasonableness of the hospitals' charges. Some examples include the following.

1. A hospital billed CDCR $20,742.50 for administering two dosages of "Immune Globulin 1GM" to an inmate with cancer on December 10, 2004, and another $20,512.50 for one dosage of the same drug on December 15, 2004. Under the contract with the hospital, CDCR is to pay 30% of the invoice amount; the department paid the hospital $12,379.50 ($20,742.50 + $20,512.50 @ 30%) for the drug administered during those two days. According to the hospital's charge master listing, which reports the hospital's rates for services, supplies, and pharmaceuticals, the price for "Immune Globulin 10GM" is $1,648. Presumably, the charge for 1 GM of the same drug is far less than for 10 GM. In the Medi-Cal Program formulary files, the Medi-Cal payments for 5 GM and 10 GM of Immune Globulin were limited to $518.75 and $1,037.50, respectively, as of September 1, 2004. This pattern suggests that Medi-Cal would only pay a little more than $100 for 1 GM of Immune Globulin while the CDCR paid $12,379.50 for three such dosages.

2. The CDCR directly reimburses a contract orthopedic surgeon for surgeries performed on inmates at a local community hospital. The hospital, besides billing the department for all support services, routinely charges another $5,600 for each surgery performed by the surgeon by listing the same procedure code for the surgery. When the HCCUP analyst questioned the charges, hospital staff members said the additional charge is for the use of their facilities and is not a duplication of the cost of the surgery. A review of the hospital's invoices disclosed that the hospital already included charges for all of its services and facilities (i.e., anesthesiologist, pharmaceuticals, medical supplies, recovery room, etc.) in its billings. Moreover, our review of invoices from another hospital revealed that that hospital does not impose a charge above and beyond all of its services and facilities. However, as the contract with the hospital in question does not contain a provision defining what constitute allowable charges for billing purposes, neither the HCCUP analyst nor her supervisor could determine whether the additional $5,600 charge per surgery was reasonable or appropriate. Later, the prison reimbursed the hospital 70% of billed charges after being told by a utilization manager at headquarters that the charges were allowable. From a control standpoint, it is not prudent to have ambiguity in contract language that affords the hospital discretion in determining what to charge and the amount to charge.

3. A Tenet-operated hospital billed the CDCR $699 and $2,440 for an inmate's emergency room visit on May 3, 2005. In accordance with the contract terms, the CDCR paid $454 and $1,586, which represented 65% of the billed amounts. According to the Medicare Physician Guide, Medicare payments for the same procedure codes were $62.08 and $193.51, respectively. In this instance, the CDCR paid the hospital 7.3 to 8.2 times more than what Medicare would have paid for the same procedures.

4. Some HCCUP analysts told SCO auditors that they don't bother to review hospital charges because of their workload and because they have no basis by which to determine the reasonableness of the hospitals' charges anyway. Hospitals could easily err in the billings. For example, an invoice from one hospital shows $39,408 for 24 units of respiratory therapy for one inmate, when in actuality the charge should have been for 24 hours (1 unit) of therapy. In another case, the hospital billed $124,720 for drugs provided to an inmate during his hospital stay because of a coding error. In both instances, the HCCUP analyst caught the errors and, after discussion with the hospital staff, adjusted the billings. However, an HCCUP analyst who does not bother to review hospital charges may not have detected these errors and would have paid the inflated invoices.

FINDING 4— Opportunity for significant State savings delayed for years

An opportunity for significant State savings has been delayed for years due to protests and objections raised by a contractor who is financially benefiting from the delay.

The CDCR currently has about 150 inmates who need dialysis treatment. Except for those at California Medical Facility, which has a dialysis treatment facility, inmates at other institutions are transported outside the institutions three times a week for dialysis treatment. For over 10 years, Colonial Medical Group, Inc. (Colonial) has provided the treatments under a statewide contract that was issued on a sole-source basis. The current contract is effective through June 30, 2008, with a cancellation clause allowing each party to terminate the contract with a written notification.

Based on recent cost data at SATF and CSP-Corcoran, each dialysis treatment costs, on average, more than $400 plus costs of inmate transportation and custody while outside of the prisons. The practice of regularly transporting inmates outside of State prison also raises public safety concerns. Clearly, if there is a better and less costly alternative, it is to the department's best interests to vigorously pursue it. After years of deliberation, the CDCR, in August 2003, initiated a process to solicit competitive bids for contractors to perform dialysis services on-site at the State prisons.

After almost three years, the on-site dialysis treatment program has yet to be implemented at the State prisons because of discrepancies in contract licensing requirements, bid protests, and lawsuits. Furthermore, even after contracts were finally awarded to two successful bidders (Colonial and American Correctional Solution) in November 2005, the program still is not operational as of July 15. 2006, with Colonial raising new concerns in June 2006 that could further delay program implementation.

Following is a chronology of events relative to this issue.

August 7, 2003	Invitation for Bid (IFB) advertised.
October 27, 2003	Due to discrepancies in licensing issues, all six bids were rejected.
January 8, 2004	Re-bid issued.
January 30, 2004	Intent to Award was posted. American Correctional Solution (ACS), the next lowest bidder, was selected. The current contractor, Colonial, was the highest bidder. Colonial filed a bid protest that was rejected by DGS on March 16, 2004.
April 1, 2004	Contract approved and sent to ACS on April 2, 2004.
April 16, 2004	Bid package for on-site dialysis services at Wasco State Prison (WSP) released.
May 27, 2004	Bids were opened. ACS was the lowest bidder.
June 1, 2004	Award letter sent to ACS. Colonial filed a protest that was rejected by DGS on June 15, 2004.
July 13, 2004	CDCR notified ACS that the already-executed contract for on-site services at SATF and CSP-Corcoran is void because ACS is not licensed to perform the services for which it submitted its bid. The department based it decision on consultation with the Medical Board of California. CDCR also rescinded the award letter for WSP.
October 4, 2004	IFBs for on-site dialysis services were issued for three sites: SATF, WSP, and Kern Valley State Prison (KVSP).
January 11, 2005	Bids were opened for all three sites. Colonial was the lowest qualified bidder for SATF and WSP while ACS was the lowest qualified bidder for KVSP.
February 9, 2005	Intent to Award issued to Colonial and ACS.
February 23, 2005	Two disqualified bidders filed bid protests.
April 18, 2005	Awards were made to the lowest qualified bidders, as DGS dismissed both bid protests.
May 17, 2005	After one of the disqualified bidders filed a Petition for Writ of Mandate, the CDCR legal office instructed the contract staff to wait until a decision had been made by the department in consultation with DGS and the Attorney General's Office.
October 24, 2005	A decision was made to proceed with the contracts.
November 15, 2005	Contract with Colonial for on-site dialysis services at SATF and WSP was finalized effective November 15, 2005, to September 30, 2008. Contract with ACS for KVSP also was finalized for the same duration.
April 27, 2006	A superior court judge rejected the disqualified bidder's Petition for Writ of Mandate.

The SCO did not assess the reasonableness of the department's decisions and actions relative to the bid protests and legal challenges made by the bidders. However, it should be noted that Colonial, which is currently providing dialysis treatments at substantially higher rates than it will be able to under the new contract awarded by the competitive bid process, has little financial incentive to implement the on-site program expeditiously. Even though the contract was executed on November 15, 2005, the program is still not operational as of July 2006. Staff members at SATF were told that the program would be operational by August 2006. In early June 2006, Colonial raised new concerns about inadequate professional medical staff at SATF and refused to name a medical director until the State prison hires more staff members. Apparently, ACS does not share the same concerns as Colonial; it indicated that it was ready to proceed with the program at KVSP. As Colonial and ACS are to use the same subcontractor to perform the on-site dialysis services at the institutions, it is not clear why one provider would have concerns about the adequacy of medical staffing while the other does not. However, even though there is nothing in the original bid submitted or the contract awarded stipulating that additional staff members are needed, CDCR headquarters prohibited ACS from proceeding with implementation of the on-site program at KVSP. The project was placed on hold until the court-appointed receiver's office started making inquiries recently. On July 13, 2006, ACS was given approval to proceed with the program at KVSP. ACS has prepared an implementation plan projecting that the program will be operational by September 5, 2006. Colonial still has its two projects on hold and the State is continuing to incur higher costs for inmate dialysis treatments.

Before initiating the competitive bid process for the dialysis contract, SATF was instructed by CDCR headquarters to purchase supplies for the dialysis machines, pending the outcome of the competitive bidding process. The institution purchased 32 cases of syringes (500 units per case), which are currently stored at its warehouse. These syringes have become obsolete because of the excessive delay in program implementation and SATF is now confronted with finding a way to dispose of them without incurring considerable expense.

UTILIZATION MANAGEMENT

Given the high cost of obtaining medical care at outside facilities, it is far less expensive for inpatient and outpatient services to be performed by State medical staff at State facilities. In the absence of qualified State medical staff, the CDCR could reduce its costs by having contracted medical personnel perform the procedures at State facilities. To ensure that services—especially those referred to outside facilities—are medically necessary and in accordance with appropriate standards of care, the CDCR employs a utilization management (UM) process that provides for four levels of review. The process begins with the UM nurse, who is designated as the first-level reviewer. The UM nurse reviews requests for services based on established review criteria and reviews invoices to verify that charges are appropriate for services performed. The chief medical officer or the chief physician and/or surgeon is the second-level reviewer, evaluating any requests the UM nurse is unable to approve per program guidelines. The Medical Authorization Subcommittee is the third level of review; it considers requests that do not meet criteria, appeals, and complex cases. The fourth and final level of review and appeal is that of the Health Care Review Subcommittee.

FINDING 5—Need for outside hospital services increased

The CDCR's need for outside hospital services increased, as at least two of the department's four acute-care hospitals are functioning at a fraction of their capacity, resulting in increased costs for contracted services.

At considerable expense, the CDCR built four acute-care hospitals; these hospitals are located in California Medical Facility (CMF), CSP-Corcoran, California Institution for Men, and California Men's Colony. The department's intent was to save money by having the hospitals provide inpatient and outpatient medical services to the inmates incarcerated in those State prisons, as well as to inmates at other prisons.

The SCO auditors visited the hospitals at CMF and CSP-Corcoran and found that both hospitals are operating at only a fraction of their capacity. Meanwhile, the amount of contracted healthcare services has increased. The department has encountered difficulties in recruiting and retaining qualified medical personnel to staff the various hospital functions. The problem is compounded by the fact that the hospitals do not have adequate equipment, supplies, and needed supportive services such as anesthesia service for their surgery rooms. In addition, decisions made by CDCR management to convert the prison hospitals' acute-care beds for other uses also severely curtail inpatient and outpatient services performed at the prison hospitals. Therefore, instead of treating inmates from other State prisons, the two hospitals are sending the inmates from their own prisons to outside hospitals, sometimes for minor surgeries. Specifically, the SCO found that:

1. The number of surgeries has declined significantly at CMF. Major surgeries performed at the prison hospital declined from 291 in 2000 to eight in 2004 and eight in 2005. Minor surgeries remained fairly constant, at 760 in 2000 to 679 in 2005. Of the 679 minor surgeries performed at CMF in 2005, 104 were for pain management and 404 were for minor procedures such as colonoscopies.

2. CSP-Corcoran staff could not provide data separated by major and minor surgeries. Available data show that the prison hospital completed 1,075 in-house surgery cases during 2003, compared with 958 in-house surgery cases during 2005. The prison hospital has two operating rooms. According to the medical staff, one of the operating rooms is functioning at a very limited capacity and the other one has not been functional since the hospital was built in 1993, due to a lack of proper equipment and supplies and inadequate staffing.

3. One of the explanations for the decline in surgeries performed at CMF is the lack of acute-care beds. Citing nurse shortages, CDCR management in 2004 de-commissioned all but seven of its 72 acute-care beds over the strong objections of the medical staff at the prison hospital. According to medical staff at the hospital, it would be very expensive to reconvert these beds to acute-care beds because current licensing requirements are much more stringent. Most of the beds are now being used for inmates with long-term care needs. At CSP-Corcoran, the chief medical officer estimates that between 90% to 95% of the prison hospital's 52 licensed acute-care beds are now being used by inmates with long-term needs. Consequently, inmates with acute-care needs must be redirected to outside facilities at significantly higher costs to the State.

4. At CMF, contract services increased from $12.6 million in FY 2000-01 to a projected $54.2 million in FY 2005-06. At CSP-Corcoran, contract services increased from $6.7 million to a projected $19.7 million over the same period.

FINDING 6—CDCR's utilization management process is ineffective

CDCR's utilization management process is ineffective in ensuring that services are necessary and consistent with prescribed guidelines or that contractors' charges are appropriate.

The Utilization Management (UM) nurses at the CDCR are the first-level reviewers of requests for services; they ensure contractors' compliance with prescribed guidelines and review contractors' invoices to verify that charges are appropriate for services performed. Some UM nurses interviewed told SCO auditors that they never received any training concerning review guidelines, protocols, and procedures, and that their heavy workloads limit the scope of their reviews. The UM nurses also said that they are often reluctant to question the judgment and decisions of specialists, despite the fact that the specialists may have financial incentives to make referrals. In some cases, the State prison's management could circumvent the utilization review process. Therefore, the UM nurses' review and monitor efforts are not always effective. Specifically, the SCO found that:

1. After a significant increase in the contracted rates, as disclosed under Finding 2 of this report, the Tenet-operated hospital's in-patient days increased from 2,111 days in FY 2004-05 to 2,928 days for the first 11 months of FY 2005-06, an increase of more than 38.7% in utilization. According to a "Monthly Budget Plan" prepared by the State prison's staff, total expenditures for this hospital were expected to increase from $2,712,831 in FY 2004-05 to a projected $8,097,468 in FY 2005-06, an increase of 298%. The SCO auditors

selected a limited sample of the in-patient cases for review and found that:

- A UM nurse's review note shows that an inmate did not meet the criteria for hospital stay; however, she left a note indicating "No further Action?" in the inmate's medical file. This inmate was hospitalized for three days in May 2006. The prison's staff could not provide any documentation or explanation justifying the deviation from established criteria. The total hospital charges were $10,200 at $3,400 per day.

- Another inmate was also hospitalized for three days in May 2006. The UM nurse's note indicated that the inmate met the criteria for hospital admittance on the first day only and requested that the inmate be immediately discharged. Therefore, the inmate should have stayed at the hospital for two days at most. However, hospital records should that the inmate was discharged a day later, resulting in an additional $3,400 charge for the extra day. Neither the file at the State prison nor the hospital could explain the delay in the discharge of this inmate.

- An inmate was admitted to the hospital on April 1, 2006, complaining of chest pain. The UM nurse's note stated, "it is doubtful that it is cardiac" and yet the inmate was retained in the telemetry unit for two days. On the fourth day, a cardiologist ordered a myocardial perfusion scan (MPS). The MPS and laboratory test results were negative and a physician note stated, "there was nothing further to do for this patient." In fact, on the fifth day, the cardiologist's note stated, "patient claims to have shooting chest pain but was watching TV without apparent problem." The inmate was not discharged until the seventh day, April 7, 2006, and the institution incurred $25,060 in hospital charges for the inmate's seven-day stay.

- An inmate was kept at the hospital for two extra days after he was discharged on May 14, 2006, because the prison hospital's infirmary had no bed space. The two additional days cost another $6,800.

- The attending physicians' review notes were either incomplete or could not be located for the sample cases selected by SCO auditors.

2. At one of the State prisons, the chief medical officer (CMO) overrode the UM nurse's objections and approved a contract physician's request to refer an inmate to a hospital that is supposed to be used for emergency services only. In a memorandum dated February 2, 2006, the UM nurse noted that the prescribed procedures were prearranged; however, the institution's contract with the hospital stipulated that it is to provide urgent/emergency services only. Apparently, the deviation from prescribed procedures occurred to accommodate the referring contract physician, who has hospital privileges only at the hospital that is to provide urgent/emergency services.

3. The same CMO also specifically exempted one contracted physician from the UM nurse's review. In response to SCO auditors' questions, the CMO stated that the contracted specialist has been working at the facility for years and in the past has had personality conflicts with the UM staff. The contracted specialist believes that his decisions should not be questioned by less experienced medical staff as long as he follows applicable medical standards governing his specialty. This rationale does not appear to be justifiable as, presumably, other contacted specialists who are subjected to the UM review process are also required to follow applicable medical standards governing their specialties. This rationale is also contrary to the purpose and intent of the UM review process, which was established, in part, to provide the necessary checks and balances against unnecessary and excessive referrals by individuals for financial gain.

4. A contracted ophthalmologist informed the SCO auditors that she sometimes performs work that results from a State prison's contracted optometrist's workload overflow. The contract rate for the optometrist is $67.50 per hours, whereas the ophthalmologist was regularly paid more than $400 per hour, and as much as $580 per hour in some instances, by charging on a per-patient basis.

FINDING 7— Decisions regarding medical treatment are made based on legal considerations

During interviews, most of the State prison's medical staff acknowledged to the SCO auditors that an increasing tendency exists to refer inmates to outside facilities to avoid litigation. Medical staff members believe that inmates are prone to file lawsuits that could, regardless of the outcome of the cases, blemish their records. Therefore, they sometimes make referrals knowing that the cases do not need to be referred to an outside facility. In addition, the State prison's management is sometimes reluctant to authorize in-house services after weighing the potential fiscal impact of lawsuits against questions about the competency of the prison's medical staff and the adequacy of the prison's facilities and equipment.

The scope of the SCO fiscal review does not include evaluation of medical necessity, as such an evaluation would require special medical expertise. However, the following two cases suggest that medical decisions were influenced by legal considerations to avoid litigation, to the detriment of cost-effective patient care.

1. An inmate serving a life sentence was stabbed while in a State prison. He became a quadriplegic, and the State already spent considerable sums on his medical care and rehabilitation costs. At the insistence of his family, the inmate continues to receive services/ treatments that are deemed unnecessary or excessive by the prison's medical staff.

    - *Around-the-clock nursing care by contract registry nurses assigned solely to him*. The inmate's nursing care was $312,559 for FY 2004-05 and $238,402 for the first ten months of FY 2005-06.

- *Specially ordered catheters*. The inmate's family demanded special catheters that cost $441.20 for a box of 100; other inmates' catheters range between $13.60 and $131 for a box of 100. CSP-Corcoran's medical staff members believe that a permanent catheter shunt is most appropriate under the circumstances. At the insistence of the inmate's family, who feel he needs regular human contact, the inmate's catheter is replaced twice daily.

- *Unnecessary special treatment*. The inmate was transported by ambulance to the University of California at Davis Hospital for treatment of a kidney stone because he expressed dissatisfaction with the local urologists. Despite concerns raised by the institution's medical staff as to its necessity, CDCR headquarters authorized the special treatment. The ambulance ride cost $8,237 for the initial visit and $7,421 for a follow-up visit.

2. On June 4, 2006, an inmate with a history of self-mutilation was sent to a community hospital for a minor surgical procedure despite the fact that the State prison has an acute care hospital. The prison hospital's chief surgeon said he could perform the surgical procedure at the prison hospital immediately. However, the State prison's management, citing the lack of an anesthesiologist that could result in lawsuits, sent the inmate to a community hospital. The hospital performed the procedure and admitted the inmate until June 6, 2006, at a total cost of $3,726. The inmate, upon discharge from the community hospital, again needed the same surgical procedure and was transported to another community hospital, where he waited for hours in the emergency room. When the community hospital would not admit the inmate, he was transported back to the State prison, where the chief surgeon performed the procedure using local anesthesia. According to the chief surgeon, it was a very simple procedure, which he completed in approximately 15 minutes.

INTERNAL CONTROL OVER PAYMENTS

After medical services are completed, the contractor who performed them sends an invoice to the CDCR's regional accounting office (RAO) for payment processing. Upon receipt, the RAO is to review the invoice to ensure that a contract is in place and, if a payment discount is available, take measures to ensure expeditious processing of the invoice. The invoice is then forwarded by the RAO to a contract manager at the State prison for review. Generally, the contract managers are the State prisons' HCCUP analysts, whose job it is to monitor the contractor's performance to ensure compliance with all contract provisions.

The HCCUP analysts' specific duties include:

- signing invoices for approval to pay;
- ensuring that the contractor is performing services in accordance with the contract requirements;
- monitoring the use of the contract (i.e., availability of funds);
- verifying that invoices correspond to services provided;
- evaluating contract performance; and
- initiating amendments as needed.

Upon receipt of the invoice, the HCCUP analyst forwards it to the contract monitor for review and approval. The contract monitors are typically the supervisors and managers who oversee the delivery of healthcare services (e.g., chief medical officers, pharmacy managers, laboratory managers, director of nursing, etc.). The contract monitor is to verify that the services were appropriate and are supported with appropriate documentation, such timesheets, sign-in logs, etc. After the invoice is approved and signed, the contract monitor returns the invoice to the HCCUP analyst for review and approval. After the contract monitor and the HCCUP analyst approve the invoice, it is returned to the RAO, which prepares a claim schedule for payment processing. Invoices that offer discount are paid directly through the RAO's office's revolving fund to ensure that payments are made within the discount period.

FINDING 8— State prisons' internal control is ineffective

Internal controls at State prisons are ineffective in identifying and preventing overpayments and billing abuses.

The HCCUP analysts at State prisons are responsible for ensuring that the contractors' charges are reasonable and consistent with the terms of the contracts. Many HCCUP analysts interviewed told SCO auditors that they have had little or no training on what to look for in their review of contractors' charges. Some HCCUP analysts said they do not have the time to thoroughly review the contractors' charges. In some cases in which the HCCUP analyst identified practices suggesting possible overcharge, the contractors were paid anyway due to the ambiguity in contract terms. In addition, as discussed in Finding 3 of this report, some HCCUP analysts said they cannot determine the reasonableness of the hospitals' charges when the hospitals are reimbursed based on a percentage of the amount billed.

The SCO auditors selected a limited sample of invoices for review and identified evidence suggesting possible overpayments or billing abuse at each of the four State prisons visited. Specifically, the SCO found that:

1. Contractors may have inflated their charges by billing at a higher level for services than what they should have charged. CDCR contracts allow some providers to bill the department on a per-patient basis that assigns a reimbursement rate for each procedure performed under the Current Procedural Terminology (CPT) codes instead of an hourly rate. Different CPT codes are assigned to each medical procedure (i.e., office visit) depending on the extent or the level of services performed. The SCO review found that some contractors have inflated their charges by billing at a higher level than those for actual services performed. Some examples include:

   - An urologist under contract with two State prisons bills based on CPT codes. The prisons' records show he was paid $400,000 for making occasional clinical visits to the two State prisons during FY 2004-05. According to gate logs, the urologist made, in total, 78 clinical visits ($5,128 per visit) to the two State prisons and typically spent three to six hours during his visits. The CPT codes he used appear to be appropriate for higher levels of services than the actual services he performed. For example, in July 2004, the urologist spent a total of 21.1 hours over five days (an average of a little more than four hours per day) at the prisons. Further review of data revealed that he used CPT 99244 for most diagnostic consultations and CPT 99223 for in-patient hospital evaluations. According to the guidelines, CPT 99244 is to be used for consultations in which the physician typically spends 60 minutes face-to-face with the patient and CPT 99223 is to be used for initial hospital care whereby the physician typically spends 70 minutes at the patient's bedside. Based on these guidelines, the urologist should have worked approximately 73 hours instead of 21.1 hours in July 2004. The urologist was paid $42,922 for 21.1 hours of work in July 2004, or $2,036 per hour.

     In August 2004, at the instruction of a former chief medical officer, both State prisons reduced the urologist's billings to reflect the CPT code for 30 minutes instead of 60 minutes. The urologist was notified of this action and he did not contest it. No adjustments were made to amounts previously paid and, even at reduced rates, the urologist would still be paid at about $1,000 per hour. Furthermore, the urologist continues to bill using the original procedure codes. Therefore, unless the prison staff takes action to adjust the amounts billed, he will continue to be paid inflated rates. Such adjustments are not always made—the SCO found at least one instance in which the urologist's invoice was not adjusted, for April 2006.

   - On July 7, 2005, an ophthalmologist billed for 33 patients, 20 of them under CPT 99244. According to guidelines, CPT 99244 is a comprehensive examination that entails the physician spending about 60 minutes face-to-face with the patient. The prison's gate log shows that on July 7, 2005, the ophthalmologist spent eight

hours at the prison, or saw about four patients per hour. It would appear that a lower-level procedure code, such as CPT 99241—which calls for a 15-minute examination—would be more appropriate. The ophthalmologist was paid $4,679.70 for July 7, 2005, or $580 per hour.

The HCCUP analyst at the State prison told SCO auditors that she has previously raised questions about the appropriateness of the contractor's charges but was told by management that the charges are allowable under the contract. However, the prison's contract with the ophthalmologist expired in September 2005, and she continues to provide services while billing based on CPT codes. Meanwhile, under a statewide contract, the State prison has issued a Notice to Proceed to another provider, for ophthalmologist services at $170 per hour, with an effective date of November 21, 2005. According to the new contractor, the State prison has not requested services under the new contract. When SCO auditors questioned why the prison would use a provider without a contract instead of a provider with contract—and apparently at a lower rate—the prison's staff said that the new contractor could not provide the services because of a lack of staff resources, an assertion disputed by the new contractor, who said he was told that the prison was working with another contractor and was in no need of immediate services.

2. Contractors billed based on CPT codes when the contract terms specify reimbursement at hourly rates. Some contracts specify that the providers are to be paid at hourly rates for clinical services, including minor procedures that are normally performed during an office visit. The contracts allow the contractors to use CPT codes only for those procedures not rendered during regular clinical visits. However, some contractors ignored the hourly rate provision and billed exclusively based on CPT codes. For example:

   - According to a contract, effective October 1, 2002, to September 30, 2004, between an orthopedic surgeon and two State prisons, the provider was to be paid at $175 per hour for clinical services and at rates based on CPT codes for surgical procedures. However, the surgeon used CPT codes for all of his billings, including clinical services. For example, in August and September 2004, the surgeon held seven clinics during which no surgical procedures were performed. Had he been paid at $175 per hour as specified under his contract, he would have received approximately $9,000. In actuality, because he used rates based on CPT codes, he was paid $28,124.50 (more than $4,000 per day), which is approximately $19,000 in overpayment. However, instead of requiring the surgeon to comply with the terms of his contract, in February 2005, five months after the contact had expired, the CDCR retroactively amended the contract and eliminated the $175 hourly rate for clinical services citing a prior verbal agreement between CDCR headquarters and the contractor.

During FY 2004-05, the surgeon was paid $1.48 million for providing clinical and surgical services to inmates at the two State prisons. A review of his billings revealed that he may also have been billing at higher levels of services than actual services provided. Based on his invoices from July 2004 through September 2004, the surgeon sees between 15 and 30 patients per clinical visit and bills all patient visits using CPT 99205 and 99215. CPT 99205 is for 60-minute consultations and CPT 99215 is for 40-minute follow-ups. One of the surgeon's billings shows that he saw 35 patients—14 at CPT 99205 and 21 at CPT 99215 during one prison visit. The 35 procedures should require approximately 30 hours to complete, which is not possible to accomplish in one visit.

- A contract between a surgeon and a State prison specifies that the surgeon is to be reimbursed at $100 per hour for clinical services, and at rates based on CPT codes for procedures not rendered during scheduled clinics. However, the surgeon instead bills and is paid in accordance with rates based on CPT codes for all of his services in violation of contract terms. Over a five-month period, the surgeon made nine clinical visits to the prison. The prison has no record showing how long the surgeon actually stayed at the prison. However, even if he had worked eight hours per day during each of his visits, he should have been paid a total of only $7,200, based on the rate specified in his contract. Instead, at rates based on CPT codes, he was paid $21,390, an overpayment of $14,190.

3. The owner of a pharmacy registry, acting as the chief pharmacist for one of the State prisons, regularly schedules overtime for himself and his employees. Due to the chronic shortage of pharmacists, two State prisons contracted with a pharmacy registry to staff its pharmacy operations; the owner of the registry serves as the chief pharmacist for one of the State prisons. The contract between the pharmacy registry and the prisons stipulates that, "CDC shall only pay overtime to contractor for unanticipated events, such as an institution emergency after a regular work schedule greater than 8 hours or lock-down at time and one-half the hourly rate." In actual practice, the contractor and his staff routinely scheduled overtime that resulted in total monthly charges (including regular hours and overtime) ranging between $22,000 and $33,000 for each pharmacist. The pharmacists also charge stand-by (on call) hours at an overtime rate of $148 per hour, even though no provision exists in the contract authorizing such payments.

4. A State prison could not produce evidence to support a contract physician's monthly charges or that the physician met the contract requirement of being board-certified. A physician registry provided three physicians to a prison at a rate of $200 per hour under a statewide contract. Under the terms of the contract, the physicians must be board-certified physicians, as the contractor is to provide internal medicine to high-risk inmates and those with chronic illnesses. The contract rate of $200 per hour is significantly higher than the rates the State prison could obtain through the local registry,

presumably because of the board-certification requirement. However, two of the three physicians were not listed as board-certified according to the American Board Certification Web site. When asked, the prison's chief medical officer told SCO auditors to check with the owner of the registry for an explanation. It is the CDCR's responsibility to ensure that physicians fully meet contract requirements regarding qualification. In addition, for one of the two physicians who are not listed as board-certified, the prison could not produce any documentation such as timesheets or personal gate logs to support a monthly charge of $33,572 (167.86 hours at $200 per hour). Further review of documents found that the names of some inmates listed on the contractor invoices—whom the physician had supposedly seen—did not appear on the appointment logs, and that the medical charts of two inmates reviewed did not contain evidence showing that the physician had actually treated the inmates. The SCO auditors then provided the State prison administrators with the names of the inmates, as they appeared on the contractor's invoices, and requested evidence verifying that services had been provided to those inmates. The prison's staff could not locate any such evidence, which raised questions concerning the legitimacy of the monthly charge.

Recommendations

The SCO recognizes that the Receiver has initiated action to revamp the CDCR's healthcare delivery system. The SCO also recognizes that the Receiver, working with the staff of CDCR and other state departments such as DGS, is in the process of developing processes and procedures to improve and streamline the State's contracting process relative to CDCR's medical contracts. As a part of this reform effort, the Receiver should consider the following measures.

Recommendation 1

Explore means to minimize the State prisons' reliance on outside contract services by improving and expanding the State prisons' capabilities to deliver needed medical services in-house. Consideration should be given to:

- Recruiting and retaining sufficient and competent medical staff. Review medical staff compensation levels to ensure that salaries are sufficient to attract qualified staff members and are commensurate with staff members' professional responsibilities.
- Modernizing the prisons' facilities to provide sufficient space, proper equipment, and adequate supplies to enable the prison staff to carry out essential functions.
- Employing modern technology to promote operational efficiency in various aspects (i.e., inmate medical records, pharmaceutical prescription system, etc.) of the healthcare delivery system and functions.

Recommendation 2

Improve the CDCR's contract management system by:

- Recruiting and retaining individuals who are familiar with contracting and administrative practices of the healthcare industry. Establish a compensation level sufficient to attract a highly qualified team of professional healthcare administrators to manage the various critical functions.
- Adopting, when appropriate, the contracting practices of other major purchasers of healthcare services and developing appropriate contract language patterned after that of other major purchasers.
- Establishing a system that would provide accurate, reliable, and timely data concerning expenditures trends, utilization patterns, and other relevant information relative to the State prisons' healthcare operations. The CDCR should utilize such data as well as data from healthcare providers in contract negotiations and contract management.
- Streamlining the contracting approval process by eliminating unnecessary or redundant procedures and prescribing a timeframe for each step of the contract review process.
- Developing a policy to immediately and appropriately address situations in which the State prisons' staff find evidence suggesting that a contractor may have engaged in abusive billing practices and to ensure that these practices are not extended to other prisons.

Recommendation 3

Improve the utilization management (UM) process by:

- Reviewing and evaluating the current UM processes and, when appropriate, making modifications to ensure that services performed are necessary, appropriate, and in accordance with appropriate standards of care.
- Reviewing current staffing levels at the State prisons, especially with respect to UM nurses, to evaluate the adequacy of staff resources to carry out the functions of the UM process. Review the level at which UM nurses are compensated and make adjustments if appropriate. If staff resources are deficient, the CDCR should hire additional staff.
- Clearly defining the functions and responsibilities of each individual involved in the UM process.
- Disseminating the UM guidelines to all staff engaged in the UM function and ensuring that staff obtain appropriate training.
- Periodically conducting additional training sessions to disseminate changes in policies and procedures, emphasizing the need to adhere to established guidelines, providing a forum in which to exchange ideas and identify and address common issues/problems.

Recommendation 4

Strengthen internal control over payment by:

- Reviewing and evaluating current payment review procedures and, when appropriate, making modifications to ensure that contractors' charges are reasonable, in compliance with contractual terms, and for actual services performed.
- Reviewing current staffing levels at the State prisons and regional accounting offices, especially that of HCCUP analysts, to evaluate the adequacy of staff resources assigned to the payment review and payment processing functions. If staff resources are deficient, the CDCR should hire additional staff. Review the level at which HCCUP analysts are compensated and make adjustments if appropriate.
- Clearly defining the functions and responsibilities of each individual involved in the payment review function.
- Providing semi-annual training to HCCUP analysts to disseminate changes in policies and procedures and providing a forum in which to exchange ideas and identify and address common issues/problems.
- Requesting that the CDCR's audit staff in the Program and Fiscal Audit Branch (PFAB) develop plans to audit a sample of paid medical invoices to ensure that the reviews by HCCUP analysts are effective in preventing overpayments. A report summarizing the results of the PFAB audits should be published on a quarterly basis. Audit findings should be promptly addressed.
- Initiating action to recoup overpayment from contractors and, if evidence suggest intentional abuse, referring the matter to the Attorney General's Office for consideration of legal action against the contractor.

Appendix A—
Comparison of Healthcare Budget and Expenditures

California Department of Corrections and Rehabilitation
Comparison of Healthcare Budget and Expenditures
From Fiscal Year 2000-01 through Fiscal Year 2005-06

	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	
Appropriations (Per Budget Act)	$ 585,080,000	$ 663,783,000	$ 835,879,000	$ 907,098,000	$ 940,763,000	$1,037,722,000	
Expenditures	675,603,403	796,773,467	878,940,830	967,821,280	1,052,375,309	1,481,424,818	*
Variance	$ (90,523,403)	$ (132,990,467)	$ (43,061,830)	$ (60,723,280)	$ (111,912,309)	$ (443,732,818)	

Source: Budget Act, Governor's Budget, and CDCR's accounting records.

* Projected amount, as reflected in CDCR's accounting records, as of April 30, 2006.

Appendix B—
Comparison of Expenditures for Contracted Services

California Department of Corrections and Rehabilitation
Comparison of Expenditures for Contracted Services
From Fiscal Year 2000-01 through Fiscal Year 2005-06

Object Code		FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06 Projected Amount *
3 26 413	HEALTH & MEDICAL-EXT SVS	$ 66,778	$ 683,456	$ 155,390	$ 319,441	$ 631,670	$ 6,255,513
3 26 413 01	HEALTH & MED: CONSULTANT-IN-HOUSE	12,096,752	12,956,099	12,499,975	13,132,632	10,486,409	32,236,078
3 26 413 02	HEALTH & MED: CONTRACTUAL/EXT	90,807,388	112,465,416	135,780,430	157,508,621	171,420,940	392,058,560
3 26 413 06	HELATH & MED: REGISTRY	28,866,076	46,790,567	63,821,922	74,550,198	89,237,744	314,622,539
3 26 413 07	HEALTH & MED: CONSULTANT - COM	21,659,871	25,987,723	25,896,954	32,348,491	38,227,184	71,491,611
3 26 413 08	HEALTH & MED: LAB - BLOOD BANK	89,440	155,444	190,371	120,976	119,760	4,132,747
	TOTAL	$ 153,586,305	$ 199,038,705	$ 238,345,042	$ 277,980,359	$ 310,123,707	$ 820,797,048

3 26 413 01 Costs for services of contracted physicians, dentists, etc., provided within the institution.
3 26 413 02 Includes the community hospital services contracts. Also includes other contracted technical services, such as lab, x-ray, and private ambulance transportation contracts.
3 26 413 06 Registry services costs, such as nursing and pharmacy.
3 26 413 07 Contracted physician services, dental care, therapy services, etc., costs for services provided outside the institution in a community facility.
3 26 413 08 Costs for lab work/tests, blood and blood-related products purchased from blood banks.

Source: CDCR accounting records

* Projected amount, as reflected in CDCR's accounting records, as of April 30, 2006.

Appendix C—
Comparison of Total Healthcare Expenditures and Contracted Services Expenditures

California Department of Corrections and Rehabilitation
Comparison of Total Healthcare Expenditures and Contracted Services Expenditures
From Fiscal Year 2000-01 through Fiscal Year 2005-06

	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06
Total healthcare expenditures	$ 675,603,403	$ 796,773,467	$ 878,940,830	$ 967,821,280	$1,052,375,309	$1,481,424,818 *
Total contracted services expenditures	$ 153,586,305	$ 199,038,705	$ 238,345,042	$ 277,980,359	$ 310,123,707	$ 820,797,048
Ratio	22.7%	25%	27.1%	28.7%	29.5%	55.4%

Source: Budget Act, Governor's Budget, and CDCR's accounting records.

* Projected amount, as reflected in CDCR's accounting records, as of April 30, 2006.

Appendix D—
List of Acronyms

ACS	American Correctional Solution
BSA	Bureau of State Audits
CDC	California Department of Corrections
CDCR	California Department of Corrections and Rehabilitation
CMF	California Medical Facility
CMO	Chief Medical Officer
CPR	California Prison Receivership
CPT	Current Procedural Terminology
CSP-Corcoran	California State Prison, Corcoran
DCHCS	Division of Correctional Health Care Services
DGS	Department of General Services
FY	Fiscal Year
HCCUP	Health Care Cost and Utilization Program
IFB	Invitation to Bid
KVSP	Kern Valley State Prison
MPS	Myocardial Perfusion Scan
NTP	Notice to Proceed
OBS	Office of Small Business
OIG	Office of the Inspector General
RAO	Regional Accounting Office
SATF	Substance Abuse Treatment Facility
SCO	State Controller's Office
UM	Utilization Management
WSP	Waco State Prison

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